Washington State Comprehensive Mental Health Plan

*** D R A F T ***

September 30, 2006

Mental Health Transformation State Incentive Grant

Comprehensive Mental Health Plan for the STATE OF WASHINGTON

D R A F T

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Mental Health Transformation Project Background

Presentation to the Mental Health Task Force
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TWG Meeting Handouts
Vision, Goals, and Objectives
Subcommittee Reports
Subcommittee Combined Outcomes Summary
Task Group Presentations and Supplemental Reports, Documents
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Newsletters

MHTP Participants and Contributors

TWG members and alternates
Subcommittee Members
Task Group Members
Research Committee Members
Contractors

List of MHTP-related Meetings

Framework for a Coordinated Mental Health System

Mental Health from a Public Health Perspective: Presentation to the Mental Health Transformation Working Group, April 21, 2006

Mental Health Framework Circles Expanded

What is mental health?

ACRONYMS

ADSA	Aging and Disability Services Administration, Department of Social and Health Services
CA	Children's Administration, Department of Social and Health Services
CAMIS	Case and Management Information System
CIT	Crisis Intervention Team
CLIP	Children's Long-Term Inpatient Program
CMHC	Community Mental Health Center
CMHP	Comprehensive Mental Health Plan
CMHS	Center for Mental Health Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CMS	Centers for Medicare and Medicaid Services
CODIAC	Co-Occurring Disorders Interagency Committee
CSDB	Client Services Database
CTED	Department of Community, Trade, and Economic Development
CTP	Community Transformation Partnership
CSDB	Client Services Database
DASA	Division of Alcohol and Substance Abuse, Department of Social and Health Services
DOC	Department of Corrections
DOH	Department of Health
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation, Department of Social and Health Services
EBP	Evidence-Based Practice
EBPEP	Evidence-Based/Promising/Emerging Practices Task Group
ECCS	Early Childhood Comprehensive Systems
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESA	Economic Services Administration, Department of Social and Health Services
ESD	Employment Security Department
FACET	Family and Consumer Evaluation Team
GPRA	Government Performance and Results Act
HIIS	Health Integrated Information System
HRSA	Health and Recovery Services Administration, Department of Social and Health Services
ICCD	International Center for Clubhouse Development
IPAC	Indian Policy Advisory Committee

JRA	Juvenile Rehabilitation Administration, Department of Social and Health Services
MHD	Mental Health Division, Department of Social and Health Services
MHD-CIS	Mental Health Division–Consumer Information System
MHPAC	Mental Health Planning and Advisory Committee
MHSIP	Mental Health Statistics Improvement Project
MHTP	Mental Health Transformation Project
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NAMI	National Association for the Mentally Ill
NOMS	National Outcome Measures
NPAIHB	Northwest Portland Area Indian Health Board
OCA	Office of Consumer Affairs, Department of Social and Health Services, Mental Health Division
ORCA	Outreach for Recovery and Consumer Advocacy
OSPI	Office of the Superintendent of Public Instruction
PACT	Program for Assertive Community Treatment
PAS	Personal Assistance Services
PIHP	Pre-paid Inpatient Hospital Plan
PTSD	Post-Traumatic Stress Disorder
RCW	Revised Code of Washington
RDA	Department of Social and Health Services, Division of Research and Data Analysis
ROSI	Recovery Oriented System Indicators
RSN	Regional Support Network
SAFE-WA	Statewide Action for Family Empowerment in Washington
SAMHSA	Substance Abuse and Mental Health Services Administration
SDC	Self-Directed Care
SMHA	State Mental Health Authority
SRDG	Social Research Development Group
TWG	Transformation Work Group
WAC	Washington Administrative Code
WASPC	Washington Association of Sheriffs and Police Chiefs
WDVA	Washington State Department of Veterans Affairs
WIMIRT	Washington Institute for Mental Illness Research and Training
WRAP	Wellness Recovery Action Plan
WSPY	Washington State Partnerships for Youth
YSPP	Youth Suicide Prevention Program

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As chair of the Transformation Work Group (TWG), I would like to thank all the members of the TWG for their time and commitment to this important topic.

On behalf of the TWG, I offer our gratitude to the Joint Legislative and Executive Task Force on Mental Health Services and Financing, and in particular co-chairs Representative Eileen Cody and Senator Linda Evans-Parlette who, through their leadership and energy, were responsible for the creation of the Task Force.

We are deeply grateful to all the members of the TWG subcommittees, and task group members who devoted tremendous amounts of time, expertise and energy to developing the framework for the future of the transformation grant project. In particular, we would like to thank the chairs of these groups for their leadership and vision to this project.

Thank you to all the individuals and organizations who participated in the resource inventory and needs assessment for providing their insights and perspectives on the current state of the system of mental health services in Washington.

Thanks also to the MHTP team: Ron Jemelka, David Brenna, Erin Peterschick, Joyce Layne-Jordan, Jill San-Jule, Jeanette Barnes, Darci Ebinger, Angela French, Stephanie Lane, and Ginger Stewart. Each of these individuals played a critical role in bringing this project to fruition.

To those consumers, family members, service providers and others who testified, submitted feedback, or volunteered their time, our sincerest thanks for taking the time to share with us your visions and hopes for mental health transformation.

We also want to thank the contractors who conducted surveys and interviews, as well as analyzed, the mountain of input gathered throughout this past seven months. And Sterling Associates, who worked tirelessly to meet our timeline for completing this report.

Finally, I would like to thank Governor Christine Gregoire and her staff for championing this important effort and for taking a strong stand for the future of mental health services in our state.

Ken Stark, Director

Mental Health Transformation Project

Office of the Governor

EXECUTIVE SUMMARY

WASHINGTON STATE COMPREHENSIVE MENTAL HEALTH PLAN SEPTEMBER 30, 2006

The mental health community in Washington State envisions that all people in Washington who experience mental health challenges will lead happy, productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. Since the Mental Health Transformation Grant was awarded to Washington State in October 2005, the Transformation Work Group (TWG) and its partner agencies have been working to develop a shared understanding and common agenda for the transformation of Washington's system of mental health services. The results of those efforts form the foundation for this Comprehensive Mental Health Plan (CMHP).

Using the President's New Freedom Commission goals as a framework for action, we have engaged in a broad public process to develop a roadmap for achieving a transformed mental health system. Chapter 1 describes Washington's transformation activities, as they relate to the six federal goals, and two additional Washington-specific goals added by our state's TWG.

Year One – Focus on Organizing for Transformation and Public Input

Year One of the grant has focused on gathering broad-based public input on the strengths of the current system and defining a vision for what a transformed mental health system will look like. Chapter 2 describes in detail the governance and organization structure established to carry out this work. The TWG appointed seven subcommittees comprised of consumers, families, and representatives of the mental health system to examine the strengths and weaknesses of the mental health system on specific populations: children, youth and families; youth in transition; adult consumers and families; older adults; homeless; co-occurring disorders; and criminal justice.

Input gathered from outreach efforts (including over 40 public input sessions and RSN listening sessions) was used by the subcommittees to define what outcomes a transformed system should be designed to achieve. The 27 priority outcomes identified by the subcommittees each correspond to one or more of the President's goals and are discussed in greater detail in Chapter 1.

Task groups, comprised of subject matter experts, then developed specific strategies for achieving these outcomes. Task groups focused their work in six areas: fiscal systems; information technology; evidence-based, promising and emerging practices; cultural competence; evaluation; and social marketing. These outcomes and strategies provide the framework for Washington's transformation activities for the next four years of the Mental Health Transformation Grant.

The strategies defined through this process are wide-ranging. Some address discrete short-term needs, others are long-range, conceptual and visionary. Members of the task groups will continue to work with the TWG in Year 2 to assess the financial and organizational feasibility of the strategies, and to establish priorities among the strategies. The TWG confirmed its support for the overarching principles and most of the strategies defined by the task groups. In a small number of cases, the TWG deferred action awaiting further definition. The TWG also adopted two goals in addition to the six outlined by the New Freedom Commission to address Washington's commitment to assuring meaningful employment and secure housing for consumers and their families.

The Mental Health Transformation Project (MHTP) team is working now with partner agencies to identify current or planned activities that move the transformation agenda forward. In particular, staff are reviewing state agency strategic plans recently submitted to the Governor to determine where state activity is already underway, and where gaps exist that will need to be addressed.

State agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the CMHP by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis can be conducted. Once that is complete, the state will have a better idea where to focus its resources to address community recommendations.

Mental Health in Tribal Nations

The TWG has been working with Washington tribes on a Government-to-Government basis, to ensure that mental health transformation extends into Tribal communities. The MHTP developed a parallel process providing Tribal input, tribal outcomes and strategies, with the support of the American Indian Health Commission, the Department of Social and Health Services, and Health Services Indian Policy Advisory Committee, and through a contract with the Northwest Portland Area Indian Health Board (NPAIHB). A report on the outcomes of this effort is provided in Chapter 3.

Year Two – Facilitating the Implementation of Transformation

It is apparent that years of funding services for the most in need has created a mental *illness* system; not a mental *health* system. In Year 2, the TWG will engage all transformation partners in a crucial discussion about how and when a systemic redesign of the system of providing mental health services in Washington will occur.

If we are to achieve our objectives related to improving the health of all individuals and families residing in Washington State, we must have a strong vision. The TWG agrees with the vision of making Washington State the healthiest state in the nation and we believe Washington State must place more emphasis on prevention and early intervention as well as cross-system planning to improve the health of our residents.

Our subcommittees' work reflects that our current system of care, while expensive, is inadequate. In response they have thoughtfully articulated a strong set of recommendations for addressing the shortcomings of the current system.

The Transformation Project will pursue a dual approach, one track seeking improvements to the existing system, as recommended by the subcommittees; and concurrently they will seek to enhance the system built around illness with a system designed to support prevention and health promotion. True transformation can only occur if we do both. A more detailed discussion of prevention and mental health in Washington is contained in Chapter 4.

Reviewing the work of the past year, six major forward-looking themes have emerged that will guide the work of the MHTP in Year 2 and beyond.

Transformation Theme 1: The state of Washington views mental health as part of overall health.

Transformation Theme 2: Mental health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs.

Transformation Theme 3: Following the lead of the Washington Health Foundation, state agencies, with leadership from the Governor, Legislature and Superintendent of Public Instruction, will develop a core set of benchmarks (outcome measures) to track the health of Washington state residents.

Transformation Theme 4: State agencies will increase opportunities for their consumers/families/youth to establish agency priorities and direction.

Transformation Theme 5: State agencies will improve cross-system data collection, data analysis and data reporting systems that focus not only on outputs but report on actual outcomes-reductions in negative consequences and improvements in overall consumer/family/youth/ community health indicators.

Transformation Theme 6: State agencies, local government, providers, advocates, consumers, and families will make every effort to implement and improve the specific recommendations of the subcommittees. Cross-system collaborations that focus not only on symptoms, but on citizens overall health, wellness and recovery must be paramount if the system is to improve, and we are to reduce negative consequences and improve the lives of our consumers, family members, and our communities.

EVALUATING TRANSFORMATION IN WASHINGTON

Chapter 5 provides a detailed discussion of Washington's plan for evaluating the transformation effort. The primary purpose of evaluation in this project will be to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this plan. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative.

NEXT STEPS

The role of the TWG in the next phases of the MHTP will shift. The TWG will not, itself, implement transformation. It will be up to the partner agencies to take up the challenge of incorporating transformational activities into their own planning and implementation. Over the next year and beyond, the TWG and the MHTP staff will refocus their efforts to provide facilitation, coordination and support to participating agencies in their efforts to translate the vision into concrete actions.

State agencies will need to modify their existing strategic plans, given Transformation priorities, and establish detailed implementation plans. These detailed plans can then be used for measuring our progress in the future.

INTRODUCTION

The state of Washington Mental Health Transformation Project (MHTP) team is pleased to submit the 2006 Comprehensive Mental Health Plan (CMHP). This plan represents the tireless work of hundreds of individuals – youth and adult consumers, family members, local and state agency staff, public and private service providers, researchers, law enforcement, and others – who have given of their considerable talents, time and insights over the past year.

BACKGROUND

While the consumer movement that ultimately lead to Washington State's transformation activities is decades old, the transformation grant process is the direct result of the President's New Freedom Commission. In April, 2002, President Bush signed Executive Order 13263 establishing the New Freedom Commission on Mental Health to study problems and gaps in the mental health system and make concrete recommendations that federal, state, and local government, as well as public and private health care providers could implement. In July, 2003, the NFC issued its report *Achieving the Promise: Transforming Mental Health Care in America*.

Washington's transformation grant was awarded in October, 2005. The grant calls for transformation to occur over the next four years.

Much of the past year has been devoted to developing a shared understanding and common agenda for transformation. It is our vision that all people in the state of Washington who experience mental health challenges will lead happy productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. We have engaged in a broad public process to develop a roadmap for achieving this vision. We are ready for change.

HISTORY OF MENTAL HEALTH POLICY IN WASHINGTON: What has led to our readiness to change?

The overriding mental health policy issue since the mid-1980s has been the escalation of health care costs, which led to the transition from block grant and fee-for-service payment models for funding mental health care delivery to managed care strategies. Rapid growth in the mental health system prompted concerns that the system was fragmented and not expanding in a coordinated, responsive manner. To address the issue of

fragmentation, the legislature passed the Mental Health Reform Act in 1989. This act created county-based Regional Support Networks (RSNs) to design and administer local mental health services to meet the unique needs of people with mental disorders. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, until 1993 they did not have the tools to manage care and to control the escalating costs of the Medicaid program.

Washington has moved progressively closer to a managed care model with the implementation of outpatient managed health care services for people covered by Medicaid under a federal waiver in 1995. Under this approach, Washington State purchases outpatient services through capitated payments to the RSNs and RSNs operate prepaid inpatient health plans by assuming financial risk to provide all medically necessary outpatient community mental health rehabilitation services to people in their geographic region.

In this system, RSNs serve as system integrators and primary purchasers of services in a comprehensive managed mental health care plan – they oversee every aspect of the mental health care being provided for participants and their families in their respective regions. The Mental Health Division (MHD) of the state's Department of Social and Health Services (DSHS) contracts with RSNs to ensure these services are available to residents of the region, using a combination of Medicaid, legislatively allocated state dollars, and federal block grant funds. RSNs, in turn purchase specific services directly from local providers, such as community mental health centers. Prior to the creation of RSNs, the state purchased a variety of services from a wide range of provider organizations, many of which have historically worked independent of each other and of the state.

In addition, RSNs (contracted through the MHD) have a statutory responsibility to serve the most severely disabled. As a result, mental health agencies at times must purchase mental health services outside the RSNs when the consumer needing services does not meet the threshold of disability required to receive them.

Today, Washington State's mental health system has the responsibility to serve different populations at different levels of service. Eligibility for services and the mix of services available varies depending on which state agency is funding the services. State residents eligible for Medicaid benefits must be provided medically necessary mental health services. Other people with serious mental illness are provided services as non-Medicaid resources allow.

Throughout this modern period of reform, a number of issues have caused the public mental health system to reach the point of crisis. These include:

- A lack of consistent, strong leadership at the state and local levels;
- Inadequate oversight of contracts at all levels, resulting in poor accountability;
- A lack of clarity from the federal government regarding Mediciad rules.
- Inadequate strategic planning that coordinates with key stakeholders such as local government, providers, consumers/families, research community, and allied fields.
- Limited cross-system planning among state agencies.

These issues have led to a fragmented system with credibility problems among the very stakeholders that must partner for the system to be effective. Compounding this problem, significant budget shortfalls and financial crises occurred, owing in large part to the state's recent history of heavy reliance on Medicaid funds to finance public mental health care, and state level interpretation of Medicaid funding policies that conflicted with federal interpretations. This period was marked by a growing distrust among stakeholders, and a general lack of confidence that the state's primary agency for mental health services, on its own, or the RSNs themselves, could solve these problems.

RECENT DEVELOPMENTS: The Joint Legislative and Executive Task Force on Mental Health Services and Financing

The Joint Legislative and Executive Task Force on Mental Health Services and Financing (the task force) was established during the 2004 Legislative session in order to carefully examine these issues affecting the delivery of public mental health services. The task force began their meetings in June 2004. At the last meeting of the task force prior to the 2005 legislative session, final findings and recommendations were offered. During the 2005 regular legislative session, the task force's recommendations helped shape legislation that addressed many of the issues brought before the task force.

Engrossed Second Substitute House Bill (E2SHB) 1290: Restructuring of the RSNs and New Procurement Processes

With the passage of E2SHB 1290, the legislature wanted to strengthen the public mental health system so that people experiencing mental illness receive treatment and support services focused on resilience and recovery, ideally within their own communities. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their own recovery from mental illness.

E2SHB 1290 promotes public policy that focuses on mental health treatments and services that are evidence and research-based (meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices [EBPs].) The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services is emphasized and includes state agencies outside of DSHS. Such coordination will also, to the maximum extent possible, include consumers/youth/ families and advocates of persons with mental illness.

The task force also directed DSHS to pursue the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation Grant. The collaboration between the legislative and executive branches on this task force ultimately resulted in Governor Gregoire establishing the Partnerships for Recovery and Resiliency Initiative.

Engrossed Second Substitute Senate Bill (E2SSB) 5763: Omnibus Substance Abuse and Mental Disorder Treatment Act

Also enacted in the 2005 Legislative Session, E2SSB 5763 integrated treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery through a series of changes to previous mental health and substance abuse screening and treatment policies and practices. The legislation also authorized pilot projects to test changes to the chemical dependency and mental health involuntary treatment laws, in hopes of better channeling appropriate referrals into each system of care.

One unique aspect of this legislation is that it grants county governments authority to add one tenth of one percent to the sales tax. The revenues from this additional tax can be used to fund mental health, substance abuse, and therapeutic courts. Thus far, four counties have adopted this tax.

TRANSFORMING WASHINGTON'S MENTAL HEALTH SYSTEM

The foundational component of the Partnerships for Recovery initiative is the Mental Health Transformation Project (MHTP), funded through the SAMHSA Transformation Grant. Using the six goals outlined in the President's New Freedom Commission final report as a blueprint, the Governor's MHTP proposal was designed to transform the state's mental health system to a more responsive network of integrated, effective services. The successful proposal was submitted in June of 2005, and Washington State received a Notice of Grant Award in October 2005.

A condition for all the states receiving SAMHSA Mental Health Transformation Grants is that the Governor's Office in each of these seven states directs Transformation activities through a high-level Transformation Work Group. Washington State's Governor Gregoire is leading the *Partnerships for Recovery and Resiliency Initiative* with the full support and participation of the director of every department and division serving people with mental illness in the state of Washington. With consumers and family members as equal partners, the partnership has launched a deep transformation effort to achieve the goals of the President's New Freedom Commission for all people in the state of Washington.

The Transformation Process relies on broad

The Transformation effort relies on the participation of consumers and families, including their

participation from the entire mental health community, particularly consumers and family members

membership in Transformation Work Group (TWG), in outreach, education and training, policy formation, evaluation and public education campaigns. This approach of bringing consumers and families into the transformation effort as full partners ensures the transformation process will result in a comprehensive, culturally competent, fully integrated, consumer- and family-centered system committed to continuous improvement.

Washington's MHTP has been built on the foundation of the President's New Freedom Commission Report. However, what is emerging in Washington State is unique to the needs of the consumers and families of Washington. The MHTP is building the infrastructure to support an on-going process of planning, action, learning and innovation that will result in measurable improvements in the lives of both young and old throughout the State.

The Transformation Work Group

Governor Gregoire appointed the Transformation Work Group (TWG) to carry out the work of the MHTP. The director of every state agency and division serving people with mental illness in the state of Washington is an active participant in the project. With consumers and family members as equal partners, the TWG has launched a deep transformation effort to achieve the goals of the transformation grant. The TWG is assisted in its work by 11 project staff, and a variety of supporting committees.

The senior executive-level TWG provides on-going oversight and direction to the Transformation Project, and is charged with implementing the transformation effort. The 32-member TWG includes state agency directors, adult and youth consumers, and family members and representatives of local government and private sector mental health providers and advocates.

The TWG was charged with developing the Comprehensive Mental Health Plan (CMHP). To accomplish this, the TWG established an ambitious Year 1 work plan. (Exhibit 1 provides a graphic overview of the TWG's Transformation Process during Year 1 of the MHTP.) The TWG first identified seven areas for analysis, focusing on target populations.

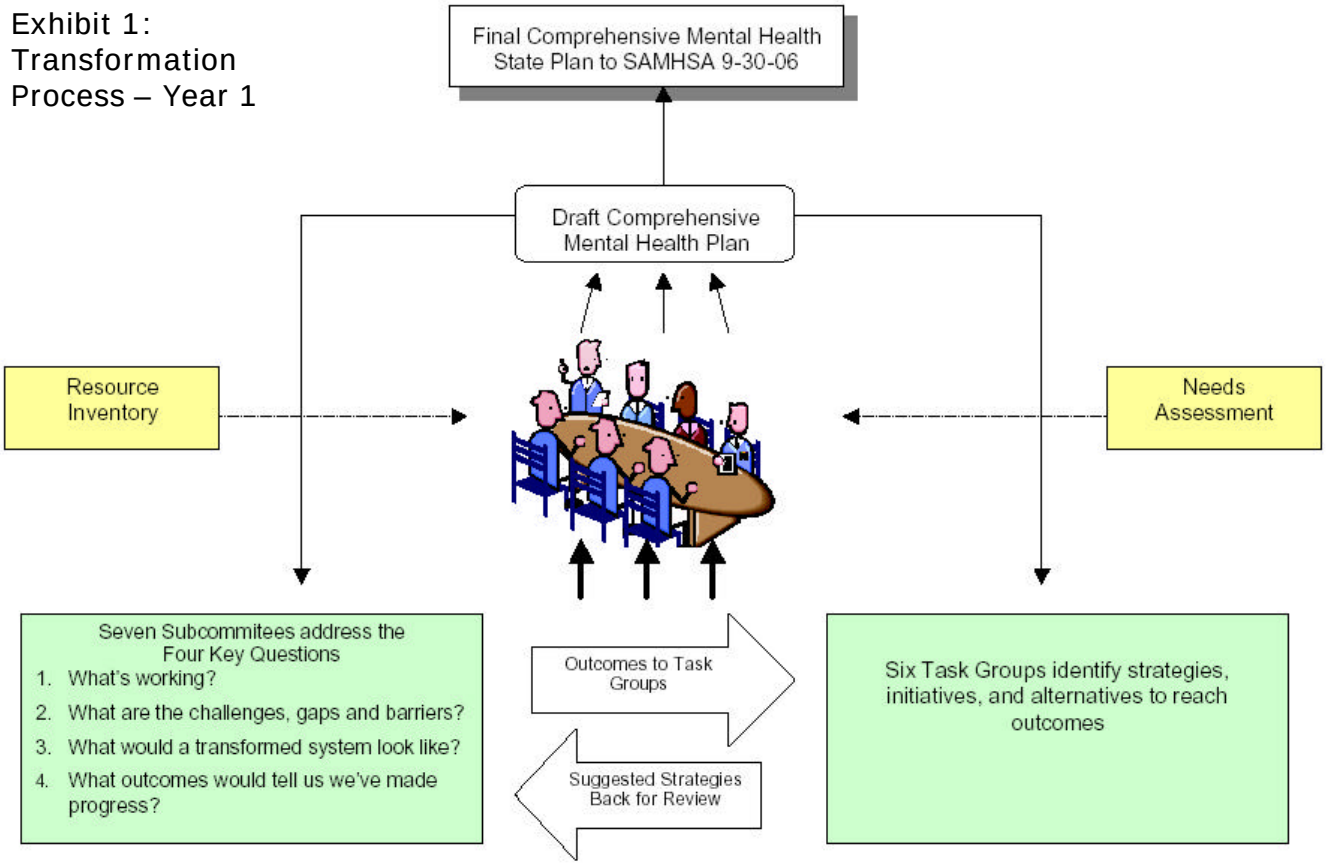
1. Children/Youth and Parents/Families
2. Adult Consumers and Families
3. Older Adult Consumers and Families
4. Youth Transitioning into Adulthood
5. Homeless Population
6. Criminal Justice-Juveniles and Adults
7. Co-Occurring Disorders (Dual Diagnoses)

Consumers, Family Members, Agency Staff, Public and Private Service Providers have all participated in creating the vision of a transformed mental health system

Subcommittees were established to examine each of these areas and to define desired outcomes for each population set. To ensure the subcommittees remained focused on envisioning a consumer-driven system, each subcommittee was comprised of at least 51% consumers and/or family members. Each subcommittee took public testimony from interested parties around the state to seek feedback on ***what a transformed system should look like.*** Testimony came in a variety of formats, including public forums, surveys, informal emails, etc***.*** Respondents were asked to address the following four questions:

- Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of the Subcommittee's target population?
- Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of the subcommittee's target population?
- Related to the subcommittee target population, what would a "transformed" mental health system look like?
- What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Exhibit 1: Transformation Process – Year 1



Transformation Process in Year One of Implementation

Relationship of Subcommittees to Task Groups, TWG and the Comprehensive State Plan

Each subcommittee met at least three times around the state, holding public forums and taking testimony from consumers, their families, local providers and other stakeholders. In total, over 40 public input sessions and RSN-sponsored listening sessions were held over a 55-day period. These forums focused on the four questions listed above and the feedback was compelling. Transcripts from each of these input sessions can be found at the MHTP website (www.mhtransformation.wa.gov). The public input and listening sessions produced over 6,000 pages of transcripts. Researchers and analysts from the University of Washington conducted a thematic analysis on these documents. Summaries of those analyses are provided in Appendix 1.

Following the public input sessions, the subcommittees had the difficult tasks of distilling the wealth of information received, and identifying the top three to five critical outcomes within their subject area. In total, the subcommittees recommended 27 key outcomes for further exploration and development. These recommended outcomes are described in more detail in the following sections, grouped by the relevant Presidential Goal. The subcommittees' recommended outcomes were adopted by the TWG without modification.

PRIORITY OUTCOMES:

Criminal Justice

1. Decreased number of people with mental illness from entering into the criminal justice system.
2. Increased access to mental health and substance abuse services for those within the criminal justice system.
3. Decreased number of people with mental health illness re-entering the criminal justice system.

Co-Occurring Disorders

4. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources.
   - Services will be specific to the individual's needs.
   - There will be access to sufficient treatment providers who trained and retained.
5. Affected parties are informed, educated and knowledgeable about co-occurring disorders and the recovery culture, principles and philosophy.
   - Peer-to-peer support is available to all who want it.
   - Communication between and among the parties is critical to making this successful.
   - Law enforcement officers receive crisis intervention training to deal with co-occurring disorders.
6. Increased system collaboration and service integration is prevalent across all allied systems and services.
   - Reduction in silos across system boundaries
   - Increased holistic services
   - Increased cross-system treatment
7. Service delivery is consumer driven and recovery focused.

   There are options available outside of the current standard options such as homeopathic services.

Youth in Transition

8. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.
9. a) Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work.

9. b) Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.

10. Consistent access to quality services and

supports available regardless of location or funding sources.

11. Consistent access to quality services and supports available regardless of location or funding sources.

Adult Consumers and Families

12. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers will have a choice of services in which they can become engaged that include at a minimum:
    - Consumer-run services of various types
    - Individual therapy with a qualified therapist
    - Clubhouse services
    - Case management services
13. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services.
    - Within five years, these services will represent 25% of all mental health services in Washington State, and
    - Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.
14. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.
15. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).
16. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality supported employment based on national standards. These programs work collaboratively with DVR to ensure employment for as many consumers as possible.

Older Adult Consumers

17. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.
18. Mental Health services for Older Adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.
19. There will be an increased number of service providing individuals with professional experience in mental health and aging.
20. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.

Homeless

21. Housing will be available immediately upon need for individuals/families.
22. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are being applied for.
23. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).

Children / Youth and Parents / Families

24. Greater availability of state-only funds.

    This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:

    – State-only funds for parent organizations, mentorships.

    – State-only funds to serve those who are not in the country legally, non-Medicaid children/youth and families.

    – State-only funds to serve working poor and people who have exhausted their insurance benefits.

25. Youth and family support (this includes any caregiver family including foster, adoptive and kinship families).

    – Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be

visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

26. Training and Education.

- This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity.
- Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface.
- Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to Three issues.

27. A system that is more proactive than reactive.

Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. Services would be available for parents/caregivers when the child is in an out of home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services.

Additional services in the continuum would include respite, wraparound services, day treatment, and evidenced based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community locations or

family preferences.

- Revisit the Access to Care standards and open the door to access.
- Decrease in families seeking voluntary placement agreements.
- Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children to home after an out of home placement (Juvenile Rehabilitation Administration, Children's Long-Term Inpatient Program, Children's Administration are a few examples where children may be returning from)
- Increase in community services and supports for families. This includes respite, wraparound services, day treatment and evidenced based practices.

Subject Matter Experts have identified recommended strategies for achieving these outcomes

In addition to the seven subcommittees, task groups of subject area experts began meeting in April 2006 to prepare recommended strategies for transformation. The TWG directed the task groups to identify potential strategies and approaches that would achieve the outcomes recommended by the subcommittees and approved by the TWG.

The task groups were charged with drawing on the most cutting edge research and practices to develop specific strategies for achieving the outcomes identified by the subcommittees. Where the subcommittees were focused by population groups, the task groups were defined by functional area:

1. Evidence-Based, Promising and Emerging Practices
2. Information Technology (IT) Systems
3. Fiscal Systems
4. Cultural Competence
5. Social Marketing
6. Evaluation

The task groups met intensively over a two-month period to develop principles and strategies for achieving the transformation outcomes established

by the TWG subcommittees earlier in the year. In considering the recommendations of the task groups, the TWG focused on the overarching principles and approaches, rather than focusing on specific individual strategies. This reflects an understanding among the TWG members that implementation activities will undoubtedly reveal unanticipated challenges, barriers, or sequencing issues. Additional strategies may need to be developed if gaps emerge, and limitations discovered during planning and implementation may require reprioritization or elimination of some strategies.

In Year 2 of the MHTP, the TWG will support efforts to translate these principles, strategies and desired outcomes into concrete action items. The TWG will provide support in the form of training, education and facilitation to ensure these transformative approaches are brought to fruition at all levels, from government policy and procedure, to clinical practice. MHTP funds cannot be used to provide services. They will be used to develop the transformation infrastructure necessary to pursue the 27 Recommendations of the subcommittees.

State Agency Strategic Plans Provide a Rich Environment to Begin the Implementation of the TWG's Transformation agenda.

Now that the transformation framework has been developed through the work of the subcommittees, task groups, and articulated within this CMHP, the TWG will shift its focus to planning and implementation. The TWG in itself cannot make this vision a reality. Instead, the TWG will encourage its implementation through education, training, facilitation and creating strategic partnerships with state agencies, educational institutions, and community organizations.

Transformation has already begun

Translating the results of the TWG's Year 1 efforts into on-the-ground changes has already begun. At the Governor's direction, Washington State agencies have completed an extensive strategic planning process. Agencies responsible for implementing mental health services included a number of strategies for implementing transformative services. Many of the agency strategic plans are being implemented in conjunction with and as a complement to the formal outcomes and strategies defined by the MHTP subcommittees and task groups. These strategic plans set forth the agencies' strategic goals for the coming years and, more

importantly, the objectives and specific strategies for achieving those goals. MHTP staff members have worked closely with agency staff to identify transformative strategies in those plans. Once identified, the MHTP resources can be applied to those areas that fit within the transformation framework articulated in this CMHP. Excerpts from the various strategic plans are incorporated in Washington's response to each Presidential Goal outlined in Chapter 1.

The Comprehensive Resource Inventory and Needs Assessment is Complete

The MHTP Evaluation Team has completed an exhaustive needs assessment and inventory of resources devoted to serving seriously mentally ill adults and seriously emotionally disturbed children and youth. This effort has deepened the initial resource inventory that was included with the grant proposal.

Information gathered from the inventory process will ultimately be assembled into a statewide mental health resource inventory database that will be updated annually. The annual summary will be provided to the Governor, the legislature and the Mental Health Planning and Advisory Council. The inventory will become more refined and useful over time and will become an integral element in the state budgetary and planning process.

The Needs Assessment component of this effort will be used to help shape the Washington State transformation effort on into the future. The results of this assessment draw a compelling picture about the need for transformative efforts to recreate a mental health system and environment that puts the consumer and families at the center. A more detailed discussion of the Resource Inventory and Needs Assessment is included in Chapter 5 and the full report is included as Appendix 2.

CHAPTER 1:

WASHINGTON'S TRANSFORMATION IN ACTION

CHAPTER OVERVIEW

The six goals outlined in the President's New Freedom Commission final report provide a framework for transforming Washington's mental health system. This chapter describes Washington's approach to achieving the President's goals. In addition, the Washington Transformation Work Group has added two new goals specific to Washington State relating to employment and Housing. These are addressed here as well.

For each goal, we provide the following:

- Priority outcomes identified by the TWG subcommittees,
- Strategies for implementing the priority outcomes,
- Agency partner strategic plans,
- Other MHTP transformation activities, and
- Gaps and next steps associated with the goal.

Taken together, these responses act as a roadmap, describing Washington's route to transformation. Specific implementation strategies and timelines will be developed in Year 2.

Consumers and their family members have been active partners in developing every recommendation and initiative. A detailed discussion about the process for involving consumers and their families in the initial outcome and strategy identification process was included in the Introduction.

Subcommittees identified 27 desired outcomes for a transformed mental health system

The previous chapter provides an overview of the process used by the TWG to develop the substance in this CMHP. To briefly recap:

Seven subcommittees were appointed by the TWG to examine the strengths and weaknesses of the mental health system on specific population groups (children, youth, adults, older adults, the homeless, individuals with co-occurring disorders, and those involved in the criminal justice system). From their outreach and public input sessions, the subcommittees identified 27 priority outcomes for a transformed system.

Task Groups developed specific strategies for achieving those outcomes

Task groups then defined specific strategies for achieving those outcomes. Task groups were structured around functional areas (fiscal systems, information technology, evidence based, promising and emerging practices, cultural competence, evaluation and social marketing).

Several over-arching strategies and goals are inherent in the task group work products

In some cases, task groups were not able to be specific about strategies until adddtional detail became available that was not planned to be available until years 2-5 of the transformation grant activities. In lieu of, or in addition to, the specific strategies the Fiscal Systems, Information Systems and the Cultural Competence Task Groups defined principles that will guide their activities in the coming years. These principles are contained in Appendix 3.

Agency partners are actively involved in transformation

Many transformative activities are currently underway and documented in each of the agency partner's strategic plans. A summary of these plans as they relate to the goals has been included in this chapter. However, agency partners have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. The project staff plans to inventory these strategies for inclusion in next year's plan.

In addition, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis between the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community priorities.

SECTION 1:

Federal New Freedom Commission Goal #1

Americans Understand that Mental Health is Essential to Overall Health.

FEDERAL RECOMMENDATIONS

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Reducing the devastating effects of stigma associated with mental illness has become a high priority in Washington State

Results from Washington's Resource Inventory and Needs Assessment highlight the need for efforts designed to educate the general public and reduce the effects of stigma:

- Over half of the consumers surveyed (53%) felt stigmatized due to their mental illness,
- Half of the responding consumers (50%) believed they had been discriminated against because of their mental illness, and
- Nearly two-thirds of the respondents (62%) believe that people ignore them or take them less seriously because they have a mental illness (See Appendix 2 for the detailed report).

To combat these disturbing results, the Transformation team is partnering with the Department of Health and other agencies to initiate a social marketing campaign. This campaign is designed to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and increase support for mentally ill individuals in the community and workplace, and is being undertaken as part of the CMHP. This initiative is described in more detail below.

Subcommittee Recommended Outcome

The MHTP Subcommittees defined the following outcome to address Federal Goal #1. A complete list of strategies and outcomes is included in Appendix 3.

Youth in Transition Subcommittee	1. Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.
Task Group Recommended Strategies	The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #1.
Evidence-Based/ Promising/Emerging Practices Task Group	1. Use social marketing campaigns aimed at reducing stigma. For example, *Speak Up When You're Down* is a social marketing campaign around normalizing post-partum depression responses and reducing stigma and is already funded by the Washington State Legislature. 2. Integrate center for health, mental health and life skills support (examples school health clinics).
Agency and Partner Strategic Directions	The following objectives and supporting activities and measures related to Federal Goal #1 are defined in state agency strategic plans recently submitted to Governor Gregoire.
DSHS, Aging and Disability Services Administration (ADSA)	ADSA will continue to participate in the Co-occurring Disorders Interagency Committee with the Divisions of Alcohol and Substance Abuse and Mental Health, and co-sponsor the annual co-occurring disorders conference.
DSHS, Division of Vocational Rehabilitation (DVR)	The DVR partners with the State Rehabilitation Council, State Independent Living Council, Client Assistance Program and others in the disability community to learn and respond to identified needs and issues.
DSHS, Division of Alcohol and Substance Abuse (DASA)	Working with other state agencies, consumers, providers and local government, DASA co-sponsors an annual conference on co-occurring mental illness and chemical dependency. In addition, multiple state agencies are involved in a planning group, the Co-occurring Disorders Interagency Committee (CODIAC), which conducts cross-system planning as well as an annual conference.
DSHS, Health and Recovery Services Administration (HRSA)	The HRSA emphasizes preventive health measures and healthy lifestyle choices. Key elements of the HRSA strategic plan include: • Retain a preventive focus in Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Access to Baby and Child Dentistry, First Steps – families with children, and family planning.

- Sustain existing state-subsidized health-care coverage for low and moderate-income children.
- Distribute evidence-based information on prevention and healthy lifestyles for clients through many different community venues, among them the Department of Health, public schools, public health districts, community clinics and libraries statewide.
- Continue efforts on reducing unintended pregnancy.
- Expand Disease Management capacity to recognize positive effects of care management on serious disease complexes.

DSHS, Mental Health Division (MHD)

The MHD will actively promote recovery, resiliency and the reduction of stigma for persons experiencing mental illness across the life span. Specific strategies will:

- Provide outreach and showcase of consumers' skills and abilities as a means of stigma reduction.
- Provide opportunities to allow consumers to share their stories of recovery with others.
- Develop advertisement campaigns promoting recovery and community support of persons in recovery from mental illness; consumers will be involved in the design and implementation of the campaign.
- Support working with counties and agencies to promote recovery and resilience and to reduce stigma regarding the mental health system.
- Create a recovery manual in collaboration with the Washington Institute (similar to the domestic violence manual) and distribute it throughout the mental health delivery system as a whole, including the Criminal Justice System.
- Develop triage units and create additional mental health courts wherein persons with mental illness, when possible, will be diverted from the criminal justice system and will be assessed for treatment at the onset of involvement with the state to intervene and prevent incarceration.

MHD will require that all persons experiencing mental health issues be treated with respect, understanding and compassion by:

- Developing mission statements for persons working with the MHD and contract agents that incorporate the values of respect, understanding and compassion as fundamental in treatment of persons experiencing mental illness.
- Working with counties and agencies to promote these values.
- Adopting philosophies such as the Rochester New York Emotionally Disturbed Persons Response Team, which makes every effort to preserve the dignity of each individual encountered who is emotionally disturbed or experiencing mental illness.
- Providing training for clinical providers to adhere to these minimum standards of treatment of respect, understanding and compassion.

Department of Health (DOH)

The state DOH is responsible for keeping Washington's citizens healthy and safe by working across agencies and with local partners. DOH's mission is to protect and improve the health of people in Washington State – mental health is part of the definition of health.

Department of Veterans Affairs (WDVA)

In our effort to care for vulnerable adults in our veteran homes, as well as within our Homeless Veteran and Trauma Treatment Programs, we stress the holistic nature of wellness, including the role of mental health, healthy choices, diet, exercise, smoking cessation, weight and stress management.

Transformation Grant Activities

Washington's Comprehensive Mental Health Plan addresses this state's commitment to overcoming these barriers by educating the general public about mental illness, educating consumers and their families about excellent care and service options, reducing obstacles to achieving needed recovery options, and increasing the general public's understanding that mental health is only one aspect of a person's overall health and should be understood and managed on a comparable level.

Highlighted below are a number of transformative strategies that have already begun with the support of the Mental Health Transformation Grant through its partners.

Reducing Stigma Using Social Marketing:

A Project Framework and Research Design

Washington's Social Marketing initiative will join other campaigns across the country working to change public attitudes and behavior toward mental health. This project is working to:

- Eliminate stigma and the barriers it creates in the work setting, at home, within the healthcare system and in the community, and
- Increase the understanding that people with mental illness can and do recover and live productive lives.

Who Is Working On This?

Health educators at the Washington State Department of Health are facilitating the social marketing aspect of the grant. They are reviewing the current literature on mental health issues as well as the transcripts and reports from the public listening sessions and subcommittees to ensure that consumer and family perspectives are reflected in the marketing plan design.

They are also convening a Social Marketing Task Group representing business, provider, consumer, family, marketing and public policy perspectives. The task group will help guide audience research decisions and help formulate the recommendations for social marketing efforts during the course of the grant funding.

The process for developing the social marketing implementation plan took place in the Spring and Summer of 2006. The work was accomplished in four phases:

Initial Planning:

- Collect available research, data and best practices
- Determine research needs and resources
- Review target audiences, segments within each audience, and characteristics that influence or determine their behavior
- Select potential target audiences and behaviors that this project will address
- Set initial goals and objectives

Formative Research:

- Conduct focus groups and interviews
- Obtain reactions to project messages, goals, objectives and potential strategies

- Test existing campaigns
- Determine baseline knowledge, attitudes and behaviors

Strategy Formation:

- Review research findings and recommendations
- Select target audiences
- Develop program strategies

Program Development:

- Finalize social marketing strategies
- Identify and mobilize additional partners to assist with dissemination and implementation

What has been Accomplished To Date?

The MHTP Social Marketing Task Group focused its initial efforts on three key groups:

- Providers of publicly funded mental health services;
- Policy makers (specifically, the Mental Health Transformation Workgroup, local elected officials, and the Joint Legislative & Executive Mental Health Task Force); and
- Consumers.

Mental health providers and policy makers are necessary participants in eliminating stigma as they are examples of what the literature refers to as "key power groups" – that is, groups that have the power to significantly affect the lives of individuals with mental illness, either positively or negatively. Involving consumers in this effort was also considered important, as the literature indicates that contact with people with mental illness is one of three effective stigma reduction techniques.

Employers form a fourth key group. Employers have significant influence on social acceptance and reducing stigma associated with mental illness through hiring practices. Employers will be included in future phases of the social marketing initiative.

The Social Marketing Task Group has focused on identifying key audiences and messages in Year 1

In the first year, formative research has been conducted with providers, policy makers and consumers using a combination of key informant interviews and focus groups. The intended outcome of this research was to determine which group(s) has the biggest potential impact on the elimination of stigma associated with mental illness, the most readiness to act, and what the effective strategies are to motivate action.

The Social Marketing Task Group reviewed research findings and provided recommendations to the TWG regarding priority audiences, messages and strategies for the duration of the Mental Health Transformation Project.

The desired actions, or behavioral outcomes, for each target audience were identified and further refined by a review of the current literature.

Future work will focus on implementation strategies

In subsequent grant years, results of the audience research will be used to develop strategies for implementation. Potential strategies include educational activities that promote understanding that mental illness is treatable, that people with mental illness are people first and should not be defined by their illness, and that recovery is the process of developing a positive and meaningful life separate from one's psychiatric condition.

Strategies will also likely take advantage of the best practice of "contact," shown to have a deep and lasting effect on reducing stigma and breaking down stereotypes. Programs that connect consumers engaged in recovery with key power groups in the community can increase understanding about mental illness as a treatable, manageable condition and increase hope for recovery for consumers and their families.

Washington is working to establish parity in its health delivery system

— Washington's Mental Health Parity Act

Washington has defined a comprehensive strategy to address the financing challenges posed by the current system. For the past several legislative sessions, mental health advocates pressed diligently for the passage of legislation that would require private insurers to cover mental health services comparable to their coverage of other medical and surgical services. During the 2005 regular legislative session, the state's first Mental Health Parity Act [SHB 1154, Chapter 6, Laws of 2005] was passed and signed into law by Governor Gregoire.

The law applies to commercial health plans regulated by the Washington State Insurance Commissioner and requires employers with more than 50 employees to provide mental health care coverage. All state employee health plans offered by the Public Employees Benefits Board and Washington State Basic Health are also included. While the Mental Health Parity Act does not apply to all employer provided health care plans, the fact remains that

	2005 was a landmark year for legislation related to mental health issues, and the four-year phase-in of the parity legislation will benefit many citizens of Washington affected by mental illness.
Gap Analysis	The community process has focused most of its attention on stigma reduction and suicide prevention. State agencies have identified a variety of activities related to stigma reduction and these activities will be pursued in Year 2 along with the Social Marketing Campaign. At least one state agency has a suicide prevention initiative and one of our research partners (University of Washington) also has suicide prevention initiatives. The issue of mental health being treated with the same urgency as physical health was not well-defined in our community process, nor was it addressed in agency strategic plans. There may be additional strategies agencies are pursuing that are not in their strategic plans or that are part of their 2007-2009 proposed budget/legislative packages. These packages will not be available until September.
Next Steps – Year 2-5	The Transformation Grant will partner with the TWG and research partners regarding suicide prevention initiatives in Year 2. Washington is pressing for a link between physical and mental health in State Policy and will also pursue treating mental health with the same urgency as physical health as part of a Year 2 priority.

SECTION 2:

Federal New Freedom Commission Goal #2

Mental Health Care is Consumer and Family Driven.

FEDERAL RECOMMENDATIONS

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
2.3 Align relevant Federal programs to improve access and accountability for mental health services.
2.4 Create a Comprehensive State Mental Health Plan.
2.5 Protect and enhance the rights of people with mental illnesses.

Consumers in Washington voiced concerns similar to those raised at the federal level

During MHTP-sponsored statewide public input sessions held earlier this year, consumers and family members voiced concerns about Washington's current mental health delivery system that mirror concerns raised in the President's New Freedom Commission report.

- Choices are limited for service offerings that are flexible, customizable to the consumers' needs and accessible in all parts of the state.
- Frequently, the only services available (although not always when they were needed) include more traditional medication management and case management services.
- The system, through its policies and financing decisions, drives treatment decisions instead of the consumer and family members making decisions based on their needs.

Current policies and practices perpetuate the perception that the mental health consumer is "ill" and do not support the notions of recovery and resiliency. As a result, services that would maintain and support the integration of a consumer into the community, such as housing and employment opportunities, are not readily available.

Subcommittee Recommended Outcomes

In response to the New Freedom Commission recommendations, the following strategies were recommended by the subcommittees to address Presidential Goal #2.

A complete list of strategies and outcomes is included in Appendix 3.

Co-Occurring Disorders Subcommittee

1. Service Delivery is consumer driven and recovery focused.
   - There are options available outside of the current standard options such as homeopathic services.

Youth in Transition Subcommittee

1. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.

Adult Consumers and Families Subcommittee

2. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers have a choice of services in which they can become engaged that include at a minimum:
   a. Consumer-run services of various types,
   b. Individual therapy with a qualified therapist,
   c. Clubhouse services, and
   d. Case management services.
3. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services.
   - Within five years, these services will represent 25% of all mental health services in Washington State, and
   - Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.

Children/Youth & Parents/Families Subcommittee

1. Youth and family support (this includes any caregiver family including foster, adoptive and kinship families).
   - Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

Task Group Recommended Strategies

The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #2.

Fiscal Task Group

1. Consumers and families should have greater responsibility/opportunity to direct services and expenditures.

Cultural Competency Task Group

1. Identify, document, validate, implement, and support promising programs and practices that currently exist in the community.
2. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.
3. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide.
4. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance.
   - Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Mobilize curricula (examples: MOVE, TARGET-T).
2. Use Youth Empowerment and Engagement/life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
3. Identify and mobilize mentors, navigators, peer advocates and other supports for family members, youth and young adults.
4. Implement a consistent statewide mechanism to ensure that the philosophy/value of family and youth involvement is taught in certification, university, and other training programs.
5. Develop a mechanism to ensure funds are available to support family and youth participation in the planning, implementation, evaluation, and policy of programs and practices (i.e., stipends, transportation, childcare, etc.).
6. Fund the development of a minimum of one independent consumer-run drop-in/resource center in each RSN.
   - These resource centers will serve as each area's umbrella organization, where trained peer counselors will assist individuals in the recovery process, including goal-setting, warmlines, developing mutual self-help groups, teaching problem-solving skills, providing vocational assistance, and developing plans for symptom management using the Wellness Recovery Action Plan (WRAP) model.
7. Fund the development of a minimum of two recovery education centers, to be run by consumers; one in Eastern Washington and one in Western Washington.
   - These centers will serve as the state's technical assistance centers offering technical assistance around consumer run services and principles of recovery.
8. Fund the development of a minimum of one clubhouse model psychiatric rehabilitation program in each RSN based on the Fountain House model.

- Free-standing clubhouse programs should be allowed to become one version of a "consumer-run entity."
- The definition of a clubhouse should be the definition of a clubhouse program as articulated by the International Center for Clubhouse Development (ICCD).
- Clubhouse programs in Washington should be required to be certified by the ICCD.
- Clubhouses should be funded in such a manner that makes it possible for the program to operate in complete fidelity to an ICCD defined clubhouse.
- Clubhouse funding must be flexible enough to ensure that clubhouse services are consumer-directed, and that the clubhouse's overarching focus is vocational rehabilitation and job and educational placement.
- Clubhouses are not clinical programs – admission criteria and service planning is not based on diagnosis, level of functioning or medical necessity. Clubhouses are adjunct to clinical services and focus on people's strengths.

9. Expand Personal Assistance Services (PAS) for people with psychiatric disabilities. PAS is a method which already has a long and successful track record for serving people with disabilities in a self-determined manner, and for which Medicaid funding is already available.
10. Provide support for consumer-owned and operated businesses.
11. Use peer support models such as dual recovery and double trouble.
12. Ensure that promising family-centered processes and support services voiced as needs by communities that are not focal treatments (e.g., Youth and Family Supports/Parent Partners, including parent organizations, peer support, support organizations, parent partners, Respite Care services, Mentoring, the Wraparound process, Day treatment programs) are supported and included as options for communities.

13. Designate funding specifically to create/support/ maintain Family and Youth Organizations and support programs.

14. Review statutory & administrative constraints to funding/reimbursement of parent/ youth partners and minimize barriers

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DASA oversees a Citizen's Advisory Council in which two-thirds of its members are required to be consumers and/or family members, some of whom have co-occurring mental health and chemical dependency issues. The division also funds the Family Resources Institute that focuses on services to families with fetal alcohol syndrome. The institute provides support and training to family members.

In addition, DASA administers a SAMHSA "Access to Recovery" Grant that allows consumers to use a voucher system to choose the services they need, including mental health.

DSHS, Health and Recovery Services Administration (HRSA)

The HRSA plans to integrate service delivery systems by putting clients at the center of their health care and recognizing that timely attention to non-medical needs can avoid greater medical needs and costs in the future. In addition, the HRSA plans to emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.

DSHS, Mental Health Division (MHD)

With the passage of E2SHB 1290 in 2005, the legislature strengthened the public mental health system so that people experiencing mental illness receive services focused on resilience and recovery. The bill was written to ensure that adults and children with mental illness, their families, and their advocates are intimately involved in designing mental health services that reduce unnecessary hospitalization and incarceration. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their communities. E2SHB 1290 aims for consumers to have the community and personal qualities that empower them to rebound from trauma, adversity, tragedy or other stresses and can lead productive lives.

MHPAC brings a strong consumer voice to policy and practice development

The Washington State Mental Health Planning Advisory Council (MHPAC), mandated by state and federal Law, reviews, monitors and evaluates the MHD's policies, plans and budgets. MHPAC also makes recommendations to the division about ways to strengthen the link between government decisions and consumer, family and advocate's needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and gender preference and sexual minorities. MHPAC's membership includes a strong consumer voice, with 51% of its members representing consumers, family members and advocates. Other MHPAC members represent RSNs, service providers, and state agencies.

MHPAC's new goals are adopted from the six goals found in the New Freedom Commission's final report, Achieving the Promise: Transforming Mental Health Care in America.

- Consumers and family members will direct their own recovery and resilience planning, through the following activities:
  - Implement a resilience and/or recovery model whereby the consumer and their community of family or caregivers determine needs for their individual recovery and resilience plan.
  - Develop an education and training program to assist care providers (including primary care physicians) and consumers in understanding resilience and recovery to ensure consistent use of these words and meanings.
- Expand the information on Social Security (SSDI, SSI), Ticket to Work, Medicaid buy-in, and other employment opportunities for adult consumers.
- Require the integral involvement of consumers in the development of their recovery and resilience process/plans.
- Request revisions to the Revised Code of Washington (RCW) Chapters 71.24, 71.34 and 71.05 to reflect current program realities and to clearly state the rights of consumers.

- Provide training to consumers in the development of Wellness Recovery Action Planning (WRAP). Training will be offered to consumers at least annually.
- Expand information on and promote accessibility to the Social Security Administration, Medicare and other community services that promote/support older adults in maintaining optimum function and meaningful activities.
- Expand peer counseling to support consumers across the life span.
- Develop and implement concepts and programs that prioritize goals and outcomes that foster autonomy rather than maintenance and codependency.

The MHD will involve consumers, their families, caregivers, and advocates in all program design and planning of the recovery and resiliency process.

- Increase the role of consumers across the life span and families in quality management activities within MHD, state hospitals, RSNs, Community Mental Health Centers (CMHC), and CLIP via the MHPAC.
- Continue to support the efforts of the Office of Consumer Affairs.
- Showcase examples of consumer/caregiver involvement across the lifespan that demonstrate recovery, resiliency and reduction of stigma.
- Insist on consumer/caregiver presence across the life span on state hospital governing bodies and encourage presence on private hospitals governing boards, particularly where Medicaid money is utilized.
- Provide training to assist consumers and caregivers to find their own voices and tell their own stories.
- Implement a culturally competent service delivery plan.
- Provide mentoring to consumers and families prior to their membership on client/consumer committees and their attendance at stakeholder meetings.

The Mental Health Division will communicate with consumers, and ensure the sustainability of the active involvement of consumers and their advocate caregivers across the life span.

- Utilize the approved consumer self-advocacy training and Executive Order project.
- Promote consumer and caregiver advocacy to assist with legislative proposals and as a tool to influence legislation that promotes recovery and resiliency.
- Develop and train consumers as mental health system advocates in order to expand committee membership expertise.
- MHD staff meets directly with consumers and caregivers through focus groups and/or attendance at meetings.
- MHD supports and receives information from clubhouses to help programs to connect and share a common goal.

The Office of Consumer Affairs (OCA) will develop an addition to the MHD's web page that is specific to adult consumers containing frequently asked questions, definitions, resources, guides, etc. Clubhouses and consumer-run programs will be added as a resource to the MHD's web page.

- Provide training to consumers in the use of the MHD web site.
- Respond to funding and infrastructure changes in the mental health system to sustain the goal of consumer driven services.
- Develop an independent Ombudsman program to support consumer driven services.
- Work with the Joint Legislative and Executive Task Force on Mental Health Services and Financing to implement system change.
- Develop and implement a plan to monitor and evaluate the impact of system changes on consumer care at the provider level.
- Create workgroups to explore the programmatic and financial impact of changing the system structure.

- Examine current law and rule to determine by survey or assessment revisions needed to change the system structure.
- Conduct a risk management review of the system structure change.
- Study the current continuum of care to identify community alternatives to residential, crisis and inpatient capacity needs.

The growing formal network of parents and others working with the MHD has increased awareness by other programs about the benefits of bringing parents, neighbors and friends in as care resources. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to deal with children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are not yet universally seen as a resource.

This network believes strongly in their role as a system partner and will continue to be involved as coordination continues to grow. One way this coordination occurs is through the former Parent Council, supported by the MHD. The Parent Council (renamed SAFE-WA -- Statewide Action for Family Empowerment of Washington) received a SAMHSA grant to be the statewide parent/family network, and a major partner in the larger children's system grant submission. SAFE-WA has representation from all of the recognized parent advocacy and support groups in Washington and meets quarterly to bring a united voice to the division's management.

The MHD's Office of Consumer Affairs (OCA) received approval to conduct a two-year, statewide consumer and self-advocacy training program. Initiated in 2004, the ORCA (Outreach for Recovery and Consumer Advocacy) program is designed to improve the division's service delivery to consumer customers, by assisting and supporting consumers statewide. Over the course of the program, OCA staff will:

- Use surveys and focus groups to identify areas requiring improvement;
- Assist consumers in finding services and resolving problems;

- Utilize provider agency consumer advisory groups for consultation and program involvement;
- Educate consumers and collect consumer voice;
- Extend reach and message of state voice;
- Include federal and regional partners in listening to views on consumer issues of interest;
- Provide public speaking and education on mental health and anti-stigma awareness. Promote values of DSHS and HRSA/MH recovery advancements;
- Process and present consumer, client and family voice. Search for success experience and recommendations;
- Retain focus that OCA's overarching mission is to assist leadership to know and value consumer insight in order to help move the system to more recovery treatment options; and
- As part of Director's Office and member of Senior Management Team, provide leadership on system evaluation and feedback; planning input; and policy and design development.

The MHD's OCA also supports the consumer network, which provides direct input to the division.

Throughout the duration of 2006-2011 strategic plan, MHD will meet with stakeholder groups for ongoing input and comment on the division's strategic plan.

DSHS Juvenile Rehabilitation Administration (JRA)

The JRA is responsible for juvenile institutions, group homes, and local parole. JRA also funds county juvenile court and detention services. Their strategic plan focuses their service delivery model continuum on family involvement in the mental health treatment of youthful offenders.

Department of Health (DOH)

The DOH strategic plan includes strategies to assure feedback from citizens. The Office of Maternal Child Health includes individuals and families as partners in shaping decisions, including a full time family consultant. The Health Systems Quality Assurance strategic plan calls for partnerships that promote the public health and customer service.

Department of Veterans Affairs (WDVA)

Since 1984 WDVA has demonstrated a strong interest in creating a specialized mental health counseling program that acts to fill in the rather large gaps that exist between the war veteran with emotional and behavioral issues, and the traditionally identified services of the federal Veterans Administration (VA). Designing the War Trauma/Post-Traumatic Stress Disorder (PTSD) Outpatient Program to be family-oriented from its inception, allowing family members to receive services even before the veteran seeks out assistance. During the current global war on terror, more family members than veterans are receiving services initially. This allows the family members of deployed soldiers, sailors, and airmen, to receive care and support for the family system. As a result, families are better able to manage the pressures of a deployment and as a result are better prepared for the veteran's return.

The PTSD Program has created a network of federal, state, and private organizations and agencies to ensure the wellbeing of children of deployed and war-exposed veterans. The stress of war exposure often acts to regress development progress in children, and to interfere with social and academic progress. Attention to these issues is believed to be essential for not only the readiness of our guard members, but for the protection of our most valuable resource, the children.

In addition, Veteran Homes also are very family-oriented, from admissions through discharge or end of life support and assistance. Social and mental health considerations are always the focus in the treatment plan for residents of the Homes. Special activities tie families together in support of the wellness and care needed for the resident family member, and the continued connections offered by the non-resident family member.

Transformation Grant Activities

As part of the transformation process, Washington State is exploring additional opportunities to expand consumer involvement that is appropriate and sustainable. The following are two examples of work currently underway.

Involvement at all levels of government and in the private sector is critical to transformation

— Community Transformation Partnership (CTP)

The Community Transformation Partnership (CTP) is a coalition of representatives from several mental health consumer, youth and family organizations who assisted in the preparation of the Washington State Transformation Grant proposal, or have expressed an interest in promoting transformation goals. The purpose of the coalition is to create an inclusive statewide structure advancing the state's mental health system transformation efforts. The Transformation Grant has supported the development of this group, but the CTP is a separate entity.

The CTP met for the first time in October 2005, and developed a charter that sets the course for future work. During the first phase of the Transformation Grant the CTP will lay the framework for policy development, education, involvement of consumers and families, evaluation, and the establishment of partnerships with transformation leaders and organizations. While the role of the CTP will evolve over time, depending on the needs of the state project team, the following objectives are examples of activities the CTP expects to accomplish.

- Provide recommendations to the TWG to ensure consumer and family participation on subcommittees and work groups.
- Assist in the development of a consumer conference.
- Assist with recruitment efforts to ensure broad consumer and family involvement in all aspects of the transformation process. This includes community meetings, subcommittees, and work groups.
- Assist in the development and implementation of transformation survey and evaluation projects to obtain consumer and family perspectives.
- Develop workshops and educational programs to widen the transformation process to include consumers and families located at the grassroots level.
- Serve as a focal point for the dissemination of information from the TWG and Transformation staff to organizations, informal networks, and individual consumers and families.

The CTP has been meeting monthly since October 2005 to pursue these goals. Their current focus is on defining their legislative agenda and preparing and offering recovery and resiliency trainings around the state. At their retreat in June, 2006 the CTP further defined its role in forming a legislative policy strategy as stakeholder partners in promoting positive transformation in Washington State. A detailed report regarding the Community Transformation Partnership including a list of the member organizations and their representatives is included in Appendix 4.

— CTP Recovery and Resiliency Seminars

As one of its first tasks, the CTP is developing Recovery and Resiliency training to be implemented throughout the state. These trainings are based on the Substance Abuse Mental Health Service Administration's consensus statement on Recovery and the concept of Resiliency and include the ten fundamental components of recovery (Self Direction, Individualized and Person Centered, Empowerment, Holistic, Non Linear, Strength Based, Peer Support, Respect, Responsibility, and Hope). A nationally known expert on recovery and resiliency will be brought in to conduct a "Train the Trainers" session, anticipated to occur in August 2006. Those trained will then conduct trainings throughout the state.

Initial activities will be dedicated to defining the fundamental principles in detail, and the remainder of the training activities will focus on creating a mechanism to foster advocacy and recovery support at the local level and to connect these communities to the Transformation Grant Process and statewide transformation efforts. The training is being developed by the CTP, through its Recovery and Resiliency Training subcommittee, with financial support from the Transformation Grant.

The purpose of these seminars is to create broad-based recovery and resiliency awareness throughout Washington State's communities

All stakeholders in the Mental Health System will be eligible to attend local sessions. The state anticipates that the seminars will result in at least three outcomes.

1. Transmit the message that mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
2. Provide general education to providers, consumers of all ages, policy makers and other stakeholders

about Recovery/Resiliency Principles.

3. Create a mechanism to build a grass roots recovery resiliency constituency.

Statewide Adult Consumer Organization

Washington State is in the process of forming a Statewide Adult Consumer Organization that includes a coalition of adult consumer leaders who will ultimately serve as one unified consumer voice to policy and decision-makers. This group will ensure the consumer voice becomes an integral part of the mental health service planning and delivery process.

Potential activities and roles for the organization are varied and inclusive

The statewide adult consumer organization will take on a variety of roles and activities. It is expected to:

- Represent the voice of the mental health consumer and become a critical participant and stakeholder in all statewide mental health policy processes;
- Promote concepts key to the recovery of individuals diagnosed with a mental illness. These concepts include hope, personal empowerment, self-responsibility, respect, and self-determination;
- Promote consumer-established/consumer-operated services as an integral part of the mental health system of care;
- Lend critical support to self-help and mutual support groups and programs throughout the state;
- Play a key role in the development of future state strategic plans;
- Share and disseminate information;
- Provide technical assistance to affiliate groups;
- Educate public officials and the public at large on recovery;
- Link groups together to support each other in their growth and development; and
- Mobilize local communities towards transformation.

Washington has defined the following initial steps for this organization.

Step 1: Identify current or potential consumer leaders representing Washington's counties and tribes.

Step 2: Coordinate an application process to determine membership. Potential applicants will be required to complete an application containing 15 questions around recovery and wellness, self-advocacy, and team-building.

Step 3: Select eight consumers from around the state who will serve as the Selection Committee. The Selection Committee will use a standardized process of reviewing and scoring each application.

Step 4: Announce individuals chosen to serve as County/Tribal Affiliate Leads.

Step 5: Develop the structure of the organization including creating the vision and mission statements, developing bylaws, and establish a board of directors.

Step 6: Provide training in leadership, networking, grassroots organizing, and advocacy skills.

Step 7: Create subcommittees that align with planks at the 2006 Conference Summit. Work with National Self-Help Clearinghouse on identifying major areas of consensus and action steps.

Step 8: Incorporate and apply for IRS non-profit status

Statewide Action for Family Empowerment of Washington (SAFE-WA)

SAFE-WA is currently refining a database to track activities related to consumer involvement in the transformation process. Activities to be tracked are: Changes in consumer advocacy membership; changes in consumer advocacy participation; community contacts via telephone, email and U.S. Postal Service; development of a consumer volunteer base; and other activities that support the President's New Freedom Goals.

SAFE-WA in partnership with Youth 'N Action is working to form a statewide youth leadership structure. SAFE-WA is also working to engage youth participation in relevant policy boards and meeting and other activities. SAFE-WA has sponsored youth and family members to attend conferences at the state and national level. Further, SAFE-WA is conducting Evidence Based Practice and Wraparound Train-the-Trainer sessions for consumers in partnership with local community mental health and family organizations.

Plans for the next year include strengthening the infrastructure of the established organization; focusing on youth in transition; expanding youth & family organizations, building relationships with Tribes and refining details for assessing the number of youth and/or family organizations across Washington State.

College Credited Consumer/Family Training Program

Transformation Project staff are working with key stakeholders to determine the feasibility of developing a 50-credit community college consumers/family training program as part of the workforce development strategy. The project will be assessing its Year 2 strategy and will only implement programs that result in peer counseling jobs at the community mental health centers.

Gap Analysis

The three major themes related to subcommittee recommendations are having clear processes that describe how consumers and families will be involved with the development and delivery of services, that models of self-directed care be implemented, and that funding be available for consumer- and family-run organizations. More specifically, consumers and families will need to address several gaps in the current services delivery system including:

- Cost effective services are not responsive, flexible and provided in the home and in the community as a first and primary choice for consumers, youth and family members.
- Services are often not culturally responsive to consumer, youth and family member needs. This gap leads to unequal access, culturally irrelevant treatments, disproportionality and recidivism.
- Natural and community supports are not explored as a first choice.
- Services are not collaboratively developed, and integrated with formal linkages between agencies perpetuating silos in funding, access and avenues for advocacy.
- Least restrictive and most normative clinically appropriate environments are not readily available. There are too many rules and regulations that create barriers to these services and consumers, youth and family members often are not taught how to understand and navigate the systems that serve them.
- Consumers, youth and family members, cannot fully

participate in planning and delivery of services as essential partners due to the following gaps:

- Meetings are held at times when consumers, youth and family members are at work or at school;
- There is no statewide funding mechanism to compensate consumers, youth and family members for their participation (including child-care);
- Consumers, youth and family members are stigmatized by their involvement in the system instead of being recognized as having valuable expertise in the systems that serve them;
- Transportation in rural areas and food are often not provided; and
- Technical assistance is needed in reducing tokenism and building true partnership relationships based on a mutual respect and understanding.

Illustrated by the above mentioned gaps, it is clear that there are no processes currently in place that describe how consumers, family members and youth will be involved with the development and delivery of services. There is no clear access point for self-directed care interventions. Access to information regarding the latest mental health and other system related findings is not readily accessible or distributed to consumer, youth and family organizations.

Further, although state agency strategic plans do discuss (varies by agency) their proposals, much more detail is needed from each agency to determine how that agency is honoring the subcommittee recommendations.

Next Steps – Year 2-5

Agencies have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. We will inventory these strategies for inclusion in next year's plan. Also, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative

package, and which items are supported by the Legislature, a more accurate gap analysis between what the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community recommendations.

Throughout the project process, stakeholders around Washington expressed a desire for a system that is proactive rather than reactive. Governor Gregoire, cabinet-level executives, and members of the state Legislature also acknowledge that a transformed system will need to systematically move away from being *illness* focused towards one that is *health* focused. The strategies defined in this CMHP will drive system level changes that Washington consumers, families, youths and leaders desire.

SECTION 3:

Federal New Freedom Commission Goal #3

Disparities in Mental Health Services are Eliminated.

FEDERAL RECOMMENDATIONS

3.1 Improve access to quality care that is culturally competent.
3.2 Improve access to quality care in rural and geographically remote areas.

Washington is committed to infusing cultural competence into its transformation process

Washington's Comprehensive Mental Health Plan addresses this state's commitment to infusing cultural competence in the transformed system by addressing barriers to treatment, increasing culturally appropriate services to all areas of the state and in all populations served, and in training and recruiting service providers that mirror the cultural make-up of the populations being served.

As part of the transformation project effort, a Cultural Competence Task Group was established to develop specific recommended strategies the state should consider in moving forward in future implementation years.

Overarching principles for infusing cultural competence in the system

The task group identified a number of overarching principles it used to produce its strategies. In order for cultural competence to be operationalized in agencies, institutions, and communities, the following items must be incorporated into the definition of Cultural and Linguistic Competence.

1. Cultural competence is measured by the availability of sufficient numbers of duly qualified personnel and consultants for the system, to provide comparable access to and results from services provided to various communities and populations in the service area of the agency, system or community;
2. The intervention or treatment must be based on cultural values of the individual, group or groups of interest;
3. The strategies that comprise the treatment must be consistent with the values, beliefs and practices of the individual, ethnic of other cultural

groups of interest;

4. Tribal nations must be given due respect for their sovereign status in selecting and receiving mental health service; and

5. Cultural competence requires a thorough understanding of the culture and language of limited English-speaking communities and also of deaf/hard of hearing, deaf/blind and other disability groups, Lesbian, Gay, Bisexual and Transgender, youth, older adults and elder communities.

Task Group Recommended Strategies

In addition to these overarching principles, the following strategies were recommended by the task groups and approved by the TWG to address Presidential Goal #3.

A complete list of strategies and outcomes is included in Appendix 3.

Fiscal Systems Task Group

1. Service equality should be reflected in the distribution of resources and the reimbursement for services across state. Should be a consistent array of services across regions and populations.

Cultural Competency Task Group

1. Require participation of all mental health employees in an initial and ongoing annual training in cultural competence.

2. Recruit and hire employees and leaders that reflect the population they are responsible to serve.

3. Develop and implement a training curriculum for cultural competence in collaboration with institutions of higher education, in particular Schools of Social work and psychology, Public Health, Medicine and Law in order for students and agency personnel to become certified as specialists and future trainers.

4. Revise Washington Administrative Code or MHD-RSN contract terms to afford opportunities for minority specialists to be available to contracting agencies.

5. Create roundtables to discuss and review cultural competence issues routinely with regional service networks, Tribes, mental health providers, and state agency personnel.

6. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.
7. Require outreach workers for diverse communities and cultural competence specialists to become a part of the treatment team planning.
8. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance.
9. Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.
10. Provide social marketing methods as a means to promote and increase cultural competence awareness.
11. Promote the development of linguistically and culturally specific intake and assessment procedures.
12. Provide certified interpreters for deaf/hard of hearing and for limited to non-speaking consumers and family members that are qualified in mental health settings. Done in compliance and alignment with appropriate federal and/or state laws.
13. Develop cultural and linguistic standards and accountability measures.
14. State and local government service agencies and their contractors and Tribes will be responsible for the achievement of cultural/linguistic standards and accountability measures.

Information Technology Task Group

1. Develop on-line training materials. Make sure they are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.

Evidence-Based/ Promising/Emerging Practices Task Group	1. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.
Agency and Partner Strategic Directions	The following objectives and supporting activities and measures related to Federal Goal #3 are defined in state agency strategic plans recently submitted to Governor Gregoire.
DSHS, Division of Alcohol and Substance Abuse (DASA)	The DASA provides treatment and prevention funding to tribes, minority programs and rural communities to target underserved or hard to reach populations. A portion of the persons served have co-occurring mental illness and chemical dependency.
DSHS, Health and Recovery Administration (HRSA)	The HRSA strategic plans encourage cultural competence through two major efforts: the HRSA diversity plan and the Indian Policy Plan.
HRSA Diversity Plan	HRSA's goal is to build an inclusive work environment and culturally competent workforce for the 2006-2011 period. While HRSA is short of these goals today, it remains committed to improvement by both our mission and policy. The HRSA 2003-2004 Diversity Plan sets forth major goals that are aligned with performance measures in the Assistant Secretary's Performance Agreement. The primary goal is to recruit and retain a diverse workforce by providing training for key managers and supervisors to ensure that the emerging HRSA Workforce of the future reflects the current commitment to a diverse, culturally competent staff. A second goal is to support a continuing education environment that promotes cultural competence to the staff so that its importance is recognized in everyday accomplishments and successes. A third goal is to integrate HRSA's diversity commitment with its business partners and other contractors. Since HRSA is not a primary provider of care a diverse provider base has a high priority because the providers are more readily visible to Medicaid communities than an HRSA staff centered in Olympia. The HRSA Diversity Plan's final goal is to ensure no disparity of health-care outcomes between ethnic groups. This includes projects like the recent

	outreach into urban African-American families to provide education about breast cancer issues, as well as a Department of Health's plan to recruit, train and retain more providers of diverse ethnic backgrounds. The strategy will emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.
HRSA Indian Policy Plan	HRSA was a pioneer within DSHS in establishing a liaison and ongoing coordination with tribal governments and the American Indian Health Commission of Washington State. HRSA is committed to the Centennial Accord and recognizes its responsibility to consult with tribes on issues of mutual interest and/or concern. That effort is now embedded within the Research and Policy Analysis Division of HRSA, and the tribal liaison officer remains the primary tribal contact for HRSA. HRSA's liaison efforts are coordinated with other tribal contacts in state government, including the DSHS Office of Indian Policy & Support Services. Washington State's medical assistance programs are formally connected with the tribes in a planning document called the "7.01 Updated Report," which is renewed every two years. It commits the administration to full cooperation with American Indians and Alaskan Natives, to share planning and problem solving, and to communicate fully on Medicaid planning and directives. The 7.01 Updated Report is prepared in response to the DSHS Policy 7.01. That policy directs each administration of DSHS to work in consultation with the federally recognized tribes and regonized American Indian organizations to develop a biennial Policy 7.01 implementation plan and annual progress reports that are specific to each region (including headquarters).

DSHS, Mental Health Division (MHD)	Several significant racial and cultural disparities in services are cited in the strategic plan. In response to these trends, MHD's statewide Performance Data Group chartered a work group to examine available penetration and utilization data to determine possible reasons for these disparities. The MHD will prioritize its renewed commitment to comply with DSHS Policy 7.01 and increase government-to-government relations with tribes. The strategic planning process must proceed sooner than time would permit for consultation. MHD anticipates consultation will occur and may result in amendments or revisions to this strategic plan. In the MHD, the regional implementation plans and annual progress reports will be submitted by the RSNs and will be specific to the RSN's Catchment area. Throughout the duration of the 2006-2011 strategic plan, MHD will meet with the Indian Policy Advisory Council in July of each year for ongoing input and comment on the division's strategic plan. The MHD, working with Tribes, will continue to explore and develop methods to facilitate increased government-to-government relations. This exploration continues the work of the 2003 Tribal Mental Health Summit. Currently, the MHD is investigating the use of a Tribal/Children's Long-Term Inpatient Program (CLIP) Administration Memorandum of Agreement to facilitate direct authority by Tribes to refer youth to CLIP facilities.
Department of Health (DOH)	The DOH strategic plan recognizes in its goals and objectives the need to assure the health status of all people in the state, and to hire and retain a diverse complement of staff. The Community and Family Health Division includes reducing/eliminating health disparities as one element of the strategic plan. In the Office of Maternal and Child Health (MHC), reducing/eliminating health disparities is one of nine MCH priorities. The Health Systems Quality Assurance strategic plan includes strategies to: 1) Increase availability of health services in underserved communities, and 2) Increase the number and types of interventions designed to improve equal opportunity to health.

Department of Veterans Affairs (WDVA)

One of the primary reasons WDVA became involved in the outpatient care of veterans with war trauma mental health needs was as a result of the lack of direct services for rural, ethnic minority, gender, and disabled veterans, and the fact that these special barriers prevented access to care. Disparities in level of care, treatment duration, and overall access continue to exist. The flood of new veterans into Washington State has required increases in our traditional efforts in these areas. This influx has prompted the creation of specialized efforts to respond when acute trauma reactions become complicated with delayed treatment, allowing substance abuse and sleep problems. When accompanied by the additional barriers of homelessness and joblessness, these take an even greater toll on WDVA clients. Removing these barriers and bringing treatment and support services to the veteran are major activities for our entire Veteran Services Division. We work at meeting the veteran where he or she is, rather than creating additional barriers. Working directly with our Washington State National Guard units and the many reserve units in our state, allows identification and referral to be done without stigma and shame for those needing help.

Transformation Grant Activities

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

Public testimony validates concerns that services are lacking in rural areas of the state

Washington embarked on a journey to capture public testimony covering all populations in the mental health system. Responses were recorded and analyzed by research professionals from the University of Washington. In-person public testimony was supplemented by hand-written statements, email, fax, as well as additional documents received from agencies and organizations that could not be present at public input sessions. One key message heard repeatedly is that not only do consumers and providers in smaller, rural areas lack options for treatment, but these areas also receive a disproportionately small share of government funding. This limited funding further reduces the options available. As a result, consumers must often travel great distances to get to treatment centers and even then may have to

travel farther to find services that actually fit their need. Equality of services and funding in all areas of the state would be an indicator of a transformed system.

Washington is working collaboratively with Tribal Governments

Washington State has worked towards developing consistent relationships with Tribal governments within our state. A report addressing this issue in detail is included in Chapter 3.

Washington is using existing commissions to provide advice on specific populations

The MHTP project team has contacted Washington's Cultural Commissions, which fall under the direction of Governor Gregoire. The Commissions that will be actively pursued for input and advice concerning transformation activities include:

Commission on African American Affairs

The Commission on African-American Affairs which examines and defines issues pertaining to the rights and needs of African-Americans, and makes recommendations to the Governor, the legislature, and state agencies for changes in programs and laws.

Commission on Asian Pacific American Affairs

The Commission Asian Pacific American Affairs examines and defines issues pertaining to the rights and needs of Asian Americans and advises the Governor and state agencies on policies, plans and needs.

Hispanic Affairs Commission

The Hispanic Affairs Commission ensures that state programs are providing the assistance needed by the Hispanic community; advises state agencies on developing and implementing policies, plans and programs focusing on the needs of the Hispanic community.

Governor's Office on Indian Affairs

The Governor's Office of Indian Affairs, recognizing the importance of sovereignty, affirms the government-to-government relationship and principles identified in the Centennial Accord to promote and enhance tribal self-sufficiency and serves to assist the state in developing policies consistent with those principles.

Gap Analysis

The primary themes raised in the community process related to this goal are training providers to be culturally competent, ensuring equal access to services regardless of population group or geographic areas, broadening types of services available including alternative or non-traditional services, and eliminating disparities. While there are

numerous activities being implemented to increase cultural awareness, improve cultural competences and eliminate disparities, each state agency is pursuing these objectives independent of the other.

Next Steps – Year 2-5

There is a need to inventory the strategies currently in place to identify what is and is not working. It may be possible to share strategies across agencies to not only create efficiencies, but to improve effectiveness in achieving community recommendations. Because the state agencies will not release their 2007-2009 proposed budgets to the Governor until September 2006, and since agencies have not listed all of their strategies in their strategies plans, there will be a need to re-visit proposed strategies and gaps after the Comprehensive Mental Health Plan is submitted. Once that exercise is completed, the Transformation Project staff can work with state agencies to determine which strategies recommended in this report will be pursued in the next year.

SECTION 4: Federal New Freedom Commission Goal #4	**Early Mental Health Screening, Assessment and Referral to Services are Common Practice.**
FEDERAL RECOMMENDATIONS	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Consistent screening and assessment processes are needed on a statewide level	Consumers and professionals provided significant feedback during the Year 1 of the MHTP that a lack of consistent screening and assessment tools and processes are contributing to inconsistencies in the availability and quality of services, depending on the consumer's location. This inconsistency is seen as a priority for both consumers and treatment professionals in transforming the mental health system.
Subcommittee Recommended Outcomes	In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #4. A complete list of strategies and outcomes is included in Appendix 3.
Co-Occurring Disorders Subcommittee	1. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources. • Services will be specific to the individual's needs. • There will be access to sufficient treatment providers who trained and retained. 2. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy. • Peer-to-peer support is available to all who want it.

- Communication between and among the parties is critical to making this successful.
- Law enforcement officers receive crisis intervention training to deal with co-occurring disorders.

3. Increased system collaboration and service integration is prevalent across all allied systems and services.

   - Reduction in silos across system boundaries;
   - Increased holistic services; and
   - Increased cross-system treatment.

Youth in Transition Subcommittee

1. Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work.

2. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members.

Older Adult Consumers Subcommittee

1. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.

2. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.

Children/Youth & Parents/Families Subcommittee

1. Training and Education

   This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity.

   - Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface.

   Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis

management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to Three issues.

2. A system that is more proactive than reactive.

   Serve the WHOLE family with a full continuum of community-based services, starting with prevention and early intervention. Services would be available for parents/caregivers when the child is in an out-of-home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services.

   Additional services in the continuum would include respite, Wraparound services, day treatment, and evidenced-based programs. They would build on family strengths and resiliencies and support parent partnering, and would be well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community locations or family preferences.

   - Revisit the Access to Care Standards and open the door to access.
   - Decrease in families seeking Voluntary Placement Agreements.
   - Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children to home after an out of home placement. (Children may be returning from JRA, CLIP, or CA, for example.)
   - Increase in community services and supports for families. This includes respite, Wraparound services, day treatment and evidenced-based practices.

Task Group Recommended Strategies	The following strategies were recommended by the task groups to address Presidential Goal #4.
Fiscal Task Group	1. Expand availability of early intervention and assessment for all populations.
Information Technology Task Group	1. Develop and pilot a consumer-focused, consumer-driven, recovery-focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings. 2. Develop a website for each consumer that contains an assessment tool and its accompanying treatment goals, which can be edited as treatment progresses, and accessed if the consumer gives permission. 3. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.
Evidence-Based/ Promising/Emerging Practices Task Group	1. Specifically address provision of appropriate infant, toddler and early childhood mental health services. • Statewide adoption of the DC:0-3R for children Birth through five years of age. • Provision of appropriate relationship-based services when possible and appropriate. 2. Create a statewide Mental Health Technical Assistance, Training and Resource Center that is modeled off of the national technical assistance centers. 3. Use Depression Care Management (e.g. IMPACT, PROSPECT) 4. Implement Gatekeeper programs 5. Use the Program to Encourage Active and Rewarding Lives for Seniors 6. Geriatric Regional Assessment Team 7. Case Management 8. Elder Wrap Around 9. Expanded Community Services 10. Ensure that a specific component of the statewide training and technical assistance center

is directed at education for Primary Health Care Providers (PHCP).

11. Utilize models incorporating aspects of cognitive behavioral therapy and Motivational Enhancement Therapy for integrated treatment for co-occurring mental health and substance abuse disorders.
12. Utilize contingency management strategies to support recovery.
13. Utilize integrated group therapy.
14. Treatment for parents in particular should incorporate trauma treatment into substance treatment approaches.
15. Screening and treatment should deliberately inquire whether clients are parenting and how these challenges impact their parenting and family relationships.
16. Implement Crisis Intervention Team (CIT) model for law enforcement officials.
17. Use peer support models such as dual recovery and double trouble.
18. Integrate systematic screening for mental health and substance use.
19. Co-treatment oriented courts (such as Family Treatment Court, Drug Court, Mental Health Court).
20. Implement a statewide approach to supporting school staff to help stabilize children and youth experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports.
21. Provide Co-occurring disorders training.
22. Provide Expanded Community Services.
23. Use individual placement and support.
24. Consumers will be required to complete their own Life Analysis, which takes the place of a professional generated Treatment Plan. The Life Analysis identifies recovery goals, and what is needed to accomplish those goals.
25. Restructure the Access to Care Standards to ensure treatment can easily be provided:

- in a non-clinic setting (home, childcare center);
- to caregiver-child dyads and other family constellations;
- for disordered relationships even without a presenting primary diagnosis in the adult or child;
- for caregivers with mild to moderate mental health challenges with a specific focus on mitigating the impact of their mental health challenges on parenting;
- for children at-risk of developing severe emotional-behavioral disorders;
- for children exposed to trauma or violence regardless of presenting diagnosis; and
- for drug-exposed infants and their caregivers regardless of presenting diagnosis.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #4 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Aging and Disability Services Administration (ADSA)

ADSA is developing community resources for specialty services such as individuals with Traumatic Brain Injury, chemical dependency needs, mental health needs, behavioral issues and dementia. Some of this work has occurred in collaboration with other systems, including the Mental Health Division. More detailed plans will be developed over the next year.

ADSA plans to increase community services for people with mental illness and long term care needs. ADSA is also working with the Mental Health Division to ensure appropriate services are provided to ADSA clients in state psychiatric hospitals as well as planning community alternatives to state hospitals. These activities may require legislative changes, budget enhancements and Medicaid waiver revisions. Finally, ADSA is revising its assessment tool to better identify behavioral issues to improve identification of client needs.

DSHS, Division of Alcohol and Substance Abuse (DASA)

Over the past several years, chemical dependency treatment providers have received substantial training in the screening, assessment, and treatment of patients with co-occurring mental health and

substance abuse disorders. Referrals between systems have increased, as have the opportunities to provide integrated treatment.

With the passage of Engrossed Second Substitute Senate Bill 5763 (E2SSB 5763) – the Omnibus Mental Health and Substance Abuse Treatment Act – in 2005, mental health and chemical dependency treatment providers are moving toward use of a common integrated protocol for the screening and assessment of mental health and substance abuse disorders.

DASA is undertaking a number of strategies to improve screening, assessment and referral processes.

- All treatment clients must be screened for mental health needs and services are coordinated with mental health providers as appropriate.
- All residential programs for youth and pregnant/parenting women must offer on-site mental health counseling. Also, pregnant/ parenting residential programs offer parenting classes and therapeutic childcare for young children who reside in the treatment facility with their mothers.
- Chemical dependency counselors have been placed in a number of group homes to serve youth with emotional/behavioral disorders.
- Mental health counseling must be available in all residential involuntary commitment programs and secure detoxification facilities.

In addition, DASA is coordinating with the DSHS Children's Administration to co-locate chemical dependency counselors in local Children's Services offices to conduct screening, assessment, and referral to chemical dependency treatment and monitoring of treatment progress for parents involved in the child welfare system.

DSHS, Mental Health Division (MHD)

As part of E2SSB 5763, the Mental Health Division is required to develop an integrated and comprehensive screening and assessment process for chemical dependency, mental disorders, and co-occurring chemical dependency with mental disorders. A cross-agency team that includes MHD, DASA, DOC, and the Washington Institute for Mental

Illness Research and Training (WIMIRT) has begun implementation of this work, with input from RSNs and mental health providers. Screening tool recommendations have been established, and will be presented to interested stakeholders in August. An assessment process team, including RSN administrators, is also being assembled and will join the cross agency team to develop the assessment process.

MHD's strategic plans contain the following strategies.

- Promote the mental health of all citizens across life spectrums and ethnicity and cultures.
- Promote screening and early intervention in primary health care facilities and schools [e.g. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] thereby actively promoting the expectation of comparable decreases in instances of mental health crisis later in life. EPSDT includes regular checkups for children to make sure they get immunizations and other preventive care needed to detect and treat health problems at an early stage
- Collaborate with other state agencies serving children and their families to provide screening for children and youth in potentially high-risk settings such as child welfare and juvenile justice settings.
- Build on service coordination and collaboration developed as part of the Children's Mental Health Initiative (Children's Administration, Juvenile Rehabilitation Administration, and Mental Health Division).
- Provide training for primary health providers to screen for and recognize early signs of emotional and behavioral problems, and to offer connections to appropriate interventions.
- Provide information, support and treatment for parents who are experiencing mental health problems to allow them to better address the needs of their children.

Improve and expand school mental health programs.

- Collaborate with other state agencies serving children and their families to address the mental health needs of children and youth in the education system.
- Develop a continuum of care to provide services and supports for children and youth in schools that includes training, prevention, early identification, early intervention, and treatment.
- Provide consistent state-level leadership and collaboration between education, general health, and mental health.

Screen for co-occurring mental and substance abuse disorders and link with integrated treatment.

- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the juvenile justice system.
- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the child welfare system (such as children in foster care).
- Identify and initiate coverage for core components of evidence based collaborative care, to include a comprehensive range of treatment modalities, i.e. clubhouses, peer counseling, respite care, and supported employment.
- Involve consumers and their caregiver advocates in program design and advocacy.
- Investigate the use of blended and braided funding to provide integrated programming.

Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

- Identify and consider coverage for core components of evidence-based collaborative care, to include case management and disease management.
- Expand mental health services in all residential and community care settings.

- Provide consultation to primary care providers by mental health specialists that do not involve face-to-face contact with consumers.
- Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening.
- Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders, including dementia.

MHD is also involved in emergency management planning work with the Federal Emergency Management Administration (FEMA) and plays a role in planning for a statewide comprehensive response. Specific tasks assigned to the mental health system include:

- Assist in assessing the mental health needs of the population,
- Provide mental health training materials for system emergency preparedness,
- Assist in arranging training for mental health outreach worker,
- Assess the adequacy of application for federal crisis counseling grant funds,
- Address worker stress issues and needs through a variety of mechanisms, and
- Maintain a current roster of available staff that can be utilized to assist in major crisis.

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. Strategic planning goals include the development of a culturally competent assessment process in conjunction with expanded, community residential-based continuum of service for youth in the justice system with mental health needs.

Department of Corrections (DOC)

All offenders will be screened for their strengths, deficits and needs. Each person will have an Offender Personalized Plan that will include community risk, vocational and health needs, including mental health. Research based interventions will be implemented in the institutions that carry the most promise for creating a readiness for community re-entry. Finally, community services, including mental health

counseling, will be focused on those services most likely to reduce re-offense rates and assist offenders in community integration.

Department of Early Learning (DEL)

In the 2006 Legislative Session, Washington created a new cabinet-level agency, the Department of Early Learning. Only officially in existence since July of 2006, the Department is already working with other entities to identify partners in their mission, and have assigned management-level focus on the MHTP. The Early Learning Advisory Council, with legislative and executive participation, is at the forefront of defining the agenda and includes expectations addressing child well-being. The MHTP is working to engage this important partner.

Department of Health (DOH)

A major objective of the DOH strategic plan is to assure people have the information they need to prevent disease and injury, manage chronic conditions, increase healthy behaviors, and make healthy decisions. The Community and Family Health Division strategic plan calls for programs that promote a healthy start, healthy choices, and access to services.

The Office of Maternal and Child Health provides quality screening, identification, intervention and care coordination.

Department of Veterans Affairs (WDVA)

The agency's focus is on the detection, treatment, and referral of veterans. Agency staff are sensitive to the special needs of veterans, and seek to support each veteran through the often difficult process of obtaining entitlement help from the federal Veterans Administration (VA). This proactive "*early is better"* approach to assessment and referral is pervasive throughout the agency's network of service officers, specialized outreach programs, Veterans Homes, and the War Trauma/PTSD Program. Since the start of the current war WDVA has been very proactive in their work with the federal VA, the Department of Defense, Washington State National Guard, and the many military reserve units all around the state. Almost every weekend, there is at least one event where on-site mental health counselors are on hand to administer standardized screening tools, to present information regarding readjustment, or to simply be available for anyone wanting to talk. The formal process often includes both screening and private interviews with the soldier and/or family member.

These meetings lead to referral via a mechanism that bypasses waiting lists and other delays. Since the agency has worked to make the links to all services to veterans seamless, a veteran can see a counselor on Saturday, and be scheduled for follow-up appointments on Monday, with either a state or federal provider, which ever is best suited to the veteran's needs.

Gap Analysis

The analysis of agency strategic plans point to numerous gaps that need to be addressed in order for transformation to take effect. While some recent and current efforts are laudable, coordinated, uniform approaches across agencies would effectively reduce costs and create smoother access for consumers and families. Particularly with young children, careful crafting of policy to include common diagnostic standards, common treatment approaches and clarity for consumers and professionals regarding screening, assessment and treatment referral would significantly improve outcomes.

Screening and Assessment

While recent legislation has established a common screening and assessment approach across the addiction and mental health systems, not all agencies are using standardized instruments for screening and assessment. Some agencies are advancing the use of standard screening, but there is a lack of clarity regarding the services that would be indicated through screening programs. Schools, child care systems and the child welfare agency would benefit from standardized models for referral and care. Referral policies vary across these systems and there is confusion regarding eligibility. When the treatment of children with emotional disturbance requires services for their parents, the systems often break down attempting to determine which agency or service system is responsible.

Access to Care Standards

The state's Access to Care Standards are established to determine eligibility for the current RSN service structure and focus heavily on current clinical diagnoses (e.g., Diagnostic and Statistical Manual 4), often keeping Medicaid eligible individuals from accessing appropriate, early care. Children and families are often caught in a vicious circle, where Medicaid eligibility is established, but no clear care system is available for referral. Medicaid eligible children and their families have no service structure through the RSN structure that will pay for needed

services. Primary care will provide assessment, but no provider service system is available that can be reimbursed through Medicaid.

School Systems

State public education systems have fragmented mental health service strategies, dependent largely on the innovation of individual districts rather than a state policy for mental health care. The state's recent creation of the Department of Early Learning and the Washington Learns Initiative are promising opportunities to improve school mental health service, but a consistent set of policies is yet to emerge.

Prevention/Early Intervention

Prevention programs in Washington State are fragmented, un-coordinated and tend to focus on specific issues/populations without regard for public health science that recognizes common risk and protective factors. While individual programs are excellent and well designed, mental health is often absent from the ongoing collaboration between the key players. The Transformation Project has brought together prevention experts from across disciplines (See Chapter 4 - *Prevention*) but significant work is required to begin crafting a statewide, multidisciplinary approach that brings mental health into focus

Next Steps – Year 2-5

During Years 2 -5 the Transformation Project will focus on several priority activities related to Goal #4 include:

- Promoting the current effort to standardize screening/assessment processes,
- Continuing development of effective school based policies,
- Partnering with schools, early learning, child care and child welfare efforts,
- Continuing development of a state prevention policy, and
- Continuing development and assessment of strategies that cross the life span.

SECTION 5: **Federal New Freedom Commission Goal #5**	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**
FEDERAL RECOMMENDATIONS	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Washington's strategy for defining practices and research priorities is inclusive of partners at all levels of the delivery continuum	Washington has defined a clear strategy for ensuring practices that best meet consumer needs are pursued. In tandem with these strategies, the MHTP is increasing research efforts that effectively target services that provide consumers the most effective options. The MHTP is ensuring consumers, advocates, clinicians, administrators, and researchers are fully engaged in the transformation process through the Evidence-Based, Promising and Emerging Practices (EBPEP) Task Group. The EBPEP task group defined the scope of strategies in the most inclusive way possible, consistent with the scope of the project. Informed by the evolution of the concept of evidence-based practice in the scientific literature and the philosophy developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) the types of strategies included in the task groups' efforts target three types of practices (evidence based, promising, and emerging) and more general system strategies.
Subcommittee Recommended Outcomes	In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #5.

A complete list of strategies and outcomes is included in Appendix 3.

Criminal Justice Subcommittee

1. Decrease the number of people with mental illness from entering into the criminal justice system.
2. Increase access to mental health and substance abuse services for those within the criminal justice system.
3. Decrease the number of people with mental health illness re-entering the criminal justice system

Co-Occurring Disorders Subcommittee

1. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy.
   - Peer-to-peer support is available to all who want it.
   - Communication between and among the parties is critical to making this successful.
   - Law enforcement officers receive crisis intervention training to deal with co-occurring disorders

Youth in Transition Subcommittee

1. Consistent access to quality services and supports available regardless of location or funding sources.

Adult Consumers and Families Subcommittee

1. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).
2. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.

Older Adult Consumers Subcommittee

1. Mental Health services for older adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.
2. There will be an increased number of service providing individuals with professional experience in mental health and aging.

Homelessness subcommittee

1. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are

being applied for.

2. Housing will be available immediately upon need for individuals/families.
3. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).

Children/Youth & Parents/Families Subcommittee

1. Greater availability of state-only funds.

   This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:

   - State-only funds for parent organizations, mentorships;
   - State-only funds to serve those who are not in the country legally, non-Medicaid children/youth and families; and
   - State-only funds to serve working poor and people who have exhausted their insurance benefits

Task Group Recommended Strategies

The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #5.

Fiscal Task Group

1. Seek to reduce funding silos and increase/expand integration of funding streams; seek waivers to expand integration.
2. Reimbursement should be outcome based with incentives for adopting evidence-based practices.

Cultural Competency Task Group

1. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide.
2. Identify, document, validate implement, and support promising programs and practices that currently exist in the community.
3. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic.

Information Technology Task Group

1. Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail,

prison or hospital.

- Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
- Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.

2. Use Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information.
   - Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, and geographic.
3. Use Outcome Database to monitor client outcomes resulting from services received from various mental health and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information from Strategy 5.
4. Develop a training and quality assurance database on selected evidenced-based practices.
5. Cost out various alternatives for charging services; choose one and implement it.
6. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
7. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Develop mechanism for supporting relationship development maintenance between incarcerated parents and their children (e.g., TAMAR's children model).
2. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
   - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
   - Consumers in this program will be eligible to purchase services for the purpose of accessing:
     - Clinical Recovery Services,
     - Psychological Assessment,
     - Medical Services (Psychiatric Evaluation, Medication Management),
     - PACT,
     - Individual and Group Therapy provided by a licensed mental health professional, and
     - Supported Employment.
   - Recovery support services (services that are alternative to traditional mental health services) such as:
     - Massage therapy as a form of touch therapy to assist an individual overcome issues documented by a licensed mental health professional;
     - Forms of art therapy;
     - Smoking cessation activities Occupational, speech, and physical therapy when recommended by a licensed mental health professional; and
     - Services related to developing employability and/or productivity that will lead to employability.

- Recovery enhancements (tangible items for consumption that relate to employment or other productivity such as volunteer work or training/education) including:
  - Transportation,
  - Non-cosmetic dental work,
  - Hearing aids,
  - Non-cosmetic eye glasses and non-disposable contacts, and
  - Other specific enhancements that relate to employment and productivity in consumers' communities are enumerated in the Task Groups report.
- Consumers will be provided comprehensive informational supports about medication assistance, treatment options, and potential providers.
- Consumers will be encouraged to complete an Advance Directive; Relapse Prevention Plan; Crisis Plan; Personal Safety Plan; and Post Crisis Plan. The goal is for participants to take control of their own lives, and not be controlled by their illness, circumstances, or others.

3. Increase Wraparound services with a specified model that includes quality monitoring.
4. Adopt a comprehensive collaborative mental health-juvenile justice strategy for intervening at critical points in juvenile justice processing (initial contact, intake, detention, judicial processing, placement, probation, aftercare).
5. Perform mental health screening and assessment routinely as youths move from point to point in the juvenile justice system.
6. Provide evidence-based treatment models while within the juvenile justice system.
7. Jointly establish procedures and policies for identifying youth who are appropriate for diversion.
8. Institute and evaluate diversion mechanisms at every key decision-making point within the

juvenile justice continuum.

9. Provide Crisis Intervention Training to Police Officers.
10. Arrange for continued access to evidence-based care upon release including models such as Multi Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions.
11. Use Life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
12. Use navigators and peer advocates.
13. Integrate centers for health, mental health and life skills support (example school health clinics).
14. Use Transition centers.
15. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.
16. Use Empowerment and Engagement curricula (examples MOVE, TARGET-T).
17. Develop institutionalized consumer advisory boards.
18. Depression Care Management (e.g. IMPACT, PROSPECT).
19. Include inquiry into provision of care giving to children.
20. Continue Geriatric Mental Health Specialty Training.
21. Provide co-occurring disorders training.
22. Implement a consistent statewide approach to ensuring that family mental health supports are available for all family members (Birth on up) during both periods of homelessness and transition.
23. Use multi-disciplinary teams including mental health and chemical dependency specialists, RN/ARNP, case managers, and peer supports are available at drop in centers and shelters to provide assessment, services and supports.
24. Make available Medical Respite for youth and young adults.

25. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.
26. Implement PACT teams.
27. Establish a medication initiation and maintenance service that can be quickly and easily accessed by people without Medicaid or those with Medicaid who have not been able to get enrolled in community mental health services.
28. Create an ample supply of outreach and engagement teams aimed at identifying, engaging and stabilizing homeless persons with mental disorders.
29. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples – Youth Care Model, Mockingbird Family Model programs).
30. Develop a statewide Youth and Family Engagement Academy to mobilize funding, develop training, and match family and/or youth involvement models to community needs.
31. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.
32. Establish some transitional housing options to provide for overflow need.
33. Use 4-year and 2-year colleges to train professionals and para-professionals in psychiatric rehabilitation.
34. Encourage reinstatement of psychiatric rehabilitation programs at Washington State University and in the Eastern Washington University Social Work departments and in additional undergraduate schools.

35. Develop certificate and AA programs at community colleges in alignment with USPRA program requirements.
36. Establish a Recovery Education Center School that would be licensed by the State of Washington (e.g., college degree in behavioral health recovery).
37. Establish Recovery Schools as a post-secondary educational institution.
38. Identify early childhood aggression and implement evidence-based practices around responding to early childhood aggression and conduct problems (e.g., the Incredible Years program).
39. Work with the schools to increase early identification of emerging aggression, conduct problems, and delinquency and implement evidence-based interventions.
40. Establish treatment courts and court-based-interventions for youth and parents/caregivers with MH or SA disorders resulting in child abuse or neglect. (e.g. Family Treatment/ Dependency Court, or the Miami-Dade Infant Mental Health Court).
41. Establish treatment courts and court-based interventions for adult offenders with mental illness.
42. Establish local Triage Centers.
43. Undertake a comprehensive, cross-system financing strategy for child, youth, and family mental health that aims to maximize federal entitlements, increase flexibility, and fit state-only funds to state and local needs.
44. Collaborate with Insurance Commissioner around options for ensuring EBTs are reimbursable through private insurance plans.
45. Ensure that a specific component of the statewide training and technical assistance center is directed at education for Primary Health Care Providers (PHCP).
46. Implement a statewide approach to supporting school staff to help stabilize children and youth

experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports (PBIS).

47. Cross train DVR staff and clinical and vocational mental health staff to increase integration and communication.

48. Treatment of parents in particular should incorporate trauma treatment into substance-treatment options.

49. Screening and treatment should deliberately inquire into if clients are parenting and how these challenges impact their parenting and family relationships.

50. Create an Evidence-Based/ Promising/Emerging Practice (EBPEP) Institute to provide mechanisms to:

- Provide oversight and direction toward the implementation of EBPs including consumers, parents, and youth;
- Review, monitor, and disseminate information on evidence-based practices and current research;
- Assist communities to identify local needs, select evidence-based approaches and provide technical assistance for implementation; and
- Evaluate and maintain strategies including evaluating current and new practices and monitoring for fidelity and outcomes.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DSHS Division of Alcohol and Substance Abuse (DASA) conducts extensive evaluation and research projects. Some of these projects have explored whether clients with co-occurring disorders have equal or worse outcomes than those with chemical dependency only. More of this research will be conducted in the future as evidence based practices for co-occurring populations are implemented.

Washington Medicaid Integration Project (WMIP)	DSHS implemented an initial pilot project of WMIP in Snohomish County in the fall of 2004 to provide integrated medical, behavioral health and long-term care services for approximately 6,000 aged, blind and disabled clients. Medicaid clients who voluntarily join the project have benefited by a "medical home" in the provider network furnished by the managed care vendor contracted to integrate current services (including drug and alcohol treatment, mental health care, and medical services). HRSA is also the lead administration in the Medicaid Integration Partnership, an effort that brings together all of the Medicaid funding streams in DSHS to create a new delivery model that is client-centered and efficient. Participating administrations include Aging and Disability Services Administration (long-term care) and DSHS's Division of Research and Data Analysis.
General Assistance – Unemployable Managed Care Pilot	HRSA is currently setting up a pilot project in King and Pierce counties (the state's largest urban population) to deliver health care services to persons eligible for general assistance through DSHS. This population is often characterized by the existence of mental illness and homelessness. The pilot project is being designed to: • Maximize care coordination, high-risk medical management and chronic care management, • Improve our citizens' health by purchasing evidence-based health services, • Establish evidence-based decision-making processes that will increase the explicit use of current best practices in making care decisions, • Establish incentives for providers, using evidence-based health promotion and disease prevention programs, • Increase educational opportunities for providers on the evidence-based process and how to access information to support their decisions, and • Establish a process to determine which benefits and related scope are most likely to improve and maintain the health status of HRSA clients in an efficient manner.

DSHS, Mental Health Division (MHD)	Two recent pieces of legislation are supporting the MHD's strategic planning process. Engrossed Second Substitute House Bill (E2SHB) 1290, passed in 2005, promotes public policy focused on mental health treatments and services that are evidence and research-based [meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices (EBPs)]. The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services within the department is emphasized and includes partners outside of DSHS such as the Office of Superintendent for Public Instruction, state mental hospitals, county authorities, community mental health providers, and other support services. Such coordination will also include families and advocates of persons with mental illness to the greatest extent possible.
Crisis Response Pilots	Engrossed Second Substitute Senate Bill (E2SSB) 5763, also passed in 2005, integrates treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery. The bill also directed DSHS to contract for two pilot sites (one urban and one rural) to test changes to the chemical dependency involuntary treatment law. The pilots will integrate mental health and chemical dependency crisis response, and allow for 72-hour detention and 14-day commitment into a secure detoxification facility. The department invited all counties in the state to submit proposals for the Integrated Crisis Response Pilots. Two successful bidders were chosen and became operational March 1, 2006: Pierce County and the counties that make up the North Sound RSN. MHD and DASA have developed contracts for the services and a training curriculum for the designated crisis responders.
Children's Mental Health Initiative	In December 2003, the Assistant Secretaries for Children's Administration (CA), the Health and Recovery Services Administration (formerly Health and Rehabilitative Services Administration), and the Juvenile Rehabilitation Administration (JRA) convened a work group to address the mental health needs of children and youth who are served by these

three systems within DSHS. The DSHS Children's Mental Health Workgroup published a report in July 2004. Two significant themes that received attention both within the Workgroup and from stakeholders were the dynamic tension between statewide consistency and local discretion, and a perceived gulf between family-driven, culturally appropriate services and EBPs.

The Workgroup set forth several recommendations that addressed these tensions:

- Implement evidence-based care statewide and develop a common approach for the provision of mental health services for consumers across the life spectrum using evidence-based practices.
- Work with MHPAC on evidence-based practices (EBPs) and promising practices to identify needs and barriers to EBP implementation. Develop clear funding streams and start up costs associated with each EBP.
- Develop requests for legislation to solicit on-going funding for EBPs not covered by Medicaid.
- Provide training and technical assistance and follow-up to sites implementing currently defined EBPs.
- Develop policies and monitoring strategies for EBPs (to include fidelity assessments, incentives, increased monitoring of consumer outcomes, and a process for incorporation of new EBPs).
- Develop reporting guidelines for EBPs.
- Showcase MH agencies with effective EBPs.
- Collaborate with other DSHS agencies to implement cross-system EBPs.
- Provide training, technical assistance for evaluation, and follow-up of new promising and innovative practices.
- Continue review of clinical practices, with inclusion of promising practices as they become supported by evaluation and consumer outcomes.
- Meet with SAFE-WA to discuss and receive input with regard to the best approaches for including families and youth in the provision of services.

- Meet with Health Action to discuss and receive input with regard to the best approaches for including youth in the provision and development of services to youth.
- Support the increased involvement of youth in system development.
- Track the progress of joint strategies developed with other administrations and divisions.

Develop an information system that integrates quantitative and qualitative data across the mental health system and facilitates access to reports.

- Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement (QA&I) reviews.
- Build on existing information systems to incorporate and integrate other qualitative data (e.g. OCA, QA&I, Ombudsmen, and P&P).
- Better integrate information systems throughout DSHS to better identify older adults service needs for the development of more specific outcome measures.

Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

- Develop Performance Indicators from the consumer outcome system.
- Develop Performance Indicators that are specific to older adult issues.
- Develop consensus within MHD about goals/benchmarks for these performance indicators.
- Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.
- Develop positive incentive system for RSNs following JLARC recommendations.
- Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

	RSNs/PIHPs are implementing protocols for service delivery for the provision of services to children and youth who receive services through cross-system initiatives. These protocols were designed with the assistance of care providers, parents and other concerned citizens. RSNs/PIHPs have been involved in the design of the services for hard-to-place adolescents and they have been involved with the DSHS Children's Mental Health Workgroup discussed above.
Children's Mental Health Pilot Project	The Mental Health Division received funding to establish a pilot program to provide evidence-based mental health services to children. In collaboration with the JRA, MHD will be preparing a request for proposal to solicit bids from potential contractors. The department, in consultation with a broadly representative group of individuals with expertise in children's mental health, will establish a list of evidence-based mental health services that the pilot sites can choose to provide. The project will require significant collaboration between all of MHD's service partners including agencies and community partners. In addition, the University of Washington will provide expertise in all phases of the project including pilot initiation, implementation, training, quality assurance and monitoring implementation and outcomes. The pilot sites are planning to become operational in December 2006.
Co-Occurring Disorders Interagency Committee	The MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee (CODIAC), a committee of providers from mental health, chemical dependency, other cross-systems and consumers. This group has been in existence for approximately 12 years and addresses co-occurring mental illness and substance-related disorders. The two divisions often engage in joint studies and are currently developing a joint demonstration project serving persons with co-occurring disorders in Yakima.
NIMH Planning Grant	The Mental Health Division received a National Institute of Mental Health (NIMH) planning grant in 2003 and was able to create both internal and external work groups to look at issues related to the implementation of evidence-based practices. A subcommittee of MHPAC has been tasked with development of a work plan to guide further efforts.

The work plan includes:

- Disseminating the practices and training providers on their use;
- Identifying barriers to implementation statewide (e.g., funding, licensing, monitoring, and oversight);
- Creating a process for reviewing and selecting new EBPs and promising practices; and
- Hosting a conference highlighting the Committee's work.

As part of MHPAC's activities, an internal work group to coordinate EBP efforts across the MHD (Assertive Community Treatment-ACT, Dialectical Behavioral Therapy-DBT, and family psycho-education), DASA (integrated COD services), Child Welfare (Wraparound and therapeutic foster care services), Juvenile Justice, and the Health and Recovery Services Administration (medication algorithms).

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA has long been the provider of last resort for adolescents whose mental health and addiction problems lead to criminal offenses. With a lack of community-based services for youth, JRA provides a variety of efforts both in institutions and at the community level to prevent deeper penetration into the justice system. An early adopter of evidence-based practice, JRA continues to expand its programming efforts. The new JRA Mental Health System Design will establish acute care, extended care, and mainstream mental health treatment units in JRA residential facilities. Their strategic plan also calls on the agency to develop and sustain quality control/adherence standards to assure fidelity to evidence-based treatment modalities and practices delivered with JRA's Integrated Treatment Model (ITM). JRA will maintain a strong continuum of care for juveniles, delivering evidence-based treatment interventions that encourages and facilitates active family involvement, and promotes successful community reintegration. JRA was the first juvenile system to integrate chemical dependency treatment services throughout the continuum, and has specialized services, coordination and management devoted to

	both addiction and mental health problems for youth in their care.
Department of Health (DOH)	The DOH strategic plan contains multiple components toward quality of care, including data and quality assurance management practices. The public health model adopted by the Department relies on epidemiology and scientific research to guide management practices. To assure that public health interventions are designed using the best available evidence, and that Public Health Standards are followed.
Department of Veterans Affairs (WDVA)	All care offered within the War Trauma/PTSD Outpatient Program undergoes several levels of assessment and guidance. The network of providers works to ensure that best practices are employed, and that outcomes meet the expectations of the program. Clients are surveyed in a variety of ways, from customer satisfaction surveys, symptom change assessments, to longitudinal outcome assessment using standardized tools. At all levels from point of referral to time of intake, to the full duration of treatment, clients are informed and offer opportunities to provide input regarding the quality, effectiveness, type, duration, and expectations of treatment. All providers are held to the highest of standards for care, and must pass audits of care and site visits. Quality of care is appraised in several ways, allowing for lowered risk concerns and offering the latest in treatment advances. Frequent training events and conferences allow contractors access to PTSD and other treatment literature and consultation resources.
Office of the Superintendent of Public Instruction (OSPI)	As the lead state educational office, OSPI funds basic education through 243 school districts. A number of coordinated efforts exist locally to provide mental health services. However, there is work remaining to instill the principles of consumer involvement and recovery/resiliency into the educational system. There are two particularly significant developments in Washington State that create opportunities to advance Transformation: Washington Learns, a joint Executive/Legislative body co-chaired by Governor Gregoire and Superintendent Terry Bergeson; and, the newly created Department of Early Learning. Both bodies will be critical to the success of transformation.

Additionally, Chapter 4, *Prevention* describes some of the work required to better understand issues regarding pre-school and school-aged children.

The OSPI five-year strategic plan includes a strategy aligned with the Presidents goal #5: improving collaboration with the Department of Social and Health Services and other child serving agencies to improve access to care for children in school. The OSPI also aligns with this goal in a number of important programs, such as chemical dependency and prevention coordination efforts, and Readiness to Learn, a school based program to improve child well-being.

Transformation Grant Activities

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

A strategic Research Partnership will bridge the gap between research, policy and practice

Mental health policy development in Washington state has historically been somewhat fragmented. As is typical in a complex public policy arena, little crossover has traditionally existed between the research coming out of the academic community and the policies and practices pursued by policymakers and the service provider community. More often than not, key players have competed, rather than collaborated, for limited funding and innovation opportunities.

The MHTP is working to change that with the creation of the informal Research Advisory Group. On a quarterly basis, the MHTP brings together university researchers and state agencies to talk about the critical needs and how to make the most of the resources available. The Research Advisory Group is designed to provide a forum for discussing practical solutions to real world problems, through the application of science-based research. Researchers are encouraged to collaborate with each other and with state agencies on projects, and strategic partnerships are developed for joint bids on grants and other funding opportunities.

The Research Advisory Group bridges the gulf between scientific research and practical applications by encouraging new collaboration and partnerships across organizations and disciplines, all with the intent of focusing the considerable wealth of knowledge and expertise to develop new empirically

based and tested approaches to mental health services. In Year 2 of the grant, local government, providers, tribes and consumers/families will be invited to participate.

Local law enforcement entities are convening a summit to examine policies and implications of mental health practice

The Washington Association of Sheriff's and Police Chief's (WASPC), with support from the Project, will conduct a policy summit in September of 2006. The agenda for the summit is examining the policy and implications for practice pertaining to consumers in local jails. The Transformation process often identified problems associated with mentally ill individuals held in jails. Local jails are often in the position of responding to and containing consumers in crisis. On most occasions, some criminal activity is involved, but statistics bear out that individuals with mental health problems spend more time in jail than non-mentally ill individuals.

The summit planning group envisions an opportunity to bring policy makers together to discuss solutions. A variety of strategies emerged in the process conducted by the Project, including Crisis Intervention Training for police officers, triage centers and better service relationships between mental health providers and jails. The audience for the summit will be state and local officials in law enforcement, justice and treatment as well as elected officials at both the state and local level. The anticipated outcome of the summit will be a set of policy initiatives to address the issue of mental health and substance abuse services and jails.

Next Steps – Year 2-5 Gap Analysis

Many of the Subcommittees recommendations proposed that new practices be implemented, in some cases to extend existing services, and in some cases to supplant existing services. Many of the practices requested do not meet objective criteria as being "evidence-based," and the EBP Task Group expanded its scope to include a number of practices consistent with subcommittee recommendations.

A review of recommendations from the Subcommittees and the Task Groups and the State strategic plans reveals a wide diversity in approaches. State agencies are planning to ensure that excellent mental health care is delivered and research is accelerated. The review suggests that a great deal of what has been recommended is indeed identifiable in strategic plans. However, many of the recommendations are broad and general, and some of the content of the strategic plans are written without enough specificity to determine the overlap or alternatively, a lack of congruence.

Generally, most of the Transformation recommendations achieve at least some mention in the strategic plans, but it is not clear precisely what is being considered that might address the issues surfaced by subcommittees. Strong congruence is evident in some areas. For example, implementation of evidence-based practices, particularly for children, is evident in both the recommendations and strategic plans. Additionally, the need for accelerated research is also evident. Another strong area of congruence was the emphasis placed on independent Ombuds services for mental health. Although the MHD strategic plan does not provide any specificity as to how it will pursue this goal, the direction is clearly stated, and consistent with the Adult Consumer Subcommittee recommendation. In general, there is greater congruence with regard to children's issues than there is for adult consumer service issues.

These gaps exist in part due to the vagueness of state agency strategic plans. Notable among these are criminal justice interventions. Subcommittees identified broad goals. Task Groups defined specific strategies. Existing strategic plans are non-committal in terms of specific activities to be pursued. The same is true for supporting recovery-oriented, and consumer run services. While clearly identified as desirable goals, some state agencies do not appear to be advocating this approach yet.

Other notable gaps include older adult issues identified by subcommittees and in the co-occurring disorders (COD) goals. The strategic plans of ADSA, DASA and MHD stress activities related to the CODIAC Committee and annual COD conference.

While these efforts are positive steps in the right direction, it is unclear whether the recommendations from the subcommittees and task groups will emanate from the efforts described in the strategic plans.

Strategic plans as currently written are often general, and for the most part, do not reflect much in the way of interagency goals, objectives, and cross systems planning to allow meaningful progress towards the identified subcommittee outcomes to occur. Future planning efforts need to be more specific and concise, and engage multiple agencies working in unison to achieve tangible progress regarding many of the recommendations of the subcommittees.

SECTION 6:

Federal New Freedom Commission Goal #6

Technology Is Used to Access Mental Health Care and Information.

FEDERAL RECOMMENDATIONS

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
6.2 Develop and implement integrated electronic health record and personal health information systems.

The Transformation Work Group has provided the Task group with guidance and direction to explore technology options

As part of the Transformation Project, the Transformation Work Group (TWG) created the Information Technology (IT) Task Group to develop strategies for transforming the state's mental health system in Washington State.

The objective of the IT Task Group was to develop specific strategies for achieving the TWG's approved outcomes. More specifically, the TWG guided the task group to develop strategies that support linked and/or integrated data across systems. Further, the state will continue to explore ways to make available to individual consumers data from their encounters with multiple providers and make that data available to the consumer's multiple providers and case managers. The goal is to make these data available "on the ground" in "real time." The TWG believes this should be a systemic approach that includes all state systems, and should not be limited to only mental health related systems.

Consumer Privacy will be a paramount concern in system development

Pursuing strategies that would further this concept would necessarily include systems that contain data related to specific individuals, therefore it is even more critical that impacts on consumer privacy and consent be thoroughly addressed. Particular attention should also be given to the relative costs and benefits of each specific strategy.

Consumer input will be a long-term requirement to improving data and technology options

All of the IT strategies will require consumer input and continuing design work. Key issues include:

- Protecting privacy for individual consumers while still facilitating integrated service provision.
- Reviewing contents of websites, screens and reports to be sure they are useful to consumers, providers and managers.
- Reviewing performance measures, outcomes, and evaluation plans: *Are they really measuring what they should?*
- Reviewing websites and reports for accessibility to persons with disabilities, for needed translations, and to be sure that the content is inclusive and respectful.
- Developing vision for continuing directions.

IT Task Group Recommended Strategies

The following strategies were defined by the MHTP IT Task Group in response to Presidential Goal #6.

1. Develop and pilot a consumer-focused, customer driven, recovery focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings.
2. Develop a website for each consumer that contains an assessment tool and its accompanying recovery goals, which change over time, and can be accessed if consumer gives permission.
    - Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital.
    - Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
3. Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.
4. Develop and pilot a Smart ID Card and associated Consumer Hub database, and link it to agency databases so they automatically draw demographic and geographic information from the

Consumer Hub.

5. Develop “spaces” on consumer website to record consumer needs and diagnoses centrally and link those spaces to each legacy website to automatically copy fields containing assessments and diagnoses into the consumer website.
6. Develop consumer “spaces” to record shared cases and link those spaces to each legacy system to automatically copy fields containing case manager actions into the consumer website.
7. Develop “spaces” on the consumer website to record prescription medications centrally, and link those spaces to each legacy website to automatically copy fields containing prescriptions, along with dates, into the consumer website.
8. Extend the DSHS Client Services Database tables to all public and charity-funded consumers (persons receiving health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital). Use monthly or quarterly extracts from each source to add consumers, services, dates and costs (paid and imputed from the encounter data). Verify results with sources.
9. Use the Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information from Strategy 5. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic.
10. Use the Outcome Database to monitor client outcomes resulting from services received from various MH and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information.
11. Develop quality assurance websites for the providers in each local area, reporting outcomes for different types of consumers.
12. On an ongoing basis, monitor the fidelity to care standards of new and expanding mental health services. Report by provider.
13. Develop a training and quality assurance database on selected evidenced-based practices.

14. Develop a data table comparing service need to service use and service supply over time. Could easily be generated for government funded consumers from the expanded consumer database and the needs assessment database for consumers generated in previous strategies.
    - Use the data table to produce tables and maps for each local area showing the "supply" of providers in relation to the "demand" from the consumer-driven needs assessments ("Supply Rate"). This will allow local communities to decide what "fill in the gap" services might be useful.
    - Use the same table to develop performance measures saying what proportion of consumers "got" the services they needed.
15. Develop the website and define a process for choosing and refining content; develop and update the general content.
16. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.
17. Provide on-line training on psychiatric rehabilitation and other topics for families, consumers and others in the community. Track both on-line and in-person usage of that training.
18. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
19. Develop an on-line "registration" form for consumer-run services and groups. Develop a webpage displaying services on the mental health website.
20. Cost out various alternatives for charging services; choose one, and implement it.
21. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.
22. Develop on-line training materials. Make sure they

are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #6 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DSHS Division of Alcohol and Substance Abuse (DASA) utilizes a variety of web-based applications for data collection and data analysis including conducting research using administrative databases (mental health, Medicaid, employment, criminal justices and others).

DSHS, Health and Recovery Services Administration (HRSA)

The Health and Recovery Services Administration (HRSA) plans to maximize use of technology to take advantage of online services, such as electronic enrollment, eligibility reviews and client communication while safeguarding client privacy. Three specific projects are underway that highlight HRSA's efforts.

Reprocurement Of The Medicaid Management Information System

HRSA has begun the process of re-procuring its legacy Medicaid Management Information System (MMIS), which is currently the main payment system for medical assistance programs as well as other Medicaid-funded services. As envisioned, the new MMIS will assume more payment responsibility within the agency, handling all medical services (both Medicaid and non-Medicaid) as well as those non-medical programs determined to be compatible to MMIS and its new capacities. The MMIS design improvements will also include reporting and decision support capabilities as well as expand into new areas of utilization and accountability, helping DSHS operate more efficiently and effectively than before. In this new role, MMIS will become less of an HRSA system and more of the basic DSHS payer and payment information system.

Outpatient Prospective Payment System (OPPS)

HRSA is modeling the Outpatient Prospective Payment System (OPPS) along the lines of a DRG (Diagnostic Related Groupings) reimbursement structure that would apply to outpatient services. The new system, which will be phased in, will decrease the amount of cost-based payments and replace them with payments based on the actual treatment

and services provided. Because the same methodology is already used by Medicare, the Health Care Authority and Labor & Industries, the new system also offers some consistency to providers.

Emergency Room And Access Research

HRSA has formed a workgroup to begin regular reports and data analyses on provider-access data, including client utilization of Emergency Rooms. Initial reports show that more providers have signed up with HRSA today – refuting rumors of a physician exodus from the program. But other patterns are disturbing – the additional physicians are not keeping pace with the increasing caseload, and Emergency Room utilization is on the increase. Ultimately, this research will provide HRSA with a more efficient grasp of access, give providers guidance on patient-access concerns, and offer clients better health outcomes.

DSHS, Mental Health Division (MHD)

As a result of participation in the 16-state pilot Indicator Project and the 2001 Joint Legislative Audit and Review Committee (JLARC) report, the MHD has moved toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the division, RSNs, and providers spent considerable time updating and revising data reporting requirements and guidelines. The BBA of 1997 has also placed a heavy emphasis on the use of data for management and quality improvement activities.

- Use health technology and telehealth to improve access and coordination of mental health care, especially for consumers in remote areas or in underserved populations.
- Survey the mental health community for current uses of health technology and telehealth.
- Continue to support RSN videoconferencing to enhance consumer and stakeholder meeting capabilities, specialty consultations, and remote site access to care and services.
- Explore financial aspects of telehealth use, and coordinating traditional health and telehealth visits.

Develop and implement integrated electronic health record and personal health information systems**.**

- Survey the mental health community for current

use of electronic health records and personal health information systems.

- Continue to support the implementation of the integrated state hospital information system.
- Continue to support the implementation of a person-centered, integrated, comprehensive electronic health record at all state facilities and community mental health agencies.

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. The agencies Client Activity Tracking System (CATS) is a technology supporting effective case management and service provision for youth in their care. The Strategic plan action calls for full implementation of this model.

Department of Health (DOH)

The DOH strategic plan requires use of data to inform the public and design public health programs.

Department of Veterans Affairs (WDVA)

The War Trauma/PTSD Outpatient Program is customer and referral agent accessible from the agency webpage. This site is cross-referenced with many other national and in-state links allowing ease of electronic access. Many veterans and family members find our mental health counseling services through our webpage. Email is used in a HIPAA safe manner to offer information that will lead to information and referral. The webpage offers many informational and educational resources that would assist the treatment seeking veteran or family member find direct information and services, such as all of the WDVA PTSD Program contractors, the federal VA Medical Centers, and all other VA clinics and resources in Washington State. Additionally, other links permit direct access to the world's largest PTSD and war trauma reaction professional library, where a user friendly search offer's solid information about PTSD and other mental health issues. Email traffic within the PTSD Program is monitored daily, even on holidays and weekends, when individuals might be most troubled by their concerns and readjustment needs.

The agency offers a host of other informational resources that would act to help stabilize the life of any veteran and family members. This includes information about benefits and placement of veterans

in one of the WDVA Veterans Homes. Emergency care through the VA Medical Centers can also be found as the customer or referring professional accesses the cross-referenced federal sites. This includes access to federal VA emergency mental health services and hospitalization contact numbers and locations of services.

Transformation Grant Activities

The Transformation Project has funded a project to integrate administration databases from multiple organizations (MHD, DASA, criminal justice and employment). This integrated database will be used for multiple purposes including tracking outcomes. The project has also funded the MHD to improve capabilities of the state to report on the SAMHSA National Outcome Measures (NOMS).

There are several Regional Support Networks who have begun development on electronic health records and project staff are following their progress. The team is also working with a statewide group with representatives from DOC, the courts, local jails, and key legislators to develop electronic health records for those organizations. The TWG has also recommended that Transformation staff follow the progress of the Health Care Authority as they are the Governor's designated lead on developing electronic health records.

Gap Analysis

Although the project is involved with multiple agencies in utilizing technology to document services and track outcomes, little has been done this first year around the telehealth strategies.

Next Steps – Year 2-5

When considering strategies related to integration of data across systems, particular attention should be given to the relative costs and benefits of each specific strategy, and to the impacts on consumer privacy. The TWG requested that the IT Task Group conduct a high-level assessment of their strategies to determine costs, resources, and implementation timelines. The Task Group should focus their assessment on those strategies they believe are the most feasible.

In addition to developing integrated databases for outcome tracking and potentially in cross agency efforts to develop electronic health records, we plan to pursue telehealth strategies in Year 2.

SECTION 7:

Washington State Goal #7

Individuals with mental illnesses have stable housing in the communities where they live.

Washington Believes Stable Housing Opportunities is Critical to Transformation

Washington consumers have identified housing as a key component to successfully managing their mental illness. However, the lack of stable housing, including the lack of support systems to maintain housing, was a key finding in Washington's Resources Inventory and Needs Assessment (See Appendix 2). Consumers also reported problems stemming from the length of time it currently takes for a person to obtain subsidized housing. Reportedly, it can take many months before a person becomes eligible for subsidized housing.

As a result Transformation Project staff asked key informants to provide recommendations for improving stable housing options for consumers.

Subcommittee Recommended Outcomes

The following outcomes were recommended by TWG subcommittees to address housing-related improvements.

Homelessness Subcommittee

1. Housing will be available immediately upon need for individuals/families.
2. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).

Key Informant Outcomes

1. People with mental illnesses have stable housing and employment opportunities in the communities where they live.
2. Increased availability/production of affordable housing, with appropriate supporting services for people with mental illnesses, throughout the state.
3. Improved discharge planning from state institutions to eliminate the release of people with mental illnesses without stable housing and supportive services in place.

Task Group Recommended Strategies	The following strategies were recommended by TWG task groups to address housing-related improvements.
Key Informant Strategies	1. Improved linkage of housing, employment, and treatment policies and resources at the state level including integration with mental health legislative initiatives related to state hospital usage and development of community-based alternatives. 2. Provide incentives at the RSN/community/ provider level to promote and fund more supportive housing. 3. Improve data collection to track the housing status of all clients receiving services through DSHS, DOC, DOH, and/or CTED.
Evidence-Based/ Promising/Emerging Practices Task Group	1. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples –Youth Care Model, Mockingbird Family Model programs). 2. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing. 3. Establish some transitional housing options to provide for overflow need. 4. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to State Goal #7 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DSHS Division of Alcohol and Substance Abuse (DASA) funds and/or supports a variety of housing programs such as the Oxford House and other transitional housing. This includes specialized housing for men, women, and pregnant or parenting women. DASA also works with local government and providers to team up with housing organizations to increase the types of housing available to chemically dependent individuals.

DSHS, Mental Health Division (MHD)

The DSHS, Mental Health Division is the contracting agent for local-level services provided through RSNs. With regard to residential and housing services, Chapter 71.24 RCW requires that RSNs ensure:

- Active promotion of access to and choice in safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- Provision of services to families of eligible people who are homeless or at imminent risk of becoming homeless, as defined in Public Law 100-77, through outreach, engagement, and coordination or linkage of services with shelter and housing.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in Chapter 71.24 RCW.

Department of Community, Trade, and Economic Development (CTED)

CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. CTED's strategic plan identifies an important strategic initiative: *Interagency coordination of homeless programs to support effective provision of housing*. A goal of this initiative is to improve the lives of homeless

	individuals and maximize resources by providing increased coordination and reducing the fragmentation of housing services. In 2006 the state created the Interagency Council on Homelessness in response to the 2005 legislative requirement to reduce homelessness in Washington State by 50%.
Department of Corrections (DOC)	DOC will assist offenders in connecting with housing services.
Department of Veterans Affairs (WDVA)	WDVA has for many years offered homeless outreach to troubled veterans and families. This has taken many forms and has worked with target populations to include rural, urban, and women veterans. Joblessness has also been the focus on other subprograms. In all cases the mental health status of each individual has been the concern when placements are accomplished. The War Trauma/ PTSD Program has long worked with those who are homeless, or who have a high potential for homelessness. Forty percent of homeless are thought to be veterans, and a very high percentage of this group also suffers significant mental health related problems. WDVA is working to create a specialized program that will house, treat, and train homeless veterans within the next year. In conjunction with the federal VA, these services will act to address to a greater degree the needs of this population
Transformation Grant Activities	As part of the transformation process, Washington State is exploring additional opportunities to expand stable housing for consumers and their families. For example, Transformation Grant staff are collaborating with other Washington stakeholders to end homelessness and create employment opportunities for individuals who are homeless and also experiencing mental illness. These initiatives include "Taking Health Care Home" which is located in King County and administered by the City of Seattle, in collaboration with the Divisions of Vocational Rehabilitation and Developmental Disabilities, providers, RSNs, members of the private sector such as developers, and other key housing and employment stakeholders.
Gap Analysis	Housing issues are intimately tied to issues of employment. Efforts to create jobs for consumers, as well as families and youth, both within the existing service delivery system and complementary to it, cannot succeed without the recognition of this

relationship. In addition, implementation of the CMHP outcomes and strategies will require that non-traditional partners (e.g., ESD, CTED) become engaged throughout the process and coordination efforts be expanded. This coordination should focus on increasing efforts to reduce stigma for individuals with mental illness who seek both housing and employment as part of their recovery. This effort will also be coordinated with the MHTP's Social Marketing Campaign and Workforce Development initiatives.

While many state agencies have identified housing as an area in need of policy attention, additional cross-agency coordination is needed to identify specific projects for future implementation.

Next Steps – Year 2-5

Many counties are developing strategies to end homelessness in ten years. This is a national movement. The Transformation Project has been in contact with several statewide homelessness and housing committees and will work toward creating collaborative strategies in Year 2.

SECTION 8:

Washington State Goal #8

Employment is an expectation and a priority in Washington for people with mental illness.

Washington Believes Improving Employment Opportunities and Outcomes is Critical to Transformation

Key findings from Washington's Resources Inventory And Needs Assessment (see Appendix 2) clearly articulate several consumer concerns regarding opportunities for consumers to obtain and sustain employment.

- Most consumers do not believe that mental health services help them get basic resources such as employment and safe housing – services are not seen as helping them gain independence.
- Almost half of the respondents reported they are seldom, rarely or never supported in getting the education and guidance they and their families need to be fully supported.
- Most respondents (57%) reported that they have never been helped by mental health services to get or keep employment.
- Only 13% of all respondents reported being employed.

As a result, the Transformation Project staff asked key informants to provide recommendations for improving employment opportunities and outcomes. These individuals developed their recommendations based two guiding principles:

1. We believe in the value of work at the earliest stages of recovery, as an aid to the recovery process.
2. We recognize that employment can help people develop motivation to change, promote dignity and self-respect, and instill hope for the future.

Subcommittee Recommended Outcomes

The following outcomes were recommended to address employment-related improvements. A complete list of strategies and outcomes is included in Appendix 3.

Adult Consumers and Families Subcommittee

1. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality, supported employment based on national standards. These programs work collaboratively with Division of Vocational Rehabilitation (DVR) to ensure employment for as many consumers as possible.

Key Informant Outcomes

1. People with mental illness are successful in getting and keeping employment in the community where they live.
2. Increased availability of targeted employment-related resources, supports and services for people with mental illness throughout the state

Task Group Recommended Strategies

The following strategies were recommended by the task groups to address employment-related improvements.

Key Informant Strategies

1. Improved linkage of employment policies and resources at the state level with the Mental Health Division and the Division of Vocational Rehabilitation jointly responsible for alignment, leveraging and accountability.
2. Incentives at the RSN/community/provider level to promote and fund supported employment as an evidence-based practice.
3. Improved data collection to track the employment outcomes for mental health customers who utilize DVR, Clubhouses, WorkSource and other employment related resources.
4. The Mental Health Division, Division of Vocational Rehabilitation, RSNs, and Consumer Organizations will jointly sponsor statewide and local working groups comprised of a majority of employers to identify/implement specific strategies and activities that result in increased employment opportunities for consumers.
5. Increase employment activities.

6. RSNs and Community Mental Health Professionals will deliver therapeutic services that increase a consumer's resiliency in a work setting and supports the individual in getting and keeping a job, based on a model that recognizes employment as an essential element of recovery.
7. Community Mental Health Services will include specific activities that enable consumers to maintain long term stability on the job, including activities that assist employers in supporting consumers on their jobs.

Evidence-Based/ Promising/Emerging Practices Task Group

1. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
   - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
   - Consumers in this program will be eligible to purchase services for the purpose of accessing:
     - Supported Employment.
   - Recovery support services (services that are alternative to traditional mental health services) such as:
     - Services related to developing employability and/or productivity that will lead to employability.
2. Use individual placement and support.
3. Use assertive community treatment with employment component.
4. Provide supported employment and clubhouse-based transitional employment.
5. Use peer support, WRAP, clubhouse, and supported education as a way to maintain recovery and retain employment.
6. Cross train vocational rehabilitation staff and clinical and vocational mental health staff to increase integration and communication.

7. Provide support for consumer-owned and operated businesses.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to State Goal #8 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Aging and Disability Services Administration (ADSA)

ADSA plans to implement the Working Age Adult policy for developmental disability clients. This policy relates to providing eligible clients with employment programs, clients with co-occurring mental illness.

DSHS, Division of Vocational Rehabilitation (DVR)

DVR will adopt methods, rules and polices that create equitable access to services for individuals with all types of disabilities.

DVR will develop counselor skills serve individuals with the most significant barriers to employment. They will modify service provider contracts to allow more flexible, outcome-based and cost effective services. DVR will work with the Mental Health Division (MHD) to develop a supported employment program as well as a strategy for sustaining clubhouse models.

DSHS, Division of Alcohol and Substance Abuse (DASA)

DASA encourages strong connections between providers, vocational employment organizations and local government in order to improve client employment outcomes. A collaborative effort between local Temporary Assistance for Needy Families (TANF) offices and the chemical dependency systems has resulted in the co-location of counselors in the TANF office to screen clients and refer to treatment as needed so that their dependency is not a barrier to obtaining or sustaining employment. DASA also monitors employment outcomes of all treatment clients utilizing administrative databases.

DSHS, Mental Health Division (MHD)

RSNs and PIHPs coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services; to assist consumers to achieve the goals stated in his/her individualized service plan; and to provide access to employment opportunities, including:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect

income and benefits the consumer is receiving because of their disability;

- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-Discrimination Law.

The Mental Health Division is a primary party to the Medicaid Infrastructure Grant that has a focus on consumer recovery, and has included the following actions, accounted for in annual reports to the public and to the MHPAC:

- Numerous trainings statewide on Healthcare for Workers with Disabilities and Ticket to Work;
- Seven “Pathways to Employment” conferences held throughout the state which provide information on employment-related programs, housing, transportation, social security benefits and other information related to recovery;
- Employment track offered at the annual Behavioral Health Conference held each June;
- Twenty conference scholarships awarded to consumers involved with employment-related programs;
- Ongoing collaboration with other DSHS partners in order to increase the infrastructure of employment-related supports for persons with disabilities;
- Membership on the advisory board for the Center for Continuing Education on Rehabilitation;
- Continued funding expected for one FTE in 2005;

	and • Continued funding is expected to initiate an Enhanced Peer Support Training module, offered in addition to the 40-hour required training for certification.
DSHS Juvenile Rehabilitation Administration (JRA)	JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA strategic planning calls for expanding and strengthening education and vocational programs throughout the juvenile systems continuum of care.
Department of Community, Trade, and Economic Development (CTED)	CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. Through local economic development councils, CTED is responsible for linking WorkFirst clients to employment opportunities. CTED recognizes the need to serve disabled and vulnerable populations; however, it remains unclear if mentally ill individuals are effectively identified for supported services in locating and keeping employment through this program.
Department of Corrections (DOC)	DOC will assist offenders in connecting with employment services.
Employment Security Department (ESD)	ESD will develop processes and methods to identify individuals who need WorkSource assistance most and increase job placement services to them. This includes individuals with disabilities who lack the education or training to compete for good jobs. To accomplish this task, the Transformation Project staff will need to work with ESD as they improve their assessment process to identify persons who have mental illness and require additional support services in order to become employed.
Department of Veterans Affairs (WDVA)	WDVA is working to create a residential transitional program currently being planned to open on the Retsil Veteran Home campus next year. This unique program will train and place disabled veterans in jobs, while also helping them return to community life. This program borrows from successful models that have worked with similar populations by

creating stability, consistency, safety, and sufficient time and treatment/support, to endure attempts to resume participation in gainful employment. The federal VA is a partner in this new program, one that will offer great hope for our troubled war veterans.

WDVA also offers a program that resulted from recent state legislature efforts. This specific effort is aimed at helping war disabled veterans return to active connections within the world of work. The Veteran Conservation Corps (VCC) has already created dozens of opportunities for disabled veterans, particularly those with war-related Post Traumatic Stress Disorder (PTSD), to work within their community on wildlife projects, most notably, salmon habitat restoration. Guided by an experienced contract wildlife biologist and former PTSD treatment provider, veterans are placed in stream, estuary, and coastal tideland restoration activities that are designed to allow the veteran to participate constructively in the work of restoring salmon runs and related critical environments. Over the next few months these activities will be enhanced when six placement coordinators situated around the state begin placing veterans into restoration work sites. Connections with various state and federal agencies, private funding resources, and organizations dedicated to restoration efforts, is allowing previously fully disabled and socially disconnected veterans an opportunity to return to healthy occupational experiences. For many of these very traumatized warriors, this is often the first time they have been able to offer something to their communities and at the same time see the products of their efforts. The results their hard work, often stands in direct contrast to what these veteran might believe and remember about the combatant lives. Performing in this way, allows for a renewal of who they are and their potential for benefit to the community.

Transformation Grant Activities	As part of the transformation process, Washington State is exploring additional opportunities to expand employment related activities for consumers.
Gap Analysis	While many state agencies have identified stable employment as necessary for an individual to achieve recovery, few of these agencies have delineated clear strategies for accomplishing this. As mentioned in Goal #7, all effort to increase employment opportunities will be coordinated with our partners to ensure that activities related to both housing and employment are considered together.
Next Steps – Year 2-5	The MHTP Project is already engaged in crafting a Workforce Development Plan aimed at both expanding the current mental health workforce in alignment with SAMHSA's efforts (as laid out in the DRAFT National Action Plan developed by the Annapolis Coalition) and expanding the number of consumers, family members and youth employed in delivering mental health services in Washington. In Year 2, we will facilitate cross-agency discussions in an effort to develop more specific recommendations and strategies regarding employment services.

CHAPTER 2:

GOVERNANCE AND ORGANIZATIONAL STRUCTURE

LEADERSHIP AND GOVERNANCE IN MENTAL HEALTH POLICY IS BROAD-BASED

In Washington State, a broad consensus has developed among the mental health community stakeholders about the need to transform the mental health system. At the state level, both the legislative and executive branches have demonstrated a firm and lasting commitment to this effort.

Legislative Commitment: In 2004, the legislature established the Joint Legislative and Executive Task Force on Mental Health Services and Financing, a body that has significantly influenced the direction of change. Based on recommendations of the Task Force, the legislature acted promptly by appropriating monies to fill a critical funding gap, and adopted legislation that has modified state policy related to the provision of mental health service and gave the state's lead agency increased authority (accompanied by the expectation of increased accountability).

In addition, this body prompted the state Department of Social and Health Services to submit a proposal for the Mental Health Transformation Grant, a move that was strongly endorsed by the Governor.

Executive Branch Commitment: Governor Gregoire not only supported the Task Force's recommendation to pursue the transformation grant but also demonstrated the strength of her leadership in this arena by establishing the Partnerships in Recovery Initiative to provide an organizational framework for pursing mental health transformation in Washington State.

Key agencies and community organizations (including tribal/state/local government, providers, consumers, families, mental health planning advisory council and law enforcement) are also supporting the transformation process by committing leadership and resources to the transformation process. A goal of the Transformation Grant is that leaders from key organizations will partner together to develop the future direction of mental health in the state of Washington. These collaborations are occurring and will continue to be facilitated and supported by the MHTP staff.

FORMAL TRANSFORMATION GOVERNANCE

Since the award of the Transformation Grant to Washington, as one of seven demonstration states, a more formal governance structure has been established. (Exhibit 2 illustrates the governance and organization structure for the project.) This, too, is broad-based and draws on leadership from a variety of mental health venues, advocates, and allied fields throughout the state. Governor Gregoire continues to assert her leadership role, and has established the Mental Health Transformation Project team within her office. By making the transformation office an arm of the Governor's Office rather than delegating the work to a state agency, the project achieves a high level of visibility and status necessary and appropriate to the task at hand. This placement also signals to all partners that this is an inclusive process that crosses agency, government, and geographic borders.

Transformation Work Group (TWG)

The MHTP is guided by the executive-level Transformation Work Group (TWG.) The TWG is comprised of 32 members, including state agency directors, tribal representatives, leaders of local government agencies and community organizations, provider associations, consumer/family organizations including youth, The Mental Health Planning and Advisory Council and law enforcement. This body is charged with establishing the vision for transformation of mental health services in Washington State, preparing the CMHP, and providing strategic direction and oversight to the transformation process. The Transformation Project Executive Director chairs the TWG.

Organizational Structure

As noted above, the TWG is supported by the MHTP team in the Office of the Governor. This small, professional staff provides staff support, community outreach and facilitation, research, analysis and other services to the TWG and to its various supporting subgroups. Team members bring a variety of skill sets to the project. Several members of the team are consumers who are charged with ensuring the consumer perspective is considered at every step of the project.

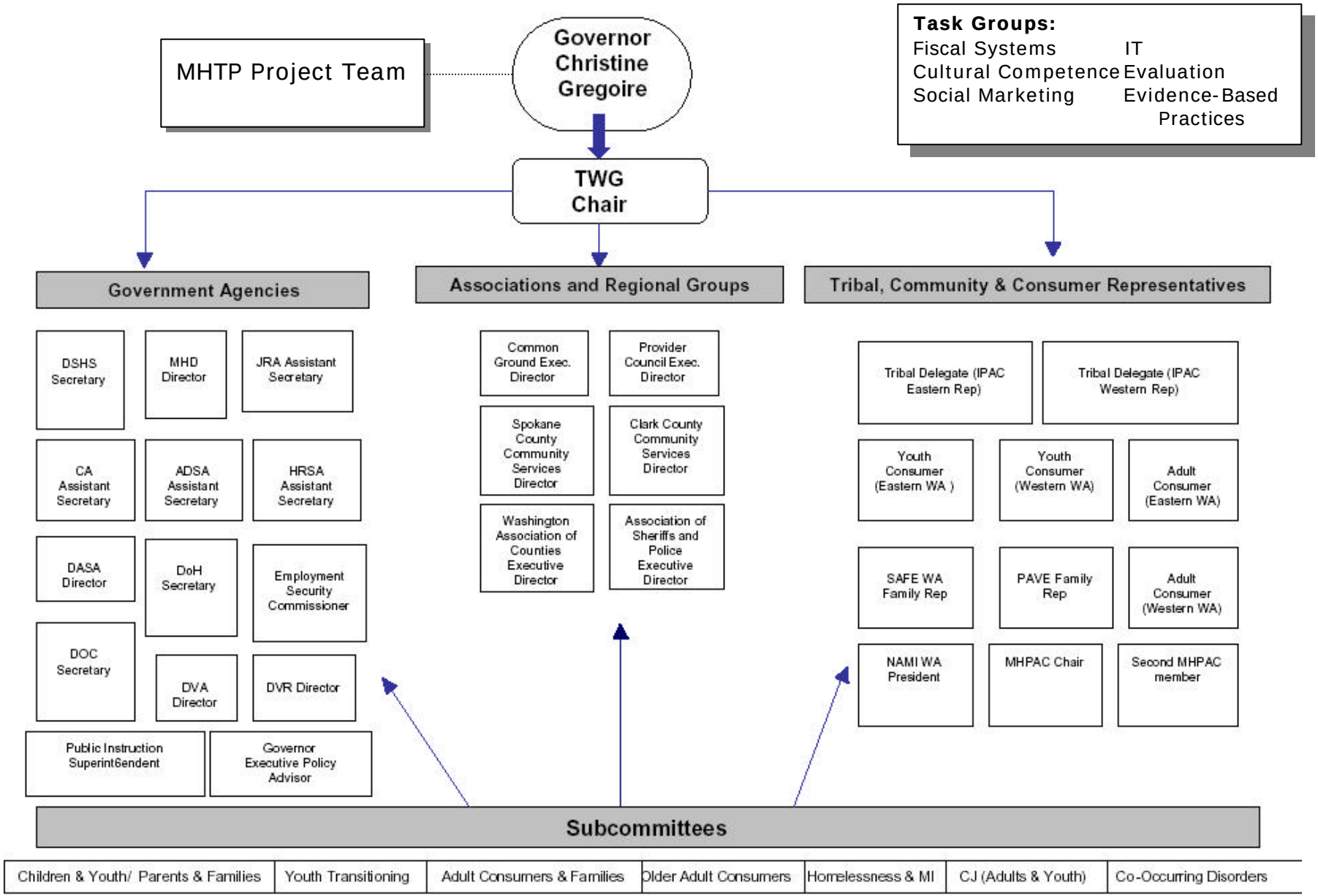


Exhibit 2:
MHTP Organization Structure

Subcommittees identified the priority outcomes a transformed system should be designed to achieve

The TWG established two sets of advisory teams to help guide its efforts. Subcommittees – comprised of consumers and family representatives, local, state and other community agencies – were appointed to gather public input on strengths and weaknesses of the current system and, more importantly, to define what a transformed system should look like. The subcommittees were charged with identifying what outcomes a transformed system should be designed to achieve. Subcommittee membership included at least 51% Consumers and family members to ensure their work reflected the consumer voice and focus.

Task Groups identified strategies for achieving those priority outcomes

The TWG was also advised by task groups, comprised of knowledgeable experts (including agency staff, clinicians and service providers, researchers, and consumer representatives). The task groups were asked to identify specific strategies that could be used to achieve the identified outcomes.

In Year 2, TWG and the MHTP shift to facilitating and supporting partner agencies

The outcomes and strategies presented to the TWG provide the direction and form the vision underlying this CMHP. The responsibility of converting these visionary action plans into reality rests with the transformation partners. The TWG and the MHTP project staff will be working in Year 2 and beyond to facilitate and support participating agencies in their efforts to translate the vision into concrete actions.

Integrating Transformation with the Mental Health Planning and Advisory Committee

The Mental Health Block Grant Planning and Advisory Council (MHPAC) is a key participant on the TWG and in the Transformation Grant process. In addition, two Transformation staff members sit on MHPAC and MHPAC members have been involved with the subcommittees and task groups established in year one of the grant. Also, MHPAC sits on the Community Transformation Partnership (CTP), a group of consumer/family organizations that the Transformation Project is helping to develop its structure and direction.

Interrelationships between Transformation and the state's Mental Health Block Grant

We do not yet have clarity on the interrelationships of the Block Grant and the Comprehensive Mental Health Plan. This discussion will begin as soon as we submit our first year plan.

CHAPTER 3:

MENTAL HEALTH TRANSFORMATION IN INDIAN COUNTRY

INTRODUCTION

Washington State has worked towards developing consistent relationships with the Tribal governments within our state. The Centennial Accord affirms the government-to-government relationship between the state and Tribes. In keeping with those expectations, the MHTP developed a parallel process for providing Tribal input, tribal outcomes and strategies contained in this chapter, with the support of the American Indian Health Commission, the DSHS Indian Policy Advisory Committee, and through contract with the Northwest Portland Area Indian Health Board (NPAIHB).

Two public forums were conducted in May 2006. NPAIHB conducted a thematic analysis of the information received during those events. Each item identified showed the number of times it was raised as an issue in the meetings (the number in parenthesis before each stated theme). In July, the Indian Policy Advisory Committee (IPAC), a function of the Department of Social and Health Services with Tribal leader membership, reviewed and organized the themes from the two public forums into two major outcomes and specific, recommended strategies for reaching those outcomes. The report appears here in its entirety: the TWG has received the recommendations and they are currently under review.

TRIBAL FORUM REPORT[1]

Overall Outcome: In accordance with the principles of the Centennial Accord, the Mental Health Transformation Grant activities will be developed and measured with a commitment to the Government-to-Government relationship of the Governor's Office and the Federally Recognized Tribes of Washington State. Participation and inclusion in all facets of the development of the transformation plan and implementation will acknowledge this relationship, and seek mutual opportunities to address the mental health needs of the Native American Communities.

(Topics are listed in order of number of responses per Issue.)

[1] Report for the Northwest Portland Area Indian Health Board, Mental Health Transformation Grant, State of Washington. Linda D. Bane Frizzell, Ph.D.

1. Issue: *(45)*

There needs to be intensive efforts developed to address cultural competency issues and problems.

Outcome: There will be an improved understanding by State officials/employees and other local governments about tribal government legal status.

– There will be tribal legal status training for non-tribal providers, local governments, and State employees.

Outcome: There will be an increase in culturally competent mental health service providers.

– Cultural or traditional services will be viewed as an equal service when compared to western/European mental health practices; and will be equitably reimbursed and recognized as legitimate services.

Outcome: There will be an increase in culturally competent mental health service programs.

– There will be an increase in research activities, with tribal government approval, to increase the body of knowledge (best practices) for Indian specific programs.

2. Issue: *(34)*

There should be regular meaningful tribal consultation meetings established (annually, or biannually, or quarterly) to work with tribal representatives at the government to government level for: discussion of health issues, policy development, collaborations, seamless operations, assessment and evaluation of programs.

Outcome: Treaty and Executive Order Tribal rights will be honored.

– Consultation meetings will be meaningful, with each government contributing, and with representatives that have "administrative authority" to make decisions about: health issues, communication, waivers, policy development collaborations, seamless operations, assessment and evaluation of programs.

Outcome: There will be tribal representation on the State's Mental Health Planning and Advisory Council, Ethnic Minority Advisory Committee, and Transformation Grant's committees.

- There will be a process developed to ensure tribal representation on all respective commissions, planning committees, and other groups established that would have an impact on tribal populations.

3. Issue: *(33)*

Mental Illness and co-occurring disorders are difficult to segregate (as is currently true in the current State system; but not in most tribal behavioral health programs) when the focus should be on the patient/client as a whole person who must be able to interact with multiple entities in their communities.

Outcome: There will be comprehensives services that are delivered in a seamless system.

– There will be Community Mental Health Centers developed to promote the seamless delivery of services.

– There will be a system developed to share HIPAA and provider approved medical record transactions that will be non-duplicative for tribal providers.

– Patients/clients will not be required to complete multiple eligibility forms or endure repetitive tests/assessments.

4. Issue: *(26)*

The RSN system has not proved to be effective, accessible, or culturally competent for use by American Indian patients nor has there been effective participation with tribal providers.

Outcome: The State must acknowledge that it has a shared responsibility with the federal government to provide health services. This responsibility should not be delegated to RSNs, municipalities or other governmental entities.

– The State, in consultation with tribal governments will develop a reimbursement system that is direct and responsive to meet the needs of patient/client. This system will provide reimbursement for all tribal behavioral health services and is not solely dependent on any single payer (e.g. public, private, other third party payers).

5. Issue: *(21)*

License/certification criteria needs to be changed to deem tribally certified professionals and facilities as eligible to be

reimbursed for services, including where desired, direct State contracts.

Outcome: There will be an acknowledgement by certification bodies and payers of services to accept practices of cultural customs and traditional health practices by tribally certified providers and facilities.

- Tribal governments will maintain records and certificates of their certified personnel and facilities.
- There will be certification programs developed to allow for acceptance of training in related disciplines to be applied toward a generalist certification.
- There will be certification programs developed to include recent advances in behavioral health services (i.e. peer counseling, motivational interviewing).

6. Issue: *(16)*

The law enforcement workforce and the court system need to be changed to adequately protect communities and become a collaborator in the mental illness service delivery system.

Outcome: There will be an increase in the overall number of law enforcement professionals, and an increase in capacity for improving outcomes for people who are mentally ill.

- Law enforcement professionals will be trained in interventions that include: coordination procedures with mental health professionals, crisis intervention, dealing with people with mental illnesses (including patient confidentiality), and cultural competence.

Outcome: The State and local governments will recognize tribal court orders with full faith and credit and accept tribal assessments.

7. Issue: *(15)*

The state Medicaid plan needs to be changed to include more reimbursable services for prevention and for patients with mental illness and co-occurring disorders. Current programs are over burdened and consequently do not have the ability to cost-shift expenses to maintain programs and services without reimbursement.

Outcome: The state Medicaid plan will be enhanced to include more reimbursable services for prevention and for patients with mental illness and co-occurring disorders.

8. Issue: *(5)*

There is not enough emphasis on the impact of the K-12 educational system and its role in mental health. This relates to the issues associated with school personnel to respond to mental health issues and administrative issues on how they operate educational programs.

Outcome: There will be increased support for the educational system to develop programs to increase their ability to deal with mental health issues, including allowance for the increasing numbers of drug abuse affected children.

- Public K-12 schools will enhance their prevention curriculums and on-site health services.
- The State will invite Tribal Colleges to become more involved in addressing the mental health needs including curriculum development, cultural competency training, research projects, and professional preparation (certification).

9. Issue: *(4)*

Resources need to be allocated to enable system changes needed to participate in the transformation project.

Outcome: There will be a commitment by the State to begin a process that brings together tribal service providers, higher education, Portland Area Indian Health Board, SAMSHA (including the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment), and other collaborators.

- This commitment will be progress toward improving the lives of Indian people and not just another pilot project that gets buried in the bureaucracy.

NEXT STEPS

Recommendations in this section have not yet been reviewed by the TWG. This will occur at the August 25, 2006, meeting.

CHAPTER 4:

PREVENTION

TRANSFORMATION PROJECT PREVENTION ADVISORY GROUP

Throughout the process of collecting public input, and engaging policy leaders in discussion, the concept of a true mental *health* system continuously emerged. Both consumers and state executives put it succinctly: "We don't have a mental health system; we have a mental illness system." The sentiment was echoed as the TWG grappled with the core values and the shift in thinking required to truly realize Transformation. Prevention always challenges state executives and policy makers. Prevention requires significant levels of resource and patience while waiting years or even decades for results. However, the evidence is clear; prevention pays. The state envisions a clear approach incorporating and coordinating prevention activities in a broad, public health model. Rather than developing a "mental illness prevention" strategy, the Project recommends a single, well-articulated statewide prevention policy with a healthy Washington as a centerpiece strategy.

Mental Health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs. Washington State Comprehensive Mental Health Plan – *Transformation Theme #2*

Prevention is a fundamental component of a comprehensive mental health system. As is typical in many states, however, Washington's current prevention efforts are fragmented and lack coordination. Further funding of prevention-related activities represent only a small percentage of overall mental health funding, if any at all. Most existing programs are targeted to discrete populations, despite the fact that most risk factors cut across multiple demographics.

The state does have at least three mature and stable prevention programs. For example, the Division of Alcohol and Substance Abuse has a well-developed and successful substance abuse prevention approach, with cross-cutting services at the state level, and close coordination with service providers at the local level. (DASA services are discussed in more detail below.) Also, the Family Policy Council, a multi-agency advisory board with both executive and legislative membership has provided sound state and local level policy direction related to prevention activities for several years. The Department of Community, Trade and Economic Development also has the Community Mobilization program that funds small projects statewide. Other prevention activities, however, are small, under-funded and disconnected from a broader prevention approach. As a result, prevention services are fragmented.

The Prevention Advisory Group has been convened to provide recommendations for overcoming this systemic fragmentation. The Advisory Group is tasked with developing cross-discipline partnerships across the state, and among organizations that share an interest and expertise in Prevention. Initially, the focus of the group is to provide a forum for discussing emerging research and to move the mental health field forward in its advancement of prevention efforts. Ultimately, however, the goal is to empower this group to develop a set of strategies for elevating the importance placed on prevention services, to inform prevention policy development, and to encourage a more cohesive system of prevention services in Washington.

The Prevention Advisory Group members are multi-disciplinary and geographically diverse. MHTP initially invited individuals representing state agencies and university researchers focusing on prevention, encouraging those initial members to reach out to others in the field and extend the opportunity to participate. Thirty-six individuals now serve on the group with interests and expertise ranging from prevention policy to early childhood learning. Other expertise on the group include: infant mental health; maternal/child health; early learning; child abuse and neglect; juvenile justice; substance abuse; health policy; epidemiology; nursing; and, medicine. Appendix 5 contains a list of current group members.

Most Advisory Group members are well versed in the public health approach to prevention; the model most often used in developing programs and demonstration projects in Washington. This focus on the public health model is enhanced by having the co-founders of the Social Research Development Group (SRDG), affiliated with the University of Washington as invited members of the advisory group. The SRDG is noteworthy for its role in advancing the risk and protective factor approach to prevention.

The current focus is on the most seriously ill, reducing the ability to respond to early intervention opportunities

The Prevention Advisory Group also explored strategic areas where a more focused prevention effort might have the greatest impact. Although the TWG task groups did include screening and early intervention strategies that could correctly be defined as preventative for *individuals*, strategies targeted to *community and family* were noticeably absent. The group examined the federal National Outcomes Measures for mental health and agreed to begin considering additional, prevention-oriented outcomes.

The Advisory Group recognized the need to more carefully define prevention. The Group agreed to focus on five specific areas in its planning work for the first year: 1. Infant mental health; 2. Pre-school and elementary school children and their families; 3. Late-adolescent/young adult mental health; 4. Preventing hospital re-entry; and, 5. Preventing mental health problems in older adults.

Infant Mental Health

The University of Washington's Center on Infant Mental Health and Development is the leading state resource for advancing training, research and policy in Infant Mental Health. Their primary focus is on prevention and intervention with high-risk groups such as families in poverty, teenage mothers, families struggling with post-partum depression, and families at risk for child abuse and neglect. Currently, there is a lack of research on treatment which makes implementing evidence based treatments difficult. Therefore, their Birth to Three Lab is translating current research into treatment models and conducting clinical research to develop evidence-based practice in infant mental health. Policy and training efforts are being developed with a wide range of stakeholders including pre-professional students, child care providers, policy makers, educators, primary care providers, child welfare personnel, legal personnel, early intervention providers and mental health providers. The aim is to embed infant mental health principles and an understanding of relationship-based approaches in all of the systems in which we serve infants, toddlers, preschoolers and their families.

Pre-school and Elementary School Children and their Families

The State is currently undergoing a significant structural change in the provision of early childhood services by creating a new Department of Early Learning. Knowledge and experience with Headstart and the Early Childhood Education and Assistance Program (ECEAP), a state funded equivalent to Headstart, has produced expertise for the state that contributes to our thinking about prevention of serious mental health disturbances in children. While excellent work occurs in pre-school education programs, issues around screening and early intervention for children in public schools remains a challenge. Services to the parents are also limited and even those who have children with the most severe mental illness report that services are woefully inadequate. The activities to promote early learning in the state of Washington have been accelerated by a Council on Early Learning appointed in November, 2005. Recommendations of the Council on Early learning resulted in the creation of the cabinet-level Department of Early Learning in July 2006.

In addition, a private/public partnership "Thrive by Five" has been established between the state and the philanthropic community in Washington. This partnership has produced combined funding of $9 million new dollars to be invested in promising approaches to promoting early learning in the state. The areas of childcare and parent support are the two foci of the activities. Mental health has been a part of the effort with the emphasis in the early learning plan being on the social emotional development of the young child. The Gates Foundation is planning two demonstration sites for providing services to families and young children. One site will be in the Seattle area in Western Washington and one will be in Eastern Washington.

The Department of Health, Office of Maternal and Child Health (OMCH) is involved in several activities related to the prevention of social, emotional, behavior and mental health problems. One of these activities is to coordinate MHT planning efforts with other planning and system change initiatives that OMCH is involved with, including:

- Early Childhood Comprehensive Systems (ECCS) Grant – A federal grant from the Maternal and Child Health Bureau to promote comprehensive systems for children birth to kindergarten entry. One of the required focus areas is Social, Emotional and Mental Health. In Washington State ECCS is part of Kids Matter. Kids Matter is a partnership between DOH (ECCS), the Governor's Head Start-State Collaboration Office (Department of Early Learning) and the BUILD Initiative, a national child care quality improvement initiative (the Washington lead is the Foundation for Early Learning). A framework has been developed and its implementation is under way. For additional information, see www.earlylearning.org/kids-matter.
- Washington State Partnerships for Youth (WSPY) – OMCH convenes this broad stakeholder group that is developing a statewide adolescent health plan, including mental health. For more information see the WSPY website: www.son.washington.edu/wspy/
- Coordinated School Health – The DOH Office of Health Promotion coordinates with the Office of the Superintendent of Public Instruction in the implementation of a federal grant from the Centers for Disease Control and Prevention. Grant activities include systems planning and infrastructure building for comprehensive school health, including social emotional and mental health.
- Youth Suicide Prevention Plan - DOH works to implement the Washington State Youth Suicide Prevention Plan through the Youth Suicide Prevention Program (YSPP). YSPP focuses on increasing knowledge, addressing beliefs about suicide, and building skills in people to seek help for themselves or youth they come in contact with. The plan and other information is available on the YSSP website: www.yspp.org/aboutYSPP/reports/Wa_plan.pdf

Late-Adolescent / Young Adult Mental Health

During the work of the Social Marketing effort, a literature review noted the demographics of first onset of serious mental illness to be between the ages of 18 and 31. The Prevention group is interested in looking at the research on early identification and intervention within this age population. Are there opportunities to identify risks in this population? Do social and

emotional disturbances in younger children predict onset of serious mental illness? Do epidemiology efforts to date inform us about individual, family and/or community risks? Are there strategies at a family or community level that might reduce the incidence of onset? What service systems connect with this population at the earliest point in the progression of mental health problems? Do first admission patients in mental health hospitals share risks? The group recognizes that there may be research available that will guide the development of policies and strategies for this target group.

Preventing Hospital Re-entry

Many of the strategies developed in this plan focus on the services needed by consumers to recover and live productive lives. These strategies can be viewed as preventative, in that they represent efforts to promote health, independence, and personal recovery. The advisory group, specifically, is interested in a prevention model for assisting community services that support individuals wishing to remain in recovery (similar to the work around relapse prevention for persons with addictive disease.) Relapse prevention has achieved significant credible results in assisting individuals and their support systems to recognizing and anticipating risks that lead to relapse. Further examination of the triggers for mental illness episodes and strategies to use when those triggers are recognized can contribute significantly to maintaining recovery.

Preventing Mental Health Problems in Older Adults

Aging adults face significant life changes. Both physical and mental health problems can increase morbidity and lower quality of life. The advisory group is interested in looking at factors that contribute to increased levels of depression and serious mental illness such as the community environment (e.g., isolation); chronic health problems and trauma (in the form of loss of friends and family members); and co-occurring disorders. The advisory group is also looking at substance use disorders among older adults. The group will examine strategies and practices available to reduce onset of serious emotional disturbances and co-occurring disorders.

Additional Prevention Activities

Beyond the work of the Mental Health Transformation Prevention Advisory Group, two additional MHTP efforts are notable. In Washington State, the Washington Health Foundation (WHF) is a non-profit organization promoting health policy. Recently, the WHF began a policy initiative: Healthiest State in the Nation Campaign. For 2007, their state policy priorities (still in draft) include mental health. The organization pursues a public health/wellness agenda. The draft policy focus is framed as "strong mind, strong body, strong spirit. It includes mental health, dental health and physical fitness"; effectively addressing the President's New Freedom Commission Goal #1. The Transformation project serves on the WHF advisory board and will continue to influence this important player.

Second, the State Board of Health is examining mental health issues from a public health policy perspective. The Board heard testimony from the project and has joined the partnership. In January, the Board adopted a new strategic plan. One of its goals is to "assure access to critical health services," and one of the objectives under that goal is to "promote access to preventive mental health services." The Board is in the early stages of this work, and its first activity is to educate itself about ongoing mental health reform efforts such as the Mental Health Transformation Grant. Another activity is to support TWG activities that take a public health approach. Ultimately, the Board expects to produce a report that "examines capacity in the state to deliver preventive, community oriented, population-based mental health services, articulates a vision for a public health approach to mental health, and makes policy recommendations."

The DASA Prevention Program has received a five-year grant to advance mental health problem prevention

In addition to the Prevention Advisory Group work, the state enjoys and benefits from the work of the Division of Alcohol and Substance Abuse's (DASA) prevention program. The program coordinates with the Department of Health, the Department of Community, Trade and Economic Development (community mobilization), the Office of the Superintendent of Public Instruction (OSPI) and others facilitating the Risk/Protective Factor framework in this state; this expertise has merit for mental health prevention.

In October 2004, Washington received a State Prevention Framework-State Incentive Grant (SPF-SIG) through the Center for Substance Abuse Prevention for $2.35-million per year for five years through DASA. Since multiple risk factors are addressed in strategies to prevent under-age drinking and substance related conditions, the project will serve as both a model and an entry point towards advancing mental health problem prevention. Through the SPF-SIG, DASA will contract with local community applicants to implement the strategic prevention framework, including local assessment of need, resources, and readiness. Once a community has moved through these first three assessment steps, it will be allowed to select and implement programs that can serve as a model framework for future Transformation prevention strategies.

Policy Potential

As Transformation discussions take shape with agencies involved in the project, attention often turns to prevention. It is apparent that years of funding services for the most in need has created a "mental illness" system; not a mental health system. The group and its audience, the TWG and agency policy leaders, recognize the importance of more clearly defining mental health, linking it to physical health, and focusing on a public health approach for creating healthy individuals, families and communities. With increasing focus on these aspects of Transformation, there is a growing understanding of policy implications for the State's mental health system. Questions asked regularly by key policy makers include: Is mental health really being addressed? How can the health of Washington's citizens be addressed without including mental health? Do we have the right governance structure to advance a model that is preventive? Should we develop a more coordinated approach to prevention by establishing an Executive Policy Manager in the Governor's office to ensure coordination across state agencies? The Transformation Project Prevention Advisory Group will clearly play a significant future role in addressing these policy questions.

This section of the report has not been reviewed by the TWG as of this date. It will be presented at the August 25, 2006 meeting.

CHAPTER 5:

EVALUATING THE TRANSFORMATION OF MENTAL HEALTH SERVICES IN WASHINGTON

OVERVIEW

The evaluation of the Washington State Transformation *(Partnerships in Recovery)* will follow the evaluation plan originally submitted in Washington State's proposal. The planning activities of the first nine months of the grant have not substantively altered the original plan and the primary components remain in place as originally proposed. Although some minor revisions to components of the plan have been introduced to attain efficiencies not apparent when the proposal was written, the approach remains essentially unchanged. The text that follows outlines the evaluation plan for the State's Transformation, explaining these minor revisions and describing the more detailed evaluation planning leading to the current version of the evaluation plan.

As stated in the original proposal, the primary purpose of Partnerships for Recovery's evaluation will be to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this proposal. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative. The proposal stressed the following:

- **The evaluation process will be consumer and family driven**. Consistent with the President's New Freedom Commission on Mental Health, the evaluation plan for system transformation in Washington State ensures that both adult and youth consumers and their families play active roles. Through establishing a Consumer Evaluation Subcommittee and a Family Member Evaluation Subcommittee and through representation on all committees and workgroups, the input of consumers and family members will drive all facets of the evaluation process.
- **A transformed mental health system centers on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections**. Implementing and sustaining large-scale changes in the way state and county agencies do business requires a multi-agency database and a capacity to use data to inform multiple stakeholders and guide implementation.

The evaluation process will have three principle components.

The principle components of the evaluation process include:

1. Development and Implementation of Government Performance and Results Act (GPRA) measures;
2. Collection and reporting of SAMHSA's National Outcome Measures across all agencies engaged in the transformation; and
3. Implementation of a Theory of Change evaluation to assess the overall impact of the Initiative on achieving the six original goals of the President's New Freedom Commission and two goals on employment and housing added by Washington State's Transformation Work Group.

The primary responsibility for the evaluation will remain with the Transformation Grant staff, who will coordinate the work with the primary contractors for this project:

- DSHS, Division of Research and Data Analysis
- DSHS Division of Mental Health Research Division
- The University of Washington, Division of Justice and Health Policy
- The Cecil G. Sheps Center for Health Services Research, University of North Carolina-Chapel Hill

The Transformation effort in Washington State spans many aspects of public heath, requires data and input from multiple cross-agency sources, attempts to incorporate consumers and family members in new ways, and creates new partnerships for evaluation of mental health services in the state. With this ambitious agenda it was decided in the original proposal planning that no one entity could address all evaluation fronts simultaneously. For these reasons, this consortium of state agencies, local and national experts in systems change evaluations, has been assembled for the evaluation effort.

Evaluation Task Group Recommendations

A more detailed level of evaluation planning occurred in April and May 2006. Evaluation was one of six Task Groups established by the Transformation Work Group (TWG). (See Appendix 6 for a list of Evaluation Team members.) While other task groups relied on expertise recruited from the appropriate professional communities, we utilized the existing evaluation team, including the

Family and Consumer Education Team (FACET) members to perform this planning effort for the evaluation. This ensured that consumers and family members were a central part of the critical planning effort, and they were central to the process. The goal of the group was to consider the Transformation activities to date, including the articulation of Transformation outcomes and to further develop the evaluation plan, beyond that articulated in the original proposal. As has been the case for several of the other Task Groups, it is difficult to plan an evaluation until some specific program and policy changes are identified. Following the lead of the other Task Groups, the Evaluation Team articulated a set of five recommendations that would further guide the evaluation effort as specific changes are pursued in the planning and Transformation process:

Recommendation 1

- As part of the Comprehensive State Plan, a logic model should be developed that will guide the ongoing evaluation of the Transformation effort. It should include Transformation goals and activities, inputs and outcomes.
- This logic model would be embedded in the evaluation plan.

Recommendation 2

- The Transformation Workgroup should frequently review data and results produced by the Evaluation Team to inform and guide development, implementation, and sustainability efforts.
- Evaluation Results should be regularly publicized and easily accessible to the general public.

Recommendation 3

- Build the capacity of consumer-run programs to participate in self-evaluation, and to contribute to the Transformation Grant evaluation.

Recommendation 4

- The evaluation should measure both process and outcome changes, and examine both consumer and system level components

Recommendation 5

- The Evaluation Team will develop and submit to the TWG for review an evaluation plan based on the final strategies outlined in the Comprehensive State Plan.

It will be important for the Comprehensive State Plan to prioritize the strategies and put them in sequential order for implementation.

Consumer, Family, and Youth Involvement in the Evaluation

The evaluation process for the Transformation effort provides one of the avenues for investing consumers, youth and family members with decision-making powers over Transformation activities and outcomes. The original proposal identified several mechanisms to accomplish this goal. The original plan was to establish two evaluation subcommittees, one for Families and Youth and one for Adult/Older Adult consumers. These committees will review all proposed evaluation activities and findings to determine if they are responsive to consumer- and family member-identified concerns and address cultural issues. Membership of the two subcommittees will come from individuals nominated by statewide and local consumer and family member groups and by providers. The proposal also identified a FACET that will be integral to all evaluation efforts, and that would participate fully in determining the responsiveness of the Transformation to consumer voice and concerns, recovery, and cultural sensitivity. The original proposal did not clearly differentiate the role of these committees, and was not clear or whether the committees overlapped in membership, scope and responsibility.

Given this ambiguity, the Transformation Staff in consultation with the evaluation partners, formed a single committee, the FACET, and centered the responsibility for consumer and family member involvement in the evaluation with this group. This was done to facilitate progress and to maximize the input of consumers with evaluation professionals early on in the process. The formal definition of FACET is:

> *The team of consumers, family members and youth that participate with research and evaluation professionals on to the MHTP Evaluation Team to conduct required evaluation activities for the grant. FACET membership will be comprised of no less than six consumers as defined above, and the two half time consumers employed by the University of Washington for this project. The total membership of FACET should include no less than four adult consumers and no less than four parents/legal guardians, should contain representatives of both Eastern and Western Washington, urban and rural areas, and represent the ethnic diversity of the state. The contractor shall consult with MHTP consumer staff in selecting members for FACET, and obtain their approval in finalizing membership*

for this group.

FACET team members were named in February 2006 and the team currently consists of 10 consumers and family members. These individuals, the evaluation partners, and MHT staff have been meeting twice monthly since

February 2006, to complete the planning and execution of Transformation activities.

The Evaluation Task Group also planned a series of training events intended to increase the skills and knowledge of consumers and family members regarding the evaluation. Beginning in the second year of the grant, the evaluation team will work with consumer groups, and the consumer network development team to identify evaluation studies that are germane to the concerns of consumers and families and may not be addressed by the main evaluation design. "Mini" contracts will be made available to family and consumer organizations to conduct small evaluation studies on these topics. Up to $10,000 is expected to be set aside each year of the grant, to be made available to consumer groups to directly evaluate their own programs. The evaluation team will be responsible for making funding decisions, with the University of Washington contractors responsible for designing the grant application process.

Together with Partnerships for Recovery staff and other consultants, our goal will be to create multiple roles for consumers and family members in evaluation, to establish roles with significant decision making authority, to actively employ these individuals in the enterprise and to create learning paths and career development opportunities for those interested in this work. This approach to the role of consumers and family members in evaluation represents a significant departure for Washington State, and demonstrates a clear commitment to consumer and family member voice in the Transformation.

Existing Resources and Approaches to Data Collection

Consistent with the President's New Freedom Commission Report, Washington State has long recognized that persons with serious mental illnesses or serious emotional disturbances may have contact with a broad range of non-mental health settings (e.g., adult or juvenile justice, education, child welfare, vocational rehabilitation, Medicaid). In response to this recognition, and prior to the SAMHSA State Transformation RFA, administrators and policy makers in Washington State recognized the

importance of improving screening and referral processes and coordinating services provided across DSHS. To this end, the state established a centralized Research and Data Analysis (RDA) division within DSHS that has access to and coordinates data from across multiple divisions. RDA has constructed a central research database that matches client service records from sixteen different data sources that record child and adult service, authorization, and management information. This technology allows RDA to record the DSHS services used by children and adults who are mental health consumers over time, the cost of those services, contact information, and consumer demography. This central research data warehouse, known as the Client Services Data Base, or CSDB, is then used to provide data for service integration initiatives across the department. The development of the CSDB is critical to creating the foundation for present and future system transformation. With additional enhancements, it will play a critical role in continuous quality improvement feedback and provide information to support the management of Transformation.

In addition to these data, the Mental Health Division of DSHS routinely collects the following data to monitor and analyze the performance of the Washington State mental health system. These data come from a combination of the following five data systems for mental health services and surveys:

- The Mental Health Division Consumer Information System
- The State Psychiatric Hospital data base Health Integrated Information System
- The Medicaid Management Information System payment database
- The Mental Health Statistics Improvement Project, Youth Services Survey, the Youth Services Survey for Families; and the Adult Consumer Survey
- The Department of Social and Health Services, Research and Data Analysis (RDA) Client Services Database (CSDB; described above)

The survey data is based on statewide surveys conducted by the Washington Institute for Mental Illness Research and Training (WIMIRT) for the Mental Health Division. Copies of the survey reports are available at the Mental

Health Division's website
http://www1.dshs.wa.gov/Mentalhealth

or on WIMIRT's Webpage
http://depts.washington.edu/wimirt/Publications.htm.

Information and Data Infrastructure Enhancements Planned

The Transformation Grant allows expenditure of funds for a number of infrastructure enhancements. Data infrastructure enhancements will be crucial to the evaluation of the Transformation, and these enhancements will constitute a key activity in transformation work at the policy, practice and evaluation activities over the life of the grant. Washington State will implement an array of enhancements to Washington's information infrastructure that are designed simultaneously to support the evaluation, guide the Transformation process, and provide information and accountability to consumers and policy makers. Elements of this Infrastructure will include:

- Expansion of the RDA Research database to include additional outcome measures, targeted to provide reporting on the SAMHSA National Outcome Measures and on elements of the GPRA related to direct consumer outcomes.
- Expansion of the consumer satisfaction surveys to include a greater range of outcome measures and to survey mental health consumers who are served by non-MHD systems.
- Implementation of additional surveys to track population and consumer trends in attitudes toward mental illness, stigma, help-seeking behaviors, consumers' perceptions of transformation activities and population-level outcomes.

Data infrastructure enhancements are allowable Transformation Grant expenditures. Although not directly a part of the program evaluation budget, the enhancements planned will be critical to the overall success of the evaluation. Key enhancements underway, in planning stages, as well as broader enhancements being considered, are outlined below.

Specific Data Infrastructure Enhancements Planned—

The Mental Health Transformation Grant will support, over the life of the grant, a significant expansion of DSHS data infrastructure through the development of new data sources, data tables, outcome measures, and reporting processes. Infrastructure development will include:

Core Infrastructure Changes Are Underway

- Processes to capture on an ongoing basis new information (both internal and external to DSHS) on the **use of and need for mental health services,**
- Processes to capture on an ongoing basis new **client outcome data,**
- New tools to measure **quality of mental health services** provided,
- New analyses to measure the **impact of mental health services on client outcomes**, and
- New **reporting processes** to meet grant and program requirements.

The activities in the first project year ending September 30, 2006 include:

1. Developing new longitudinal client-level RSN service tables organized around State Plan mental health service modalities.
2. Developing new longitudinal client-level medical claims diagnosis tables organized around RSN access-to-care standards.
3. Developing longitudinal client-level data tables capturing indicators of need for mental health services from new source systems:
   a. Medical Assistance Healthy Options encounter data,
   b. Economics Services Administration Barcode incapacity data, and
   c. Aging and Disability Services Administration CARE functional assessment data.
4. Identification of non-MHD service categories in existing DSHS data sources that reflect the provision of and/or need for mental health services; development of longitudinal client-level data tables summarizing these service encounters.

Data Infrastructure Enhancements Planned—-Data Needs Outside DSHS for Mental Health Transformation Monitoring and Evaluation

Several questions cannot be answered at all with the current system of data silos.

- How many low-income consumers are we serving overall, across all government agencies?
- How much are we (government) spending on their mental health services?
- What mental health service modalities are they receiving from government?
- Are they receiving government-sponsored help with employment, job training, and housing?

To answer those questions, we need to match consumers receiving mental health services across agencies – especially the other TWG agencies. Currently, we match within the DSHS, but not across the other agencies.

As a next step we need to gather information on the mentally ill persons served, the mental health service modalities provided, costs and dates, from the following state agencies, other government entities and/or programs and services:

- Health Care Authority (requires analyzing encounter data)
- Department of Veteran's Affairs
- Department of Corrections (Prison data)
- City and County Jail data (through the new WASPC data or through our 1290-related data)
- Tribal clinics and Indian Health Services
- Veterans Administration (federal)
- Medicare-Medicaid Dual Eligibles (need the Medicare services)
- Public Schools (if possible)
- Charity hospital care from Comprehensive Hospital Recording System
- Medicaid Management Information System (Drug Pharmacy Formulary)

Data Infrastructure Enhancements: Anticipated Activities in Years 2 Through 5

In subsequent years we anticipate using MHTP resources for the following purposes:

- Ongoing maintenance of the new data tables developed in the first year of the grant.
- Developing longitudinal client-level data tables capturing stability in housing and living arrangements using homelessness and household composition information from the Automated Client Eligibility System.
- Developing longitudinal client-level data tables capturing employment outcomes measured in Employment Security Department earnings data.
- Developing longitudinal client-level data tables capturing standardized measures of access and quality of care that can be derived from administrative data; for example, specific HEDIS measures including quality of psychotropic medication management and follow-up after hospitalization for mental illness.
- Developing access to student-level school outcome data maintained by the Office of the Superintendent of Public Instruction.
- Developing mental health treatment need indicator tables from CAMIS (Children's) and CATS (JRA) information systems.
- To the extent feasible, developing data tables other data sources external to DSHS such as the Veterans Administration, local jails, and housing programs.
- As requested by project staff to support Transformation Grant activities, performing analyses and reporting information describing medical service use, service need, and client outcomes
- Providing longitudinal client-level data tables, documentation, and consultation to the Mental Health Transformation Grant evaluation team

Transformation Evaluation Activities

The grant team will expand current data and evaluation capabilities to address GPRA indicators as well as SAMHSA's National Outcome Measures (NOMS) to assess overall system performance. The GPRA indicators will be

collected, managed, analyzed, interpreted, and reported to monitor, guide and evaluate the process of the evolving Transformation. The collection, management, analysis, and interpretation of the NOMS will assess the impacts of the evolving transformation (i.e., who, what, when, where, and how) on individual consumers and their families. These activities are described below.

Development and Reporting of Government Performance and Results Act (GPRA) Measures

The following steps will be taken to ensure Washington State's ability to collect and report on the GPRA measures:

Step 1: A GPRA workgroup will be convened from the membership of the Evaluation Team.

Step 2. With MHD, RDA, and MHTP staff leadership, the GPRA Workgroup will develop a comprehensive plan to measure and report required GPRA measures and to propose GPRA measures unique to the state of Washington.

Step 3. The GPRA Workgroup will submit the recommended GPRA measures, annual performance targets, and budget implications, and make a recommendation to the TWG.

Step 4. The TWG will finalize the GPRA measures and approve procedures to collect and report on the measures. These will then be submitted to the SAMHSA Project Officer for review/approval.

Step 5. GPRA and related performance measures will be reviewed by the Evaluation Team and at regular TWG meetings. They will be modified, if needed, by the TWG using the process described in the steps above, in coordination with SAMHSA Project Officer and the coordinators of SAMHSA's national field evaluation.

These steps will allow the Partnerships for Recovery to monitor the process of the Transformation using GPRA outcomes for all six of the goals of a transformed mental health system as outlined by the President's New Freedom Commission on Mental Health. GPRA outcomes will be collected and reported as required by SAMHSA.

Initial GPRA Measures Plan

Because SAMHSA's cross-site evaluation contract has not been finalized, we cannot define precisely how we will collect GPRA data for the project. We must await SAMHSA's final instructions before proceeding. However, the Evaluation Guidance document provided by SAMHSA does permit development of an initial GPRA data collection plan. Our initial plan is presented as a draft below.

The seven required GPRA measures are:

1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan.
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan.
3. Percentage of financing policy changes completed as a consequence of the comprehensive Mental Health Plan.
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan.
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.
6. The number of consumers and family members who are members of statewide consumer– and family–run networks.
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan.

Washington State's initial plan to operationalize and collect these data is contained in Table 1 beginning on the following page.

TABLE 1 - GPRA MEASURES

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan	Require participation of all agencies in partnership with the Mental Health Transformation Project to report the percentage of all policy changes as a result of the approved strategies by the TWG	GPRA Monthly Monitoring Report Who is your WAC Coordinator/or P&P person? Any RCW/WAC/P&P changes in period?	
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan	Require all agencies in partnership with the Transformation Project report the number of persons and related workforce who have been trained in service improvement recommended by the Comprehensive Mental Health Plan	Listing of Training Events By events, sign in sheets Count of participants by: Demographics Consumer status Employed by: Others First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training	
3. Percentage of financing	All Require all agencies in	GPRA Monthly Monitoring Report	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
policy changes completed as a consequence of the Mental Health Plan	partnership with the Transformation Grant to report the percentage of financing policy changes completed as a consequence of the Mental Health Plan	1. Who is your WAC Coordinator/or P&P Person? 2. Any RCW/WAC/P&P changes in period?	
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan (includes interagency agreements)	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	3. Are there any organizational changes relevant to CMHP in period? 4. Are there any MOU's changes relevant to Mental Health in period?	
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan	MHTP staff and the Evaluation Team will research the number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.	5A. Is your organization regularly collecting data relevant to the CMHP? 5B. Is your organization regularly analyzing data relevant to the goals of the CMHP? Develop a monitoring tool to obtain information from: **State Level** State Agencies Regional Level Regional Support Network	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **Consumer Level** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations Develop a Monitoring Tool to obtain information from: **Local Level** State Administrators Regional Support Network Local Providers	
6. The number of consumers and family members who are members of Statewide consumer - and family – run networks	MHTP Staff will establish a list of consumers and family members who are members of statewide consumer and family – run networks.	Listing of all statewide consumer and family member organizations. For each: **Roster of membership** **Count of participants by**: Demographics	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer status Employed by etc. Others…. First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training Develop a monitoring tool to obtain information from: **Consumer Level** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	Develop a Monitoring Tool to obtain information from the **Local Level** State Administrators Regional Support Network Local Providers Develop a monitoring tool to obtain information from: **State Level** State Agencies	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Regional Level Regional Support Network Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **Consumer Level** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	

Operational Definitions on how to count GPRA Measures will be collected in Washington State

For Policies and Procedures that change in the grant period, number that:

1. Change as a direct result of Comprehensive Mental Health Plan (mandated change)
2. Change associated with Comprehensive Mental Health Plan
3. Change results indirectly from the Comprehensive Mental Health Plan
4. Complementary change that might be enhanced by CMHP

$$\% = \frac{\text{Numerator}}{\text{Denominator}}$$

(N) Count of:
1. RCW
2. WAC
3. State Agency Policy
4. Local Policy

(D) Count of: Policies related to Mental Health within each administration: (total of 1, 2, 3, and 4))

Levels:
1. Governor – State Initiatives
2. State Agency Secretary
3. DSHS Administration Assistant Secretary
4. Division Director
5. Local policies (broadly speaking)

Scope: Only TWG Agencies Representative – Administration/Division

National Outcome Measures (NOMS)

In addition to the GPRA Infrastructure Indicators, the RFA specifies that improvements in State performance on the SAMHSA NOMS will be expected as a long-term result of the grant program. The NOMS are listed below.

1. Decreased mental illness symptomatology/increased level of functioning
2. Increased or retained employment and school enrollment/school attendance
3. Decreased involvement with the criminal justice system
4. Increased stability in family and living conditions
5. Increased access to services/number of persons served

by age, gender, race and ethnicity

6. Decreased utilization of psychiatric inpatient beds/readmission to a State psychiatric hospital at 30 and 180 days
7. Increased social support/social connectedness
8. Increased positive reporting by clients about outcomes
9. Increased cost effectiveness
10. Increased use of evidence-based practices

An important limitation of the URS data is that the NOMS are reported only for people served by the State Mental Health Authority (SMHA). A critical concept of Transformation is that all agencies, and not just the SMHA, should participate in improving the accountability, capacity, and quality of services for people with or at risk for serious mental illnesses or serious emotional disturbances. In keeping with this vital concept, to most effectively measure the impact of transformation on client outcomes, NOMS data must be collected from all relevant agencies.

Specifically, Washington State will expand its data collection strategy to routinely collect NOMS data from all identifiable service recipients in Washington State, not just those served by the Mental Health Division. We will begin this work by including in our first year survey, all adults with mental health diagnoses being served in all eleven administrations of DSHS. We will expand the scope of NOMS surveying in the Years 2 through 5 to include children and family, and those hitherto unknown to DSHS, but who have identified mental health problems.

Recovery and Resilience

A requirement that states measure and report recovery and resiliency was issued in SAMHSA Guidance for the Evaluation of Transformation. That document specifically stated:

> *In order to determine whether transformation has met its goal of facilitating recovery, the national evaluation will help each SIG State to select and use one recovery outcome instrument and one service system recovery-facilitation process instrument to measure their recovery results. We would expect substantial consumer involvement in selecting the recovery measures and in collecting data on recovery. The*

national evaluation will also examine whether corresponding information on resilience can be captured.

As with the GPRA and NOMS data, we would not expect to see measurable effects on the recovery and resilience measures immediately. Most States are not currently quantitatively assessing recovery, and significant data infrastructure development will be necessary in order to institutionalize these measures Statewide. Moreover, our transformation theory predicts that the recovery-orientation of a system will follow institution of the infrastructure changes, which will take some time to implement. We would not expect to see measurable change in the recovery-oriented service systems measures, therefore, until at least the end of year 3 of the grants. Changes in client-level recovery outcomes may not occur until after the grants have ended.

The evaluation team in Washington State decided in the first year of the grant to pilot test the Recovery Oriented System Indicators, one of the recovery measures listed in the compendium offered by HSRI. We have completed a first year pilot of that instrument, found it to be of value, and will make the case that it serve as an acceptable measure of recovery for Transformation States. A report of those findings will be available from project staff in the near future.

Resource Inventory and Needs Assessment

The Resource Inventory and Needs Assessment completed as part of the Evaluation Team's first year of work is included in Appendix 2. That detailed report used multiple methods to identify need and resources available in the state, and has many uses for planning transformation efforts. In terms of evaluation, the principle findings from this report serve to refine the focus of the evaluation, and will constitute place markers for the logic model to be developed. Principal findings from that study fell into four categories:

1. **Expand access to mental health care, to reduce unmet need and to ensure that consumers are served when the problems first manifest themselves.**
   - This may include changing benefit designs to maximize federal match and get more matching dollars, and working to maximize third party reimbursements. Should also include reducing and

simplifying the record-keeping burden for providers, which would save funds throughout the system.
- May also include closing hospital wards to transfer some funds into community services.
- It may also mean some new state funds, since it seems unlikely that the above steps will save enough in the short-term to serve twice as many people as DSHS is serving now.

2. Change community treatment options for all consumers to emphasize recovery, consumer choice and improved outcomes.

- Attend to cultural and geographic subgroups here as well as consumer choice generally – one set of services does not fit all consumers.
- This set of changes alone should improve recovery outcomes and may generate cost offsets in psychiatric hospitalizations, medical costs, and criminal justice costs.

3. Reduce stigma and improve public knowledge about mental illness, treatment options and recovery.

- This is important for every group of consumers – it may be particularly important for people with co-occurring health problems, people who are homeless or in jail or prison, and children and youth.
- This should improve recovery outcomes – it may also enhance potential cost offsets in psychiatric hospitalizations, medical costs, long-term care costs and criminal justice costs.

4. Integrate and coordinate services more effectively for clients with multiple problems.

- This is very important for the wellbeing of consumers, more than half of whom report encountering discrimination and stigma.
- This too is important because the first treatment and referral source for mental illness will always be families and friends in the community.
- Community and family members need to know how common mental illness is, that effective community based treatment is available, where it is, and that it works!

Theory of Change Evaluation

The Evaluation Team will utilize all that was learned in the first project year to develop a complete logic model, with activities, timelines, and benchmarks clearly specified. Then in Years 2-5 the Evaluation Team will conduct an

impact evaluation using a theory of change evaluation approach. The evaluation will assess long-term outcomes addressing the eight goals adopted for this project (the President's six New Freedom goals, plus the employment and housing goals adopted in Washington State by the TWG. The areas of need identified through the Resource Inventory and Needs Assessment will also be essential components of an articulated theory of change for the Transformation.

Elements to consider. An integral part of the logic model/theory of change for this evaluation will consider the elements suggested by SAMHSA in their Evaluation Guidance Document, for the focus of the model. The following were suggested by SAMHSA as likely candidate processes that might contribute to successful organizational change in Transformation. Each will be carefully considered in constructing the model:

- leadership
- workforce competencies
- workforce training and development efforts
- effectiveness of incentives
- organizational readiness and culture
- interagency policy and standards alignment
- integration of mental health-related data across agencies
- performance indicators
- effectiveness of quality assurance mechanisms
- consensus building among stakeholders
- goal achievement
- needs assessment
- interagency collaboration (e.g., number of meetings/conference calls among diff agencies for each goal)
- barriers encountered and how resolved (e.g., see identified barriers from the New Freedom Commission Final Report, Executive Summary, p. 23)
- resource flexibility
- contract expectations
- values orientation
- public/private partnership/relationship
- impact of economy and financing cuts on MHT efforts
- interim steps in making infrastructure changes, e.g., meetings held, agreements reached, etc.
- impacts of MHT on other agencies and impacts of other agencies on MHT; how MHT is taking its place in the consortium of other interests

- inclusion of consumers in above areas

The four principle areas of findings from the Resource Inventory and Needs Assessment (see Appendix 2) will also constitute key elements (inputs, outputs, processes in the construction of the model.

Focusing on many of the processes above, the following issues will be addressed in the logic model that will serve as the articulated theory of change for this project. That document and model will then guide evaluation efforts over the life of the evaluation. Among the questions to be addressed, the listing below is offered as an initial scope and purpose of the evaluation. Finalization will occur after the TWG and participating agencies and stakeholders come to consensus about the directions that Transformation will take. Thus the suggested topics below are preliminary:

1. ***The need for mental health care.*** How many people have been screened or served somewhere in DSHS in ways that indicate a "need" for mental health services? What is their age, gender, race, ethnicity and location?
2. ***Mental health service use and costs across systems***. How many consumers needing treatment used mental health services from DSHS? How many from MHD, how many from other parts of the agency? Were the rates and patterns of mental health service use different for different subgroups of people? What kinds of mental health services were used, and what did they cost? How many consumers needing treatment accessed services through non-mental health settings? How well were their needs and preferences met?
3. ***Mental health service cost offsets***. How do non-mental health costs across DSHS compare for those who received various sorts of mental health services, including "no treatment." Are there state costs to NOT serving people, which could be used to expand treatment?
4. ***Mental health service outcomes for consumers and families***. How did various groups of people needing and/or receiving mental health treatment fare in their daily life? How do the groups compare in employment and wages, school enrollments and success, arrests and convictions, and use of medical care? How do consumers and family members feel about the way they were served? Did they report being

involved in individualized planning for their services and supports?

Sound quasi-experimental designs, econometric analyses, multi-level modeling and structural equations will be used to answer critical questions about the macro-level impacts of mental health transformation. The questions include but are not limited to:

- How do the mental health outcomes for child and adult consumers compare before, during, and after the transformation?
- How do community outcomes for mentally ill persons detained in jail (e.g., public health and public safety) compare before, during, and after the transformation?
- What are the intersystem effects of the transformation with respect to point-of-service entry (i.e., irrespective of entry point, do consumers get appropriate services?), information sharing and accountability among agencies involved in serving multiple system users, and the alignment of policies and procedures across multiple systems (i.e., criminal justice and Medicaid)?
- What are the costs of these various transformation efforts? Are cost-efficiencies realized from expanded service delivery and in what sectors?
- What regional differences are observed, and how do these relate to regional demographic characteristics, service configurations, funding arrangements, and other ecological factors.

Feedback and Continuous Improvement

The Evaluation Team (with the consumers, family members and youth an integral part), will report, evaluate, and synthesize evaluation findings on an ongoing basis to the TWG throughout the Transformation process and beyond. These findings will be disseminated in series of reports, presentations, and web mediums among consumers, family members, advocacy groups, key stakeholders, administrators, and other constituents in order to facilitate dialogue about the Transformation's processes and impacts. This dialogue will be used to re-shape, re-focus, and modify the Transformation.

CHAPTER 6:

SHIFTING THE PARADIGM

This first year of the MHTP has been devoted to developing a shared understanding and common agenda for Transformation. The outcomes and strategies presented to the TWG provide the direction and form the vision underlying this CMHP. The responsibility of converting these visionary action plans into reality rests with the Transformation Partners. The TWG and the MHTP staff will be working in Year 2 and beyond to facilitate and support participating agencies in their efforts to translate the vision into concrete actions.

The MHTP team has been working closely with staff in partner agencies to inventory the efforts already planned or under way that help to move the Transformation agenda forward, starting first with a review of state agency strategic plans recently submitted to the Governor. Agencies have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. We will inventory these strategies for inclusion in next year's plan.

Also, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis between what the community recommendations are and what agency activities are planned. Once that is done, the state will have a better idea about where to focus its resources to address community recommendations.

It is apparent that years of funding services for the most in need has created a "mental illness" system; not a mental health system. The TWG, consumers, families, partner agencies, and policy leaders, recognize the importance of more clearly defining mental health, linking it to physical health, and focusing on a public health approach for creating healthy individuals, families and communities. With increasing focus on these aspects of Transformation,

there is a growing understanding of policy implications for the state's mental health system. In Year 2, the TWG will engage all Transformation Partners in a crucial discussion about how and when a systemic redesign of the system of providing mental health services in Washington will occur.

SUMMARY

If we are to achieve our objectives related to improving the health of all individuals and families residing in Washington State, we must have a strong vision. The Washington Health Foundation is on the right track with their "Healthiest State in the Nation Campaign." Key organizations must come together, agree on a vision, establish cross system goals/objectives, identify a core set of outcome measures to track our progress and focus our resources in such a way as to provide more holistic services to individuals and families.

In our quest to raise the bar regarding improving the health of all citizens, we must broaden our philosophical approach to include mental health as an essential component of overall health. It is imperative that we acknowledge the interrelationships of mind, body and spirit. When we talk about health we must incorporate the spectrum of medical, mental health, alcohol/drug and related health areas. By viewing health in this broad fashion, our planned interventions will become more holistic and effective. We cannot continue the traditional piecemeal approach in which partial services are rationed to those in most desperate need, and expect peak results.

Governor Gregoire and the Washington State Legislature have recognized that our young children are our greatest assets. If we do not prepare these children for adolescence and adulthood, we will face tremendous social and economic costs well into the future through poor academic achievement, increased criminal activity, unprepared and untrained workforce, family strife, poor mental health, increased alcohol/drug use and overall decreased health of our families. On the other hand, if we focus more attention on being preventive in our approach and are more holistic in our strategies to assisting families in developing healthier lifestyles, then we can reduce the cost of more expensive government services in the long term.

The Mental Health Transformation Project leadership agrees with the vision of making Washington state the Healthiest State in the Nation and we believe that the state must place much more emphasis on prevention and early intervention as well as cross system planning if we expect to improve the health of our residents. Improved health of citizens will in the long run result in less demand on publicly funded health and mental health care systems. At the same time, our subcommittees' work reflects that our current system of care, while expensive, is inadequate. We don't purchase enough of the needed services, in some cases purchase services that aren't wanted or valued, and have an evolved benefits package in public mental health particularly where only the most ill citizens qualify, and usually require the most costly care, draining limited financial resources. Our subcommittees have articulated through their hard work, a strong set of recommendations for addressing the ills of the current system.

The Transformation Grant Team recommends a dual approach, one effort seeking system improvements, recommended by the subcommittees; the other addressing prevention and health promotion, recognizing that failure to address these issues dooms the state to make patchwork improvements to the current system, only on the margins. The challenges are many. The resources are limited. If Washington is to become the healthiest state in the union, it will require a commitment to both: To prevention, early intervention and health promotion, AND to improvements in the current system. True transformation can only occur if we do both.

Reviewing the work of the past year, six major forward-looking themes have emerged that should infuse and guide the work of the MHTP in Year 2 and beyond.

Transformation Theme 1:

The State of Washington views mental health as part of overall health.

This theme does not necessitate any structural change. Rather it promotes a philosophical approach where mental health is an assumed part of a person's overall health. This supports the contention that health is about mind, body and spirit. The Governor may want to distribute a policy directive or Executive Order

directing this approach. Further, the Legislature may want to pass a resolution supporting this approach.

Transformation Theme 2: **Mental Health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs.**

While there have been a variety of prevention and early intervention strategies implemented in Washington State, most have been focused on very specific population groups (preschool, elementary school, youth at risk for tobacco use or substance abuse), few have perceived their charge as broad health initiatives and few have involved workers from the mental health field as part of their planning and policy team. The Governor could create an Executive Policy Position on Prevention and Early Intervention. This person could work with various agencies to inventory prevention/early intervention programs and develop a clear vision with strategies to ensure coordination across these initiatives. And, all of these strategies could follow the approach that a healthy Washington is about focusing on a healthy mind, body and spirit.

Transformation Theme 3: **Following the lead of the Washington Health Foundation, state agencies, with leadership from the Governor, Legislature and Superintendent of Public Instruction, could develop a core set of bench marks (out come measures) to track the health of Washington state residents.**

Essentially this theme proposes that Washington State develop an annual report card that tracks key measures that monitor improvements of health status for Washington state residents and compares our progress to that of national benchmarks where applicable. Several state agencies already produce reports using this framework that may simply need to be expanded.

Transformation Theme 4: **State agencies will increase opportunities for consumers/families to establish agency priorities and direction.**

The intent here is to ensure systems are more consumer and family driven. While this mantra has been adopted by many health care systems, there has been little or no documentation of how health care

systems have actually included consumers/families in system development or delivery other than conducting consumer satisfaction surveys. State agencies and their contractors must clearly define, as part of their strategic plans, how consumer/family involvement will be increased in the planning and delivery of services.

Transformation Theme 5:

State agencies will improve cross system data collection, data analysis and data reporting systems that focus not only on outputs but report on actual outcomes-reductions in negative consequences and improvements in overall consumer/family/community health indicators.

This theme supports the Governor's Government Management and Accountability Program and encourages agencies to identify cross-system impacts. For instance, what family/individual/community risk factors affect a student's readiness to learn? One has to look beyond classroom size and teacher training. One also has to look at the health (mind, body and spirit) of that individual student and their family/community environment.

Transformation Theme 6:

State agencies, local government, providers, advocates, consumers, and families will make every effort to implement the specific recommendations of the subcommittees. Cross-system collaborations that focus not only on symptoms, but on citizens overall health, wellness and recovery must be paramount if the system is to improve, and we are to reduce negative consequences and improve the lives of our consumers, family members, and our communities.

This theme supports all the subcommittee recommendations and encourages agencies to identify cross-system opportunities for improvement. These efforts support and build upon efforts already underway across all state agencies to improve outcomes, increase voice of consumers and family members in decisions, and develop more effective, efficient, evidence-based and promising programs to the forefront as standard practice in the Washington State network of mental health care.

APPENDIX 1 Summaries of Public Input and RSN Listening Sessions

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

ADULT CONSUMERS AND FAMILY MEMBERS SUBCOMMITTEE
April 3, 2006

Introduction
The current report represents an analysis of the content of public testimony related to the Adult Consumers and Family Members Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Adult Consumers Subcommittee were included in this analysis.

Method
Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

1. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
2. Within Washington State, and for all mental health services, public or private, 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?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and

summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

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To increase ease of use and interpretation, a single analysis of all statements was conducted. The information presented here combines responses to all four questions into a single summary of all testimony received. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments
Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:
Suzanne E. Kerns, PhD ABD, Eric J. Bruns, Ph.D., Phoebe Mulligan, and Justin D. Smith, University of Washington Division of Public Behavioral Health and Justice Policy
Maria Monroe-DeVita, Behavioral Tech Research, Inc.
Sabina Low Sadberry, Ph.D., University of Washington Evans School of Public Affairs

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
ADULT CONSUMERS AND FAMILY MEMBERS SUBCOMMITTEE

Data sources:

1. Public Testimony at the Adult Consumer and Family Subcommittee Meeting, SeaTac Holiday Inn, 2/9/06
2. Public Testimony at the Adult Consumer and Family Subcommittee Meeting, Eastern State Hospital, 2/13/06
3. Data transferred from the first two Children/Youth and Parents/Families Subcommittee Meetings, Highline Community Health in Burien, 2/7/06, and at the Everett Library, 3/1/06
4. Department of Health (DOH) Response to the Four Questions, 3/24/06
5. Additional written submissions from individuals, agencies, and organizations statewide

Total Statements coded = 167

Summary of findings

Public testimony relevant to the Adult Consumers and Family Members Subcommittee consisted of 167 unique statements coded from 36 individuals who gave testimony at public hearings (or written submissions) as well as additional documents submitted from individuals, agencies, and organizations. These 167 statements were sorted into 12 main categories or themes. The two categories into which the most statements were coded (35 statements each) were: (1) maintaining a focus on recovery and consumer-driven care, and (2) vocational training, employment, and education. Other major themes included using evidence-based practices and improving the effectiveness of services (27 statements), concerns about hospital-based care (15 statements), and workforce development and provider training issues (13 statements). Additional categories included providing financial assistance, medication, funding issues, health disparities, and transportation. Ten respondents also stated specific adult consumer and family member outcomes that should be focused upon and tracked. A summary of these results is presented below.

Major Theme #1: Vocational Training, Employment, and Education

Half of all respondents reported that vocational training, employment, and education are essential components of a transformed mental health system. The majority of these respondents reported that persons with mental illness are in great need of better vocational training/rehabilitation in order to obtain employment in the community. In particular, respondents cited the need for the Division of Vocational Rehabilitation (DVR) to employ specialists who have been trained to work with persons with mental illness. One recommended way to achieve this was to integrate or shift funding from DVR to the Mental Health Division (MHD).

Respondents further cited the need for continuing to support the Clubhouse model (specifically referencing Evergreen Club in Spokane and Rose House in Tacoma) and implementing more supported employment programs statewide. Respondents further reported that employment opportunities are half the battle in achieving positive vocational outcomes. In particular, they reported the need for a range of employment opportunities -- from competitive employment with

fair wages to "meaningful employment" that provides the consumer with both the choice of job as well as support on the job. This range in employment needs and goals has implications for employers who may not have experience in working with persons with mental illness or an understanding of mental illness, and may provide an important opportunity for consumer providers (i.e., peer or recovery specialists) to fill these important roles (see also recommendations under Recovery and Consumer Involvement). Finally, respondents reported that opportunities for obtaining various types of education goals, particularly in a supported environment, are crucial for recovery (e.g., the SEER Program in Spokane).

Major Theme #2: Evidence-Based Practices and Improving Services

Nearly half of all respondents reported that a transformed mental health system should focus on implementing evidence-based practices (EBPs) and improving service approaches for adult consumers and their families. Among these, most respondents reported the need for more support and psychoeducation programs for consumers and families (e.g., NAMI's Family-to-Family program, illness management, a peer mentoring program in the State of Alaska). The same percentage of respondents also reported the need for more psychotherapy or counseling services available in both community mental health centers and the state hospital. This theme further overlaps with one of the themes listed below related to the need for more clinical training for providers, particularly case managers (see Workforce Development and Provider Training). Respondents further reported that more psychiatric rehabilitation programs (e.g., skills training) are needed and described strengths and weaknesses related to current assessment practices in Washington. Related to assessment concerns, while practices such as the Behavior Risk Factors Surveillance System (BRFSS) are reportedly "working" in the state, respondents reported that more attention to an integrated approach, including assessment of physical and mental health, is needed. Other minor themes in this area included the need for more crisis and acute services, as well as prevention programs. Respondents indicated the need to make sure to individually tailor services, as well as include promising and emerging practices.

Major Theme #3: Recovery and Consumer Involvement

In line with the vision of the Mental Health Transformation Grant, many respondents reported that both recovery and consumer involvement will be critical components of a transformed mental health system. Among the top responses within this category were consumer voice and choice in treatment (e.g., more say in who they see and the types of therapy are available) and the need for mental health providers to incorporate recovery into their current practices (e.g., moving beyond simply wanting symptom stabilization without attending to larger life goals defined by the consumer). The vision for a consumer-driven mental health system was also reported, including the need for consumers to be more involved as providers as well as in policy and administrative roles. Many respondents reported concerns about consumer rights, including the extent to which they are informed about the services they are receiving and the extent to which they can share their concerns without negative implications within their treatment.

Major Theme #4: Workforce Development and Provider Training Issues

The need for workforce development and better provider training was reported by a number of respondents. In particular, respondents reported that there is little education or practical training within undergraduate and some graduate programs, particularly in working with the complex and diverse needs of persons with mental illness. Suggested avenues to improve this area included

state certification through the U.S. Psychiatric Rehabilitation Association (which requires provider demonstration of competence in this area), as well as better classroom instruction and specific training at both the Bachelor's and Master's levels in working with persons with mental illness in the community. Other workforce development issues included concerns about staffing shortages and the need to train police and correctional staff to work with people with mental illness.

Major Theme #5: Financial Assistance
About a quarter of respondents reported that financial assistance is essential for consumers. It is a basic need that – without its presence – makes recovery very difficult. Respondents cited the need for consumers to have money to pay for their medications, as well as personal income and/or benefits to pay for personal needs.

Major Theme #6: Specific Concerns within Eastern State Hospital
Since one of the two Adult Consumer and Family Subcommittee Meetings was held at Eastern State Hospital, several respondents provided feedback specific to this service setting. This feedback can be divided between those related to treatment *within* the hospital and those related to *transitioning* out of the hospital to the community. Concerns within the hospital include limited activities on the unit, prescriptive programming (without individualized services), and concerns that staff have too much paperwork which takes them away from direct care. One respondent reported that there was a need to get more assistance with advocacy and arbitration. Another respondent reported that sometimes consumers are placed at ESH because there weren't any beds open closer to their homes, which has many implications in terms of ongoing support from family or assistance with disposition.

Feedback regarding transition from the hospital to the community included the need for a better disposition planning process and limited resources in the community (e.g., not enough transitional programs, need for more independent and supported housing).

Other Major Themes

Transportation, Funding, Medication, and Health Disparities
Several respondents reported that each of these four areas need improvement. Regarding transportation, respondents reported that the public transportation system is inefficient and unavailable in many places.

Funding concerns focused on the system as a whole, as well as specific programs (e.g., SEER program, congregate care, Evergreen Club). Respondents also reported concerns about the state focusing on funding toward short-term vs. long-term solutions.

Medication concerns included worries about overmedication as well as the effectiveness and side effects of the new atypical antipsychotics. There were also concerns about the mental health system's focus and resources devoted to medications vs. other forms of treatment.

Regarding health and mental health disparities, respondents reported concerns about the fact that people with mental illness have disproportionately higher rates of tobacco use. Furthermore, one

respondent noted concern that while health disparities keep getting brought up in many venues, it always gets lost in the shuffle of priorities.

Consumer and Family Outcomes

A few respondents provided feedback specifically on important consumer and family outcomes, with a total of 10 statements provided in this area. Suggested outcome areas included decreased hospitalization, decreased incarceration, reduced substance use, decreased tobacco use, stable housing, better transportation, and stable employment. In addition, there were recommendations to further measure the percentage of consumers working as providers (target = 50%) and the percentage of consumers working at the policy level. One respondent suggested making sure that the system use an outcome measure that can't be manipulated to look like people are improving when actually they are getting poorer results every year.

A full summary of all themes and statements within each theme is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Adult Consumers and Family Members Subcommittee (N=167 statements total).

Themes	N Statements
Recovery & Consumer Involvement	**35**
Consumer-Driven System and Services	**12**
Need consumers working at the policy and administrative levels/ being politically active	4
Need consumers working as providers/ Consumer-operated services (e.g., Peer to peer programs, peer recovery specialists)	3
Need a formal venue where consumers can express what's going well/not going well in their treatment	2
Consumer-driven aspect of the Transformation Grant is a positive step in the right direction	1
Consumers are an underutilized resource and knowledge-based technical assistance base	1
DVR should hire consumers and recovery specialists	1
Providers Incorporating Recovery into Practices	**8**
Many providers focus on more basic goals in treatment, rather than helping the individual achieve recovery	3
Need more compassionate treatment/respect for consumers	3
Some pockets of providers really "get" recovery and are transforming their work to promote this model	1
"Warehousing" in state hospitals with little emphasis on recovery	1
Consumer Voice/Choice in Services	**7**
Consumers don't feel that they are "heard"	5
Consumers should have more say in who they see and what types of therapy are available to them	2
Consumer Rights	**6**
Need better informed consent process	2
Society and providers treat consumers like they don't have any rights	2
Consumer concerns that what they say will be held against them	2
Expanding definition of recovery	**2**
The definition of recovery should not just be about living with the fact that you haven't fully recovered	1
We need to promote the concept of interdependence as well as independence	1
Vocational Training, Employment, & Education	**35**
Vocational Training/Rehabilitation	**12**
More vocational training/support is needed	9
Need DVR specialists who know how to work with people with mental illness	2
Integrate/shift funding from DVR to MHD to better assist with skill building in employment	1
Employment Opportunities	**8**
Job placement in the community can be difficult due to some consumers' history	3
Need more emphasis on competitive employment/fair wages for employment	3
Need more meaningful employment for people with mental illness -- however that is defined for each person	1
Need partnerships with businesses for placing consumers in jobs and developing	1

vocational skills	
Clubhouse Model	**7**
Clubhouses are working well	4
Evergreen Club (run through Spokane Mental Health) is a good clubhouse program	2
Rose House is a good clubhouse program/ should be replicated across the state	1
Education	**6**
Need more supported/supportive education	4
SEER Program is excellent	2
Supported Employment	**2**
Community supported employment is needed to make clubhouses work	1
I believe in supported work/employment	1
Evidence-Based Practices (EBPs) and Improving Services	**27**
Support/Psychoeducation for Consumers and Families	**7**
More supports/education for families	4
Need more education of consumers about their own illness/ wellness management programs	2
Need mentoring program like they have in Alaska -- pairs a person with MI with a brother or sister in the community for doing outings, work programs, etc.	1
Psychotherapy & Counseling Services	**7**
More counseling and therapy services	6
More support groups for depression	1
Psychiatric Rehabilitation	**3**
More psychiatric rehabilitation / skill-building to increase capacity to be independent	2
Need more help with dealing with issues around relapse, symptom management, and medication management	1
Prevention & Early Intervention	**3**
Early Intervention Program (for HIV clients) is working well (see specifics in DOH doc 3/24/06)	1
First Steps provides important services to pregnant and postpartum adult females	1
More prevention programs to prevent harmful, dangerous situations for consumers living in the community	1
Assessment	**3**
Need more holistic or integrated approach to assessing mental and physical health	2
The Behavior Risk Factors Surveillance System (BRFSS) is working well -- assesses mental health, anxiety, and depression	1
Crisis & Acute Services	**2**
Acute treatment unit/something between community and hospital is needed	1
Need crisis lines	1
Considerations for Conceptualizing and Implementing EBPs	**2**
Expanding definition of EBPs (e.g., promising, emerging) will increase room for innovation	1
More individualized approaches to all services	1
Eastern State Hospital Concerns	**15**
Concerns With Transitioning from Hospital to Community	**9**
Better disposition planning from state hospital	4

Not enough community and transitional programs to connect someone discharged from state hospital (p. 84, 2/13)	3
More independent and supported housing options are needed	1
Difficulty with transitioning to the community when the person is hospitalized far from home	1
Needs Within the Hospital	**6**
Limited activities on unit	2
Prescriptive programming	1
Too much paperwork takes unit staff away from client care	1
Need the ESH ombuds and more help in advocating/arbitrating for consumers	1
Placement at ESH because there weren't any beds open closer to the person's home -- little support for the consumer	1
Workforce Development/Provider Training	**13**
Education and Training for Community Providers	**9**
People coming into this field need better education and training	7
Education of providers should start in the classroom, beginning with practical learning at the bachelor's and master's levels	1
Certification process through the U.S. Psychiatric Rehabilitation Association would ensure provider competencies	1
Other Workforce Development Issues	**4**
Staffing shortage	2
Need training for police force/ Corrections in working with persons with mental illness	2
Financial Assistance	**10**
Need more personal income/benefits	5
More assistance with paying for meds	4
Information to take "default" status off student loans due to mental illness/improve credit	1
Adult Consumer and Family Outcomes	**10**
Percentages of people employed	2
Decrease in hospitalizations	1
Substance use decreases	1
More stable housing, transportation	1
Percentages of consumers employed as providers (target = 50%)	1
Percenrage of consumers working at the policy level	1
Tobacco use rates among people with mental illness decrease	1
Decrease in incarcerations	1
Make sure you use an outcome measure that can't be manipulated to look like people are improving when actually they are getting poorer results every year	1
Medication	**6**
Overmedication is a problem	3
The newer atypical antipsychotics don't necessary have a better profile in terms of side effects than the older medications	1
Many people do better and eventually recover without antipsychoatic medications	1
We're spending hundreds of millions of dollars on medications, leaving little for other resources	1
Funding Issues	**5**
Limited funding/resources in the system	2

Problems with cutting funding for quality programs (e.g., SEER)	2
We spend our money on short-term vs. long-term solutions	1
Health disparities among people with mental illness	**3**
Cigarette/tobacco use is problematic	2
Health/mental health disparities are a problem	1
Transportation is a problem	**3**
Other Responses	**5**
Parity law is a good thing	1
Paperwork barriers	1
Anticipate that adult consumers will become older adult consumers and plan accordingly	1
Concern about for-profit companies taking over mental health services	1
Lack of housing and services for adults who have neurological problems, but do not have the requisite low IQ	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
ADULT CONSUMERS AND FAMILY MEMBERS SUBCOMMITTEE

Selected Representative Quotes

Major Theme #1: Vocational Training, Employment, and Education

Needing DVR specialists who know how to work with mental illness:
"…not to pick on DVR, but there's a big problem in delivery of services in helping people with psychiatric disabilities get employment. They have a low percentage of people get jobs and maintain jobs and part of it is that DVR workers aren't well trained in how we work with people with psychiatric disabilities (p. 66, TWG Subcommittee, 2/9/06).

Evergreen Club is a good clubhouse program:
"Now, that's another job training program for people from mental health. That's an excellent program for people. I was there for three years. I got two jobs; a Pepsi Company job. I was helping a Pepsi Company guy. I was getting paid minimum wage. I was giving pop and helping him put pop in the truck. He gave me a small paper route" (p. 23 TWG Subcommittee, Feb. 13, 2006).

Job placement in the community can be difficult due to some consumers' history -- Need more jobs that do not discriminate because of this factor:
"I have a college degree…Can I go out there and get a job because I've been out sick for two years or two and a half years? I doubt it. And I got 20 years of experience turning wrenches on cars. Could I get a job in the automotive field? Not a chance in your lifetime, let alone my own" (pp. 128-129, TWG Subcommittee Meeting, February 13, 2006).

Need more emphasis on competitive employment/ fair wages:
"…jobs provided for consumers with pay – not 50 cents an hour, like we used to get – would provide realistic incentive for consumers to participate" (p. 20, TWG Subcommittee, February 13, 2006).

The Support Education Enhancing Rehabilitation (SEER) program (in Spokane) is a good supported education program:
"It helps persons with mental illness integrate either into the work world or into the academic environment…it has been very beneficial for people to get integrated into the community and get their GEDs and all sorts of stuff. There's a transition-to-college program…a basic adult education program and all sorts of programs that help different types of persons with mental illness get their needs met in a very supportive environment (p. 28, TWG Subcommittee, February 13, 2006).

Major Theme #2: Evidence-Based Practices and Improving Services

Consumer and Family Support/Psychoeducation:

"…Family-to-family, which, I think, of course, being a NAMI person, I think is excellent. Support groups that we have through NAMI for families, and also for the consumer and their particular need, whether they're bipolar, schizophrenic, whatever, we have support" (p. 35 TWG Subcommittee, February 13, 2006).

"I think there should be more therapy for mental health" (p. 23, TWG Subcommittee, February 13, 2006).

Major Theme #3: Recovery and Consumer Involvement

Need better informed consent:
"…informed consent (is) not present in your current mental health system. Clients are not adequately informed to the consequences of treatments. They're not informed of the alternatives available..." (p. 85, TWG Subcommittee Meeting, February 9, 2006)

Providers aren't helping consumers to move into recovery
"I think that people don't really have an appreciation for how to help people really maintain and move into recovery after they're leaving this hospital…If a person has moved beyond (relapse, symptom management, medication management), I don't feel like people know how to really support a person in their next steps of recovery" (p. 82, TWG Subcommittee Meeting, February 13, 2006).

"…I also believe there's a problem with a lack of positive expectations from case managers…Just stabilizing people is enough for a lot of case managers and when consumers will come and say 'I want to go to school, I want a job…I want a house,' that they'll say we don't want to set you up for disappointment, so lower your expectations so that doesn't work" (p. 67, TWG Subcommittee Meeting, February 9, 2006).

Venues where consumers can express what's going well/not going well in their tx
"In Napa, California, they have self- self-government, both California and Arizona both. They have – the patients elect a president and they have meetings where they…They express what they think should be done and should be done and stuff, and it works very well. I was on the Director's Advisory Council" (p. 118, TWG Subcommittee Meeting, February 13, 2006)

More consumers working as providers and helping with implementation
"I would see that as a very under-used resource and knowledge-based technical resource, technical assistance base. Whether that's for starting up clubhouses, starting up drop-in centers, educating the public, educating the police, technical assistance to a consumer-run system" (p. 93, TWG Subcommittee, February 9, 2006).

"…and I learned this from the supported education teacher because she was a consumer. And that's why I say consumers need to be hired. They need to be working in mental health centers. She's the only one I would have learned it from. A case manager could tell me until she's blue in the face 'you can recover' or 'you can get up,' but I needed to hear it from somebody who had done it" (p. 70, TWG Subcommittee Meeting, February 9, 2006).

"I would like to see peer recovery specialists and we're looking at training some that are employed in mental health centers and state hospitals and other agencies at a competitive wage with the same status and stature of case managers" (p. 67, TWG Subcommittee Meeting, February 9, 2006)

Need more consumers working at the policy level/getting politically active

"I'd like to see a lot more policymakers with mental illnesses sitting at the table and I'd like to see them (get the) support to get their graduate degree so they can have the qualifications (and) that nobody can say 'you're not qualified.' I'd like to see them sitting at that table" (p. 71, TWG Subcommittee Meeting, February 9, 2006).

Major Theme #4: Workforce Development and Provider Training Issues

Provider education and training:

"…I work with WSU and EWU, and I would say that in terms of – some of the concerns about case managers and therapists, for persons who are leaving Eastern State Hospital, I'm not sure that we are doing a really good job of really training and teaching people who are coming into the field about – to have the kinds of skills that are really needed and are really current…students that are coming into the field don't have the practical skills that they need to be able to do the work. And you, as consumers, probably know that" (pp. 82-83, TWG Subcommittee Meeting, February 13, 2006).

"I work with a lot of students who don't get it. They don't get this, and they end up working in mental health, and they do the best they can, and they're very compassionate people, but they have to kind of figure it out on their own, read a lot on their own. It's not something they're grounded in when they walk into the field" (p. 87, TWG Subcommittee Meeting, February 13, 2006).

Certification process through the U.S. Psychiatric Rehabilitation Association would ensure provider competencies

"They have a certification process, which means that not only do you have to have a degree from a discipline, but you also have to be certified to work in psychiatric rehabilitation, which means you have to have X number of hours. You have to actually take a test. You have to demonstrate your competencies" (p. 86, TWG Subcommittee Meeting, February 13, 2006).

Major Theme #5: Financial Assistance

"Definitely putting a little money on the release, not just the treatment -- or with medications; assistance in helping them continue to pay for their medications" (p. 14, TWG Subcommittee, February 13, 2006).

Major Theme #6: Specific Concerns from Eastern State Hospital

We need more congregate care facilities and beds to support transition from hospital to community

We need help with and more of a focus on finding *independent* living (not just board-and-care, group homes) after discharge.

Other Themes

Transportation

"I have received quite a few complaints about the Paratransit setup; the way it is, too, with making people doing routes in, like, groups of people where people are left sitting for hours waiting for their ride, even though their class may be done" (p. 31, TWG Subcommittee Meeting, February 13, 2006)

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

CHILDREN, YOUTH AND FAMILIES SUBCOMMITTEE
April 17, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Children, Youth, and Families Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Children, Youth, and Families Subcommittee, were included in this analysis.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

5. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
6. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
7. What would a "transformed" mental health system look like?
8. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

Questions about this report can be directed to:
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To increase ease of use and interpretation, a single analysis of all statements was conducted. The information presented here combines responses to all four questions into a single summary of all testimony received. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a number of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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Sabina Low Sadberry, Ph.D., University of Washington Evans School of Public Affairs

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CHILDREN, YOUTH AND FAMILIES SUBCOMMITTEE

Data sources:

6. Transcript of subcommittee hearing #1: Feb. 6th, 2006 (Burien, WA)
7. Transcript of subcommittee hearing #2: March 1st, 2006 (Everett, WA)
8. Transcript of subcommittee hearing #3: March 13th, 2006 (Wenatchee, WA)
9. 41 additional written documents from individuals, agencies, and organizations statewide

Total Statements coded = 682

Summary of Findings

Public testimony relevant to the Children, Youth, and Family Subcommittee consisted of 682 unique statements coded from 97 individuals who gave testimony at public hearings and 41 additional documents submitted from individuals, agencies, and organizations. These 682 statements were sorted into 11 main categories or themes. The category into which the most statements (186) were coded was commentary about existing services or service types, followed by a second category (with 84 additional statements) related to the desired outcomes of a transformed system. Funding (73 statements), availability of services (73 statements), continuity of care (60 statements), training and education (50 statements), Foster Care issues (39 statements), and family support issues (32 statements) also were major themes. Other themes included administrative concerns, transitions for youth, and early intervention. Discussion of each of these themes is presented below.

Information about current programs (Including statements about services that are working well, services we need more of, considerations for Evidence Based Practice, additional considerations, administrative concerns, and cultural diversity)

- Wraparound was the program most often named as a successful program that should be expanded. Additionally, there is a significant lack of day treatment options available. Parents are finding they have only 2 choices: inpatient hospitalization or inadequate weekly counseling sessions.
- Many folks brought up the importance of using evidence-based practices (EBP's), although with several stipulations. First, there must be consideration to the "whole person", not just their disorder. This includes sensitivity to issues of cultural and sexual diversity.
- A transformed system would provide services in the communities where people live and use therapeutic techniques that are appropriate and valid for presenting concerns. Services would be delivered at various levels of need, ranging from primary prevention to crisis and everywhere between. Clinicians would have a minimally sufficient amount of paperwork and administrative considerations. All programs would be culturally sensitive and relevant.

Effectiveness of interventions and services (Primary prevention, integration within primary care, general lack of effectiveness, additional considerations)

- The current system places the majority of emphasis on crises – often waiting until it is too late to do effective intervention.
- A transformed MH system would put the preponderance of support in prevention and early intervention. MH services would be fully integrated within primary care. A transformed system would not require diagnostic labeling to receive services and significant efforts would be put forth to reduce stigma associated with mental illness.

Funding (Including managed care, program funding, and staff pay)

- A transformed system would have funding available to pay for services for all kids. Care would not be dependent on the type of insurance available for the individual family. Mental health staff would be compensated at a higher level (will help reduce staff turnover which benefits clients and agencies). Flexible funds would be available to facilitate community-level work – including funding for transportation and community-based recreation.

Continuity of care (e.g., agency collaboration and mechanisms for continuity)

- Many people noted that there are significant fractures between agencies at multiple different levels. "Turf" wars and a "silo" mentality prevent continuity across and between services.
- A transformed system would consist of reliable partnerships across multiple systems accessed by youth (school, community, juvenile justice, families). Money would follow the kid as opposed to being "owned" by the providing agency.

Availability of services

- The biggest issue pertaining to availability of services is that the largest amount of services are available for Medicaid-eligible kids. Respondents indicated that there is very little available for kids whose families are not eligible for Medicaid but who do not have private insurance (working poor).
- A transformed system would have services available at multiple access points (e.g., primary care, school, community, more formal MH centers, juvenile justice, etc) and services would be available for all who are in need, regardless of insurance situation.

Family support

- Families of children with MH issues are in need of support. The way the current system is set up, a child/youth must be in crisis before often much-needed respite services can be activated.
- In a transformed system, parents, siblings, and other caregivers will be educated about their child's (or brother/sister's) mental health issues and have support networks available and easily accessible.

Training

- The most significant training issue is that those folks who are on the front-lines with children and youth (e.g., teachers, police officers, primary care docs) are not well trained for managing and treating mental health problems.
- A transformed system would have trained service providers outside of the traditional MH roles (counselors, psychologists, social workers, psychiatrists).

Foster care (Including Training and access)

- Overall, the current foster care system is not meeting the needs of foster kids across several levels. There are problems with access to foster care, discontinuity across placements, and availability of appropriate services.
- A transformed system would spend money up front to train foster parents and direct service personnel on the unique needs of foster care kids. Great attention would be placed on issues of placement and service continuity (so kids don't have to change service providers if they change placements).

Transitions (into, out of, and between placements)

- One very sad reality is that sometimes, for kids to become eligible for services, parents must give up their parental rights and turn their children over to DCFS.
- The way the confidentiality laws are currently written, parents of teens over the age of 13 may not be privy to therapy plans or transition plans after their teen leaves a hospital.
- A transformed system would involve parents/caregivers at all levels of intervention. Children/youth would be able to seamlessly access and float between services that are minimally sufficient to meet their needs. Caregivers directly responsible for managing a youth will be given adequate information to facilitate provider-family partnership in treatment of MH disorders (recognizing that treatment does not just happen at the clinic)

Desired outcomes (Child and family-level, provider level, system level)

- Mentioned most frequently: increased perception of availability of services, fewer kids entering into the juvenile detention, improved school performance, and restoration to more normative development (including full integration back into community).

A full summary of all themes and statements within each theme is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Children, Youth, and Families Subcommittee (N= 682 statements total).

Themes	N Statements
Types of Services/Service Characteristics/Programs	**186**
More of These Types of Services are Needed	**80**
Day Treatment Programs	13
Home-Based/In-Home Care	9
Need More Counselors/Mental Health Professionals (other than psychiatrists)	8
Need Greater Availability of Psychiatrists	6
Adolescent Services/Beds in Hospitals/Inpatient Care	7
Programs for Co-Occurring Disorders	5
Emergent Beds for Kids/Adolescents	5
Emergency Mental Health Assessments	4
Simply Not Enough Services in Some Areas	3
Community-Based Behavior Therapy	3
Respite Care	2
Preschoolers and Kindergartners Expelled Too Often for Behavior Problems	2
Housing Options	2
Child and Teen Therapeutic Schools	2
Peer-to-Peer Programs	1
Age-Appropriate Group Homes	1
More Mental Health Assistance in the Juvenile Justice System	1
Adolescent Diversion Plan	1
Counseling for Sexually Abused Children	1
Programs for Our Returning Military and their Families	1
Wraparound More Available	1
Crisis Intervention	1
Zero Programs for Schizophrenic Kids	1
Additional Considerations	**39**
Diversion from Hospitals and Juvenile Detention When Mental Illness Happens	6

Individualized/Tailored Treatment for Each Child	4
Need Better Diagnoses	4
Overmedication Without Side-Effect Monitoring/Experimenting	3
Adult Model of Care Not Appropriate for Children	3
Child Needs to Have a Voice	2
Strength-Based Delivery	2
Client-Centered Approach	2
Increased Value Placed on Family and Consumers Input	2
Limited Number of Providers Who Can Address Both Child and Parent Mental Health Needs	2
Don't Want to Have to Use Counselors in Training but they are Often the Only Ones with DSHS	1
Some MH Agencies Do Not Strive for Reunification/Permanency but Rather Try to Keep Child in Their Service	1
Personal Values are Put Ahead of Good Science Too Often	1
For In-Home Care Providers, Consideration to Travel Time Important	1
Increased Accountability Due to Legislative Actions Working Well	1
Need Developmental Perspective for Crisis Management	1
Consideration of Disaster Plans Regarding Medication Management	1
Children in Hospitals Not Working - (does not address the family at all)	1
Mechanism for Parents to Defend Themselves if Child Accuses - Don't Just Take the Kid Away	1
Services that are working well	**33**
Dedicated and Skilled Mental Health Counselors	10
Wraparound is Positive Program	7
Advocacy Client System Working Well	2
Head Start and Early Head Start Working Well	1
YWCA Mental Health Counseling Working Well	1
West Gate Chapel Working Well	1
Pathways for Women Working Well	1
Intensive Family Preservation Services Working Well	1
Peer Groups for Kids Working Well	1
Parent Support Groups that Meet Regularly (something working well)	1
Mental Health Services Reach Kids in Juvenile Detention	1
Psychiatrists are Accessible	1

Child is Informed About Their Treatment	1
Shared Children's Program Working Well	1
Madonna School Working Well	1
Children's Administration Working Well	1
Crisis Lines Working Well	1
Considerations for Evidence Based Practice's	**18**
Holistic as Well as Using an EBP	5
Support use of Scientifically Validated Programs	4
Expertise in the State Around EBP's	4
Need Better Integration from University-Based EBP's	2
EBP Reports Should be Disseminated to Public	1
Should Be Allowed to Choose Non-EBP Care	1
State Wants EBP's but Doesn't Understand the Costs Associated and Won't Fund Them	1
Cultural Awareness	**16**
No/Limited Multicultural Program in the Community and Few Ethnically Diverse Staff	7
State Not Acknowledging Differences in Providing Rural Care	7
Good Access to Culturally Diverse Providers (esp. Spanish speaking)	2
Desired MH outcomes	**84**
Services and Programs	**46**
Availability of Appropriate Services	17
Timeliness to Access of Service/Getting Into The System	9
Shorter Length of Stay	2
Better Integration of Services	2
Availability of EBP's	2
Feedback Loop with Consumer Input	2
Evidence That True Provider-System Partnerships Have Been Formed	1
Employment of Youth and Families at Local Agencies	1
Faster Treatment Processes and Outcomes	1
Reduced Out of Home Placements	1
Accurate Assessment of the Problem	1
Stable Foster Homes	1

Mutual Respect Between Services/Providers/Administration/Clients	1
State Determined Outcomes Carried Out by Local RSN's and Services	1
Greater Respect Given to Mental Health Providers	1
Comprehensive Services for Youth in Crisis	1
Increased Screening and Appropriate Referrals	1
Higher Job Satisfaction for Service Providers	1
Client-Related	**38**
Fewer Kids in Juvenile Detention	7
Restoration of Normative Development	5
Reduction in Hospital/In-Patient Visits	5
Family Functioning Higher after Treatment	4
Improved School Performance/Attendance	4
Decreased Substance Use	2
Reduction in Behavior Problems in School	2
Increased Satisfaction with Services	2
Less Family Homelessness	1
Greater Self-Confidence	1
Reduced Disparities in School Readiness	1
Fewer Infants Placed in Foster Care	1
Increased Community Engagement	1
Family Has Better Understanding of How to Help the Child	1
Get Kids Out of Foster Care and Back to "Normalcy"	1
Funding	**73**
Funding Limitations	**38**
Flexible Funding Options Needed - Too Many Restrictions Between Services/Agencies	12
Medical Insurance for All Kids Who Need It	7
Integrated Funding	6
Siloing or Departmentalized Funding Not Working	3
Need Social Commitment to Pay for Mental Health Services for All Kids, Including Homeless Kids	2
Money Should Follow the Kid	2
Need Subsidized Funding for Working Poor	1

If Both Parents Cannot Work, Not Eligible for Assistance with Child Care	1
Capitated Funding Helps with Reliability	1
Mental Health System is Money-Driven - Leaves People Out	1
Medicaid and Managed Care	**17**
Private Pay Kids are Difficult to Get Services For - Dependent on Managed Care	9
Must be Given a Diagnosis to Get Funding - May Not Always be Appropriate	5
Ability to Pay Funding, Not Limited by Medicaid	3
Not Enough Providers Accepting Coupons	2
No Services for Undocumented Kids	2
Medicaid Integration Project Working Well	1
General Program Funding	**13**
Simply Not Enough Funding to Serve All Who Need It	5
Need More Stability of Funding	4
Not Enough Funding for Diagnostics and Testing	2
Personnel Costs Make it Difficult to Provide Adequate Funding Within the Current Funding Structure	1
Peer-to-Peer Supports Should be Available Across the Board Regardless of Funding Source	1
Mental Health Staff Pay	**5**
Mental Health Staff Poorly Paid/Should Be Paid More Appropriately	5
Availability of Services/Access to Care	**73**
Access to Care Difficult for Non-Medicaid or Private Pay	19
Need More Access Points	12
If you are Eligible there is an Array of Services that are High Quality and Work Well	10
Takes Too Long to get into Services/To Get Access to the System	9
Schools Serve as Central Locations for Services	3
Lack of Programs Geared for Children, Youth and Families	3
Better Access to Psychiatrists Needed	3
Medicaid Limits Availability and Quality of Service	3
Private Pay Services are Not Available - Must Have Medicaid	2
Private Services are More Accessible if you Can Pay for Them	2
Lack of Education About how to get Medicaid	2
Need Immediate Access for Infants as soon as Problem is Identified	1

Should Not be Such a Gap Between Child and Adult Services	1
No Profound Delays in Accessing Services	1
Dependable Safety Net of Primary Care, Hospital Care, other Services to Catch People at Many Levels	1
Most seriously needy Children are Receiving Services	1
Continuity of Care/Integration	**60**
Integration and Collaboration	**52**
Counties Not Working Together - Could Use A Central Agency	16
Not Enough Partnering Between Mental Health and Schools	9
Lack of Encouragement for Service Provider Partnerships	7
Consideration for Co-Occurring Disorders	3
Better Continuity Between All Mental Health Services	3
Good Collaboration Between Agencies	3
Better Integration of Mental Health and Courts	2
Between Mental Health Agencies and Schools	2
Access to Care Standard Are Too Reactive	2
In-House Treatment Providers Instead of Contracting Out	2
Duplicative Efforts Between Multiple Bureaucratic Agencies	1
Two Tiered System (crisis intervention followed by a more developed system after crisis)	1
MIS System to Allow Streamlining of Transfers and Referrals	1
Mental Health and Primary Care	**8**
Integration and Communication Between Primary Care and Mental Health	6
Train Primary Care Physicians/First Responders about Mental Health	4
RN's Need Training in Childhood Issues	2
Need Medical Coverage that Does Not Include a Spend Down	2
Behavioral Health Consultants in Primary Care	2
Education for Identification of Mental Health Disorders by Primary Care Physicians	1
Hard for Primary Care Physicians to Bill for Mental Health	1
Training and Education	**50**
Public Education Around Mental Health Issues/Destigmatization	15
Mental Health Professionals Need Better Training in Children's Issues	11
Teachers Not Well Equipped to Deal with Behavior Problems	10

Parent Education	4
Parenting Classes	3
Counselors Not Trained Well in Family Models and Don't do their Background Work	2
Crisis Intervention Training for Police Officers	2
Need More Social Skills Training Programs	2
DSHS should Train Mental Health Professionals in Children's Issues	1
Foster Care	**39**
Other Issues Related to Foster Care	**22**
Foster Kids - Decrease Discontinuity Between Placements	2
Mental Health Needs for Foster Kids Not Adequately Being Met	2
Child Can Get Services With Coupons but Parents Don't Qualify and Can't Get Help	2
Too Much Cost Associated with Litigation and Remedial Programs - Early Intervention Would Curb This	1
Respite Care Allows Work With Whole family Not Just the child	1
Increased Accountability for Foster Parents	1
Amazing Parents in the Foster Care System	1
Adults Fighting Over the Children is Detrimental	1
Parents Need to Be Advocates of Their Children	1
Moved From Home to Home	1
Changes Without Warning	1
Find Out More About the Child	1
Child Needs to be More in Control of Their Life and Situation/Take Away All Their Power	1
Need More Follow-Up in the Home	1
Do a Good Job With Reunification and Permanency Planning	1
Lack of Team Building for Multisystem Children	1
Mandated to Provide Mental Health Services But No Supports to Do So	1
Better Supports to Keep Kids in Foster Homes and Out of Hospitals/Jail	1
Screening of Homes and Parents in Foster Care	1
Access	**11**
Need More Foster Homes	4
Children in Foster Care Have Access to Trained Child Mental Health Providers	2
Too Long for Foster Care Services to Activate	2

Excellent Access for Services for Children in Foster Care	1
Access for Those in Foster Care is Very Difficult	1
Foster Care Infants and Toddlers have Access to Trained Infant Mental Health Service Providers	1
Training	**6**
Inadequate Training for Foster Parents	4
Not Enough Practitioners Trained in the Unique Needs of Foster Kids	1
Foster Care Classes in High School Curriculum	1
Family Support	**32**
Need More Services Available to Support Family Members of Mentally Ill Child	16
More Respite Services (current system requires a child to be in crisis before services and supports are activated)	6
Family Should Be the Consumer Not Just the Child	5
Greater Awareness of Community Services for Families	2
Early Childhood Programs Integrate Family Support/Education	2
Network of Family Advocates is Strong	1
Administrative Concerns	**24**
Too Much Administrative Burden on clinicians and Paperwork for Clients	10
Limited Time/High Case Loads for Psychiatrists, Counselors, and School Counselors	6
High Staff Turnover Rates	6
Need to Decentralize	2
Transitions	**21**
Transitions OUT OF Services	**12**
Difficulty With Transitions Out of Mental Health Placements - More Work Preparing Family for Re-Integration	4
Parents Need to Be More Aware of Treatment - Better Partnership with Treatment Providers	3
Have Done a Good Job Creating Family-Friendly Partnerships and Liaisons with Programs and Agencies	2
Youth Should Not "Age Out" of System if Still Dependent on Parents After Age 18	1
Full Integration of Children with Mental Illness Into the Community	1
Better Funding and Support for Transitional Services	1
Transitions INTO Services	**5**
Difficulty With Process of Getting Kids Hospitalized - Not Timely and Sometimes Discharged Early	3
Parents Should Not Have to Give Up Kids to DSHS to Get Services	2

Transitions BETWEEN Services	**4**
Services for Kids Between EBD Classrooms and General Ed Are Needed	2
Different WAC Reporting Requirements Create Problems for Blending Programs	1
Need for Short-Term Eval, Triage, Stabilization Services Between Outpatient and Inpatient	1
Early Intervention	**18**
Early Intervention Approach and Focus of Programs	12
System Now is "Crisis-Driven"	6

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CHILDREN, YOUTH AND FAMILIES SUBCOMMITTEE

Selected Representative Quotes

Availability of Services

The thing that I think would be available with the transformed system would be the accessibility to all, including parents, for wraparound services for their kids, real wraparound services. You know, we talked about kind of wraparound services, but nobody wants to tell anybody anything.
--*March 1st CYF transcript*

Types of services/service characteristics

I work with a dear friend who has shared with me his experience when his daughter was in high school a few years back and she suddenly disappeared. He had no idea where she was. It took him eight days. And he thought he had a fairly happy home life and so forth. It took him eight days to find out that she had been secreted away to the Cocoon House, and she ended up back home again. He still doesn't know if she had an abortion or whatever, but she ended up back home again. Somebody believed her when she said that she got mad at dad and apparently said that, "I'm homeless." And somebody took her off to a counselor and the counselor took her off to the Cocoon House and for eight days he didn't have any idea where his daughter was. And she did ultimately come back home, but what a travesty.
--*March 1st CYF transcript*

Accessibility, Funding, Types of services/service characteristics

There are not enough providers in our area that accept medical coupons. The services that are provided by our case managers are not always therapy, which a lot of the clients need. If there's limited resources for the youth it seems that the amount of time that they're given for the services as well is cut. There is no longer a multicultural program for youth in our community, which needs to be addressed. There's not enough ethically diverse staff in the area, not enough housing for youth for transitioning into adults, and the criteria that them lose their housing if they're accessing the housing with mental health reasons and then they lose the housing because of this reason without providing another housing opportunity puts them into the street where they become more endangered, and, also, youth are not receiving enough mental health assistance in the juvenile criminal system as well.
--*March 1st CYF transcript*

Funding

If you don't have private pay insurance, if you don't have transportation, you are unable to access any mental health services in Darrington. You don't have any options about whether or not you get along with your therapist or whoever you see if you don't have private pay insurance.
--*March 1st CYF transcript*

Family support/Effectiveness
Also, kind of early intervention would be better awareness for the community so when the kids are born with these issues, they're not blaming one another and trying to, you know, ignore and avoid the issue so negative habits start to really grow and become a way they deal with things.
--*March 1st CYF transcript*

Family support
More Respite for the parents who are dealing with the mental health service -- I mean, with a kid who has mental health issues so that they don't just lose it one night with their kid because they don't know what to do.
--*March 1st CYF transcript*

Transitions
My daughter spent a week in the hospital to get stabilized and medicated. When she came out of the hospital, Fairfax Hospital with their services there could not even set me up with a child psychiatrist and counselor up here in Snohomish County, absolutely unbelievable. With money, with education, with two very determined and loving parents who would do anything for their child, like most of us would, and are capable, we could not find care for my daughter. They sent me off with a psychiatrist's name who didn't even treat children.
--*March 1st CYF transcript*

Availability of services/Training
There is terrible access up here in the city of Everett for children's mental health issues and because of that, it extends to the schools. We educated our school counselor on what bipolar disorder even was and our principal and the people in the schools who are supposed to be helping with mental health services. They were lovely people. We are so fortunate. The school district is a wonderful place to be, but they were so uninformed it was unbelievable, even to the point when my daughter just simply needing a place to sleep -- pretty much every day about 1:00 o'clock she could no longer stay awake from the high anxiety, from the medications, whatever, our school could not even accommodate her needing to take a nap.
--*March 1st CYF transcript*

Transitions
There's nothing transitional between an EBD class and a resource special ed room, and it's very difficult for children when they're leaving an EBD class and going into the general population again because the best that we can do for them is to send them to the resource room for extra support and to modify their assignments like crazy….. So, one of the things that I think would be fabulous, if you can find a way to do it, would be to give these EBD kids some kind of in-between point as they're leaving EBD and going into the general population.
--*March 1st CYF transcript*

Family Support
The other thing that I would really like to see is something that I can sum up in three words, Respite, Respite, Respite. I can afford a babysitter, but I can't find one who wants to work with a psychotic child. We have no family here. That means we don't go anywhere. Parents of kids with special needs are desperate for Respite, and there's very little out there for them.

--March 1st CYF transcript

Funding/Availability of services

So, what money could be saved to help public funding was if we had effective community-based treatment centers. There was not an entity for us to put Brennan in; and what he needed and what he had, in effect, was a day treatment program. That doesn't exist. [woman whose husband shot and killed Brennan [grandson] and himself in front of the police station]
--March 1st CYF transcript

Outcomes

We want outcomes identified in real world terms. We want Johnny to be able to go to the playground, go down the slide – instead of some physical therapist terms -- or, you know, being able to sit supine, you know, and that sort of thing. So, we're really moving our system toward becoming the family friendly, real life, real every day activities or learning experiences.
--March 1st CYF transcript

Family Support

More support groups of all kinds both for families and friends and suffers of mental illnesses themselves need to be established. This takes a realization on the part of the public that it takes volunteers to make support groups as well as mental health professionals themselves that are volunteering pro bono or are supported by funding of some sort to help make these groups effective. We cannot do it ourselves. We would like to, but we can't.
--March 1st CYF transcript

Types of services/service characteristics

And I think that as we think in terms of transforming the system, we really need to think in terms of implementing evidence-based practices by using a concept that comes right out of the system of character of being very grounded in families and families' perceptions of things and culture and the individual -- the individual communities within our state that have a very, very different perception sometimes about how they want their kids treated and how they want to be dealt with within the system. So I think that's a piece that's not yet perfected, and we've got a lot of work to do on that.
--February 6th CYF transcript

Transitions

So one thing that I think is not working is that there's a lot of trainings being offered to foster families. Oftentimes -- my daughter is at CSTC, and the big thing she says isn't working is the transition. She has also been at Martin Center, which is a Bellingham inpatient psychiatric care that is long term. And her need was that when she left Marten Center, she was immediately home and had to do the transition. And the whole healing of children is a family healing. Not that we did something wrong, not to blame, but the whole family has to learn a different lifestyle of living or else everything that our kids go and get from these inpatient places is foreign to us when they return home.
--February 6th CYF transcript

Transitions

Another thing is when they get treatment and you aren't able to communicate with the therapist because of privacy, being able to have family professional partnerships that allow parents to know the treatment plans since we live with them the other six days of the week, to build that partnership is going to help these children, and that's not happening.
--*February 6th CYF transcript*

Family Support

And speaking of that, the other outcome I'd like to see is some support for siblings. I cannot tell you the hell my son, who's now 15, has gone through because of his sister's mental illness. I took him to NAMI because -- just for his own healing and so that he can understand more. And that was good. But there's no support system for him out there. There aren't adolescent groups that I can take him to and he can hear from other siblings of mentally ill kids or even behavior disordered kids. I mean, it's all of the siblings of these kids. And there are probably more siblings than there are the child consumers. And they're all suffering. And we're going see just like with kids of alcoholic parents, those kids are going to still have the effects when they're grown ups. And so we're talking about lifelong problems for these kids because their needs are being neglected.
--*February 6th CYF transcript*

Funding

This is why it's very important to me where the rubber meets the road that the money does need to follow the kids because it just doesn't happen.
--*February 6th CYF transcript*

Foster Care

The other thing is a different way for us to approach the serving of foster kids. The foster care system is not part of the mental health system, but we in the mental health system serve many, many foster kids, and there's a great difficultly in doing that for a number of different reasons. Sometimes it can be that the mental health provider is really seen primarily as a tool to be used by the DSHS case manager, and once we've provided our function, then we are thrown away.
--*February 6th CYF transcript*

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

YOUTH IN TRANSITION SUBCOMMITTEE
April 3, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Youth in Transition Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Youth in Transition Subcommittee were included in this analysis.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

9. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
10. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
11. What would a "transformed" mental health system look like?
12. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

Questions about this report can be directed to:
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To increase ease of use and interpretation, a single analysis of all statements was conducted. The information presented here combines responses to all four questions into a single summary of all testimony received. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a number of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
YOUTH IN TRANSITION SUBCOMMITTEE

Data sources:

10. Transcript of subcommittee hearing #1: Feb. 22nd, 2006 (Burien, WA)
11. Transcript of subcommittee hearing #2: February 27th, 2006 (Vancouver, WA)
12. Transcript of subcommittee hearing #3: March 9th, 2006 (Spokane, WA)
13. Feedback submitted from RSNs statewide
14. Additional written documents from individuals, agencies, and organizations statewide

Total Statements coded = 112

Summary of findings

Public testimony relevant to the Youth in Transition Subcommittee consisted of 112 unique statements coded from individuals who gave testimony at public hearings, as well as additional documents submitted by individuals, agencies, and organizations. These 112 statements were sorted into 11 main categories or themes. The category into which the most statements (24 statements) were coded was commentary about the quality of services and standards for services provided, followed by a second category (16 statements) related to the availability of services and service capacity. Public education and availability of information (13 statements), access to care and related age of consent issues (12 statements), description of services that are promising or working well (11 statements), and financing issues (10 statements) also were major themes. Other themes included housing, collaboration with schools, need for services to be specific to 18-21 year olds, and screening and assessment issues. These themes are summarized below.

What were the major themes?

- Emerging adults have their own unique needs, and the current system does not seem adequate for those who are no longer children but qualitatively different from middle-age adults; they feel "suspended" between systems. For example, where do 21-24 year-olds go for acute crisis care or acute eating disorder treatment?
- Mental health must be addressed in order for youth to successfully transition to adulthood.
- The shift in financial and social supports makes transitioning adults particularly vulnerable to "falling through the cracks."
- There is a need for continuity and collaboration between agencies/services and comprehensive, multi-disciplinary approaches to treatment.
- The system does not adequately identify, treat and provide ongoing supports for those with co-occurring disorders.
- Families and youth feel confused by system and need education and advocacy in order to maximize quality of care.
- Standards of access to care seem overly stringent; need flexibility in options for those who are less "severe."

What is working well?

- Community-based youth support programs (Youth House, Connections, Clubhouses)
- Parent support/education programs (YES, Pebbles in Pond)
- Holistic, comprehensive services in housing communities (e.g., New Futures, Wonderwood)
- Vocational support/training programs (e.g., Worksource, Ticket to Work, Project Dream)
- Grass-roots volunteer groups
- Wraparound programs

What is not working well?

State support is not consistent

- Need for consistency across state in provision and quality control of services and screening (e.g., inconsistent availability of wraparound, inpatient beds, screening).

There are many financial barriers, including stable housing

- Transitioning youth, especially vulnerable youth, need stable housing.
- Transitioning youth face significant obstacles and discontinuity in benefits: eg, SSI re-determination age, Medicaid cut-off, loss of parents' insurance coverage.

Need for psychoeducation and to reduce stigma

- Need for education around benefits, service options, mental disorders.
- The public needs more education about mental health issues, toward a reduction in stigma against these individuals.

Service Capacity

- Need for increased inpatient beds
- Need for increased triage services from crisis/acute care and/or involvement in juvenile system
- Need for increased services for those with co-morbid disorders

Service Quality is inconsistent and must be addressed

- Need for comprehensive, multi-disciplinary wraparound services
- Need for continuous quality control
- Need for family-centered, individualized care, and the financial supports to allow families to be part of care (e.g., travel money).
- Systematize standards of access to care statewide

Need additional support for vulnerable youth in foster system, juvenile court system

- Need for transitional services, vocational supports, housing
- Need for early entry-screening across state

Point of entry barriers

- Families see age of consent as barrier rather than protection for youth
- Families feel frustrated in getting children involuntarily committed
- Families feel like they have not options if youth are not "severe."

A full summary of all themes and statements within each theme is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Youth in Transition Subcommittee (N=112 statements total).

Themes	Number of statements
Standards/quality of care	**24**
Family-centered/individualized care	6
Coordinated System of care / Wraparound	5
Cross-system collaboration	4
Continuity in care after age 18	3
Integrate evidence-based treatment into standards	2
Need Medicaid to support travel for long-distance care	1
Need for more outreach	1
More direct service could be provided if RSN system were replaced (lose money to inefficiency/bureaucracy)	1
Need for continuous quality improvement	1
Service Capacity	**16**
Services needed	**9**
Need more services outside King County	4
More short-term, crisis, stabilization services	3
Need more inpatient beds	1
Services that treat crhonic physical and mental health problems	1
Transitional services (e.g., from crisis care, acute care) or for vulnerable populations	**7**
More transitional/triage services out of mental health and education system	5
Need transitional services for youth in foster care and juvenile system	2
Need for more Psychoeducation and help navigating the system	**13**
Stigma/Public education	6
Need for Internet resources, state-on line forum/information warehouse	4
Need benefits counselors to help navigate benefits system, determination, application process	1
Lack of education for 'dual eligibles' (i.e., Medicaid/SSDI) and ability to choose drug plans	1
Medicare Part D Confusing and cumbersome	1
Access to care standards and age of consent barriers	**12**
age of consent at 13 seen as barrier	4
Continuity in services for foster youth "aging out" and youth in juvenile justice system	3
access to care standards too stringent	2
make autism Medicaid reimbursed	2

Themes	Number of statements
age of consent misinterpreted	1
Some Programs and Efforts are Working Well	**11**
Parent Support	**3**
YES Parent Support program working well	1
Pebbles in Pond Parent Group	1
Local support groups	1
Vocational Training/Support Programs	**3**
Project Dream vocational training	1
Vocational Programs (e.g., Worksource, Ticket to Work, Career Path Services)	1
SEAR (Spokane)	1
Youth Support Programs (Options, Connections, Youth Source)	**4**
Clubhouses	2
Programs for Transitioning youth (e.g., Mockingbird, Treehouse, Common Voice)	1
Safe Laws, Youth in Action	1
Comprehensive, holistic community-based projects are beneficial (Daybreak, New Futures)	**1**
Financial Barriers	**10**
Increase flexible spending, money for wraparound and cross-service use	2
Medicaid coverage for psychotropic medications limited	1
Medicaid benefits for mental health visits vs. pharmaceuticals sometimes inconsistent	1
Medicaid Cutoff at age 18	1
SSI Redetermination Age: need other supports in place if youth lose SSI at age 18	1
DDD cutoff for foster youth at age 18	1
SSI difficult to obtain and maintain after 18 due to bureaucracy	1
Increased funding for co-occurring disorders	1
Medicaid food coupons insufficient	1
Housing supports	**6**
Transitional housing limited (esp in rural communities	4
Employer financial supports for housing needed	1
Housing stability important	1
Screening and Treatment for Co-morbid SU/MH disorders limited	**6**
Need for more treatment services for this population	2
Need for early identification co-morbid disorders	2
Lack of transitional services for CD youth in transition (age 18)	1
No consistent screening for co-morbidity in juvenile justice system across state	1

Themes	Number of statements
Collaboration with Schools/School supports	**5**
Schools need to increase vocatinal training for SED students	1
Improved IEP	1
Enhanced youth say in IEP	1
More school-agency collaborations	1
Youth want more input on IEP plans	1
Screening	**5**
No screening in diversion across state	1
Need screening in the educational system	1
after age 18, no screening in MH courts	1
Mental health/drug courts limited to King County	1
Inconsistent screening in juvenile courts	1
Services need to be specific to 18-21 year-olds	**4**
many adult services/facilities not appropriate for young adults	2
Transportation, flexible scheduling for young adults who are working and going to school	1
no appropriate facilities for young adults with co-morbid disorders (treatment facilities ignore unique needs of this population)	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
YOUTH IN TRANSITION SUBCOMMITTEE

Selected Representative Quotes

Youth ill-prepared to assume demands of adulthood at age 18
"So you're a young person who's been told they have no future from age 7. They have IEP's. They have the label. They're going through school. They've been told there's something radically wrong with you, so we're going to put you over here in the radically wrong room and – you transition into the adult System of Care where they're expected to make all of their own choices. ..So what doesn't work is when you take young people who never had a opportunity to speak for themselves, who've never known they could speak for themselves and tell them they can speak for themselves. My son needed to have the dignity of his own process."

"When kids in the system turn 18 and enter the adult system, they have no reason to have hope and to have the skills to be able to navigate the system. And they don't have their mom to advocate on their behalf any more."

"So I've seen it firsthand what happens when someone's going to transition from the alcohol and drug, COD, program that we have at Native Projects when they transition into the adult system. There is no absolute welcome. If they don't have Medicaid, they may as well forget about getting their medications. There's supposed to be this magical cutoff date when someone turns 18 that all of a sudden they're adults and they should know how to do this, and I believe that we abandon them. We force them into the streets, and we say, "Go to Spokane Mental Health," here. I'm sure it's somewhere else there, but well meaning, you know, put these 18-year-olds in with people who are 50, 60 years old, maybe have been in the mental health system forrever. So you're looking at putting them into a system where they're all treated the same. In actuality, they're late adolescents and need to be treated as such.

Parent support
"Parents are exhausted and what doesn't work—is that we do not have resources for parents because exhaustion is not a criteria for access, so we don't have resources for families to help them process what's happening in their family. And we don't have help for families to help them understand how much of this is part of normal adolescent transition into young adulthood and how of this is disability."

Stigma
"What we need is to be able to get families the help they need without having to label themselves and their children as mentally ill. If we could provide support for families…outside the mental health system, maybe they wouldn't worry about the stigma."

Unmet Need
Director of Janus Youth Programs. "We have 3 shelters here in Washington, and what I'd like to say is that when I started 10 ears ago, the type of kids we were seeing were a whole lot different than what we're seeing today. The kids we're seeing today have a lot of mental health issues,

some have a lot of dual diagnosis, we have a lot of suicidal kids, a lot of BRS type kids. And although the type of kids have changes, the services and funding to provide these kids with what they need has not."

We provide crisis shelter, and we want to work with these kids, but we need help from services in the community to be able to provide trackers or somebody who can come and speak to these kids in person, not on the phone. They need to see somebody face-to-face."

Inconsistent services by funding and geographic location
"That brings up that -- you know, it's actually, if you're a very impaired kid, it's better to be on Medicaid than private insurance. There should be some way to partner with the private insurance to fill in the gaps for those kids, as well as the non Medicaid population. So we're lucky we have the IST in King County, but that only serves x-number of kids. There's wait lists."

Mental Health/Physical Health co-morbidity
"And the other thing, it's just a broad concept that I keep thinking about, is that we really need to think about mental health more in the context of physical health. You know, we've still got that big division between mental health, physical health, and there isn't that division. The brain is part of the body. And I feel like sometimes these kids don't get a thorough physical evaluation. That's all I have to say."

Need for continuity in state-financial supports
I just had one comment. My kids get to stay on my private insurance until they're 22. Why can't we let kids on a medical coupon be considered a kid until they're 21 so they can get access to Medicaid in that 18 to 21 years old. That's when we see them really fall off.

Family-centered care not financed by Medicaid
The other thing that hasn't really been brought up that is of concern to me is when you have a child in CYT over in treatment, which is, of course, over there on the other side, and when you're over here, or you're in Republic, Washington or Kettle Falls, and you're supposed to be having visitation, and you're on coupons and on Medicaid, how can you afford to be traveling back and forth be seeing your child, to be integrated in your child's care and treatment?

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

OLDER ADULT CONSUMERS SUBCOMMITTEE
April 4, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Older Adult Consumers Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Older Adults Subcommittee were included in this analysis.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

13. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
14. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
15. What would a "transformed" mental health system look like?
16. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

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To increase ease of use and interpretation, a single analysis of all statements was conducted. However, this report also includes a Table with responses broken out by all four questions. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony for each of the 4 Mental Health Transformation questions, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
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Acknowledgments

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WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
OLDER ADULTS SUBCOMMITTEE

Data sources:

15. Transcript of subcommittee hearing #1: February 16th, 2006 (Seattle)
16. Transcript of subcommittee hearing #2: March 2nd, 2006 (Spokane)
17. Relevant statements from Adult Consumers Subcommittee and Children, Youth, and Families Subcommittee meetings
18. RSN responses to the 4 Transformation Questions that specifically address this Subcommittee's population
19. Additional written submissions from individuals, agencies, and organizations statewide

Total Statements coded = 286

Summary of findings

Public testimony relevant to the Older Adults Subcommittee consisted of 286 unique statements coded from 30 individuals who gave testimony at public hearings (or written submissions) as well as additional documents submitted from individuals, RSNs, and other agencies and organizations. Fifty-one statements were coded from responses to the question "What is working well," 95 statements were coded from responses to the question "What is not working well," 119 statements were related to the question about what a transformed system will look like, and 21 comments were coded regarding proposed outcomes of a transformed mental health system.

A brief summary of the results across the four questions is provided below:

- A main point of testimony was found to be that **Older Adults Do Not Seek Treatment** and they also often **Refuse Treatment** when it is offered or even mandated. Outreach and case finding practices were thus mentioned as being useful and needed. The reduction of mental health stigma is related to this issue and is seen as an area of emphasis for a transformed system.

- **Residential Services and Adult Family Homes** were noted as working well and also as something that needs to be added since there are inadequate resources in these areas.

- **Access to Care** is seen as being discriminatory to older adults. Some common reasons: treatment and practices and intake and outreach procedures are not specific to older populations and do not take into account their unique needs.

- **Under-Funding** of services for this (and other) populations was noted consistently in testimony.

- **Lack of Flexibility** of funding and funding options was also noted as being a barrier to receiving quality treatment. **Non-Medicaid Funding** options are very scarce. Those without Medicaid are often excluded or alienated from treatment.

- **Lack of Integration** between services and programs: An increase of integration would be helpful. The most common issues: utilizing multiple services without communication of any sort between the two, as well as a lack of involvement with the medical community, in which many mentally ill older adults are involved.

- **Treatment Providers** are viewed as not being competent to serve the needs of older adults and not having enough training about this population. Understaffing across the board was also noted.

- One suggestion for a transformed system that arose often was the need for **In-Home Adult Care and Treatment**. **Transportation** needs are also tied to this issue. Older adults often do not have transportation to get to services and supports. Providers that would be able to go to their homes for appointment would make access easier, increase the level of comfort for the patient, and would eliminate the need for transportation services to get these people to their treatment providers.

- **Staff Wages** are viewed as being unfairly low. This causes **turnover** which upsets older adults who are served by new care professionals all the time. Another issue related to turnover is case loads. **Case Loads** are too high to provide adequate services to the clients and are adding to the turnover rate since staff are overworked.

- A transformed system would also include **Well-Trained Staff** in the area of geriatrics. Staff and treatment professionals are currently seen as not being educated about this population.

- **Other issues**: too many older adults having to go to emergency room for treatment, which is not good MH treatment and is very costly; older adults are too often incarcerated instead of going to MH professionals; older adults are feeling very ignored in the MH system, despite the high number of mentally ill older adults.

A full summary of all themes and statements for each of the four questions is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Older Adults Subcommittee (N=286 statements total).

Themes	N Statements
What is working well?	**51**
Mental Health Services	**41**
Type of Programs or Services	**19**
Residential Services/ Adult Family Homes	7
Case Finding Practices	4
Older Adult ECS Programs	3
Clubhouses (work because they are peer-to-peer)	2
Integrated Services	2
Elderly Support Groups	1
Mental Health Services (Specific Examples)	**13**
Avondale House	3
Midway Residential Program	2
Gatekeeper Program	2
Hope Options	1
Senior INA	1
Adult Day Health	1
Care Cars	1
COPES	1
Assistant Dogs of Puget Sound	1
Treatment Practices	**9**
Evidence-Based Treatments	2
Diversion practices away from state hospitals	2
Wraparound Approach	2
Prevention-Based Approaches	1
In-Home Treatments	1
Community MH Services	1

Themes	N Statements
Funding	**7**
Community Services Grant	2
Treatment Options for Non-Medicaid Eligible	1
AAA Long-Term Care - Senior Citizens Service Act	1
Section 8 Vouchers	1
Treatment Expansion Dollars	1
Combined Sources of Funding	1
Education/Training Programs	**3**
Geriatric Mental Health Certificate	2
Case Workers with broad knowledge and ability to integrate services	1

Themes	N Statements
What is NOT working well?	**95**
WMH System Problems (general)	**40**
Limitations to Care For Older Adults	**28**
Access to care is Discriminatory against older populations	8
Older Adults don't seek/refuse treatment	8
Medicare Discriminates against mental health needs	3
Medicaid too limiting in what it will cover	3
Consumers don't know what is available or where to go to find out	2
Not enough services/programs specific to older adults	2
Too many unrealistic and conflicting laws	1
RSN's discriminate against the elderly	1
General System Problems	**12**
Paperwork is Unmanageable (for consumers and providers alike)	4
It takes too long to get in after referral/appointment	3
Service Delivery is Inconsistent	2
Too many ER visits - no other options for immediate treatment	2

Themes	N Statements
Too many mentally ill older adults going into criminal justice system	1
Funding	**25**
Mental Health system Under-funded Across the Board	8
Lack of flexibility of funds	5
None for non-Medicaid eligible	4
Medications too expensive	3
Staff Wages are Unlivable, unfair	2
Too many Insurance Issues around mental health services	1
No Integration of funding sources	1
Lose Funding b/c Clients end up In Medical Hospitals	1
Not enough funding for Gatekeeping programs	1
Treatment Providers	**17**
Programs Chronically Understaffed	4
Providers are Under-trained in Older Adult mental health	4
High Employee Turnover Causes Distress to Clients	3
Case Loads Too High	3
Not enough Psychiatrists	2
Providers young and not seen as relatable	1
Treatment Practices	**12**
Lack of Integration	**6**
Not enough integration with Medical Care	3
Lack of integration between programs and providers of different agencies	3
Practices (General)	**6**
Privatization doesn't work	2
ECT Treatments	1
Adults in Nursing Homes don't receive adequate treatment for Mental illness	1
Reduction of treatment hours with clients recently	1
Lack of community resources for older adults	1

Themes	N Statements

Themes	N Statements
What does a *transformed* system look like?	**119**
Services Needed	**27**
More Adult home health care options	8
Housing Options	5
Transportation Resources for elderly	4
Add Programs that Fill gaps	2
Specialty Crisis Services	2
Day programs	2
Soft Interventions	1
Rural Services Increased	1
MH treatment at long-term care facilities	1
SA assessments in elderly group homes and own homes	1
Client-Related	**21**
Access to Care	**11**
Easier access to care	7
A place to get information about available programs	3
Medications easier to get and to use	1
General	**10**
Recognition of dementia as a mental illness covered by insurance/Medicaid	3
Increased Safety for Clients in treatment facilities/trying to get to treatment	3
Family feels empowered and not victimized by the system	2
Involuntary treatment centers available	1
Consumers more active in decision-making	1
Training	**17**
Provide Adequate Training for Staff (general)	7

Themes	N Statements
Provide training about Geriatric Populations Specifically	8
Patient and Family Rights	2
Funding/ Use of Funds	**16**
Staff Wages Increased	4
Support for Clubhouses	3
Funding Options For Non-Medicaid	2
MH staff at senior centers/nursing homes regularly	2
Increase funds for community mental health	1
PACT Funds	1
Flexible Sources of Funding	1
Combined Sources of Funding	1
Supplement cost of medications	1
Treatment Focus	**12**
Evidence-based treatment	3
Age-based	3
Prevention Based/Focused	3
Assertive Community Treatment	1
Cultural Awareness	1
Individualized/Tailored Treatment	1
Additional Services	**10**
Reduction of stigma	6
Recruitment of Older adults/Outreach	4
Treatment Services/Professionals	**9**
Things to aid treatment providers	**6**
Reasonable Case Loads	2
State Computerization Effort - get providers on same system	1
Social service network email directory	1
Greater Support from the State Government	1
Increased Safety for Workers/Staff	1
General	**3**

Themes	N Statements
Consumer peer counselors	1
Use medical social workers	1
More Caregivers trained in mental health	1
Integration of Services/Agencies in general	**7**

Themes	N Statements
Outcomes of a *transformed* system	**21**
Client-Related	**14**
Reduction of Hospitalizations for mental health issues alone	4
Reduction of Incarcerations	3
Less older adults at state hospitals	2
Increase independent living rates	2
Increased Client Satisfaction	1
Older Adults get mental health treatments	1
Increase in Client Skills	1
Treatment Provider Factors	**5**
Reduced Number of Case Loads for Providers	4
Reduced Turnover Rate of MH Staff	1
Treatment Services and Delivery	**2**
Quality Services	1
Decreased intake times/paperwork	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
OLDER ADULTS SUBCOMMITTEE

Selected Representative Quotes

Exemplary Quotes

Limitations to Access to Care

"Crisis services for Older Adults do not meet the needs of older adults—they are unresponsive"

Treatment Providers Under-trained in Older Adult

"Older Adults under-use MH services due to MH services not being geared to the different needs of older adults who are have mental health challenges, e.g.: grief and depression can express themselves differently in older adults."

Access to Care is Discriminatory against Older Populations

"Many issues that older adults experience as mental health needs are not funded through mental health dollars. For example: Grief, Dementia, or personality disorders are not adequately addressed by MH services and they can't get services for these disorders."

Limitations to Access to Care – Access is Discriminatory against Older Populations

"Older Adult Mental Health problems don't look the same to the community and are not necessarily funded by MH—therefore older adults may quietly de-compensate in the community until they've reached a crisis point - then the MH system acts."

Limitations to Access to Care – Access is Discriminatory against Older Populations

"Many ways that older adults manifest mental health problems do not meet the MHD's Access to Care standards, and therefore Aging money often funds the gaps by providing services that actually prevent crises before they reach that standard that would allow MH to serve them."

Transformed System – Services Needed – More Adult Home Health Care Options

"Older Adults would receive mental health services in appropriate settings (that is settings that serve the older adults where they live or can very easily reach)"

Limitations to Access to Care – Medicare Too Limiting

"Restrictions/limits to Medicare coverage for mental health. Medicare provides no long-term mental health coverage. Only short-term crisis services and only by RN's."

Funding/Access to Care/Treatment Options for Older Adults/MH System discriminates Older Adults

"Inadequate funding, access barriers, and limited treatment options are among the many issues preventing the mental health system from meeting the needs of older adults."

Stigma/Older Adults Don't Seek Treatment

"Myths held by older adults, the general population, and service providers that being depressed is a normal part of aging. Many seniors resign themselves to feeling miserable without realizing that help is available. Family members and others that interact with seniors may believe that being old is depressing. Service providers in both mental health and aging may also hold some of these beliefs to varying degrees."

Transportation Needed/In-Home treatments needed/Consumer-Driven Treatment Focus

"Too few mental health services are designed to be brought into the homes of older adults. The stigma surrounding mental health problems can prevent seniors from visiting community mental health centers. Health problems, mobility limitations, and lack of transportation can make it extremely difficult for some seniors to leave their homes. In survey after survey, seniors have expressed a strong preference for remaining in their homes and aging in place. The mental health system needs to respond to this consumer preference as well as its obligation to provide services to homebound seniors."

Lack of Collaboration/Integration of Services/Lack of Communication between Providers

"Mental health providers seemingly operate in an insular fashion, and often do not operate collaboratively with other entities, even when there are shared clients. The barriers are so significant that outside agencies, such as our T XIX Case Management Programs, have had to circumvent these barriers and find alternative methods outside the system to get our clientele's mental health issues treated, such as contracting with a Private Psychiatric ARNP using our own agency funds. Primary physicians are the primary prescribers of psychiatric medications, and admittedly are not experts in this field."

Transportation Needed/In-Home Treatments Needed

"Also, most of our mental health providers DO NOT provide in-home services, which are a major barrier for our home bound disabled and elderly clientele whom have difficulty getting to and from services. This is further complicated by the older generation having difficulty accepting mental health services, even if they have a form of medical transportation that takes them to a facility if is known to provide mental health services."

Access of Care/MH System Discriminates Older Adults

"Who else is not getting services? You know, it's interesting in this system that in Medicare, if you are an older adult and had a callous on your foot and you could go to a podiatrist; but if you lost your significant other of 60 years or just moved out of a house and you had these intense grief issues, you can't get services because it's not a diagnosis. If you have a general depression and someone makes the mistake and calls it depression NOS, you don't get in. So, we -- we -- if you are non-ambulatory, you require someone to come out and see you, you don't get in. If you're physically ill, the chances of getting to be seen by a mental health professional is rare. If you are incontinent, you don't get -- you seldom will get the opportunity to be seen by a mental health professional in a facility and God help you if you need a residential facility or an ENT who – right now in our state, if you become mentally ill and you're an older adult and you're incontinent, you won't even get into an evaluation treatment center because they will proudly announce that they're not equipped to handle that. So, where will they go? And that's also including substance abuse, too, by the way."

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

HOMELESSNESS SUBCOMMITTEE
April 3, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Homelessness Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Homelessness Subcommittee were included in this analysis.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

17. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
18. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
19. What would a "transformed" mental health system look like?
20. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

Questions about this report can be directed to:
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To increase ease of use and interpretation, a single analysis of all statements was conducted. The information presented here combines responses to all four questions into a single summary of all testimony received. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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Maria Monroe-DeVita, Behavioral Tech Research, Inc.

Sabina Low Sadberry, Ph.D., University of Washington Evans School of Public Affairs

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
HOMELESSNESS SUBCOMMITTEE

Data sources:

20. Transcript of subcommittee hearing #1: February 14th, 2006 (Seattle)
21. Transcript of subcommittee hearing #2: February 17th, 2006 (Everett)
22. Transcript of subcommittee meeting #3: March 10th, 2006 (Yakima)
23. Relevant statements from Co-occurring Disorders Subcommittee and Children, Youth, and Families Subcommittee meetings
24. Feedback submitted from RSNs statewide
25. Additional written submissions from individuals, agencies, and organizations statewide

Total Statements coded = 187

Summary of findings

Public testimony relevant to the Homelessness Subcommittee consisted of 187 unique statements coded from 76 individuals who gave testimony at public hearings (or written submissions) as well as additional documents submitted from individuals, agencies, and organizations. These 187 statements were sorted into 9 main categories or themes. The category into which the most statements (71) were coded was commentary about existing services or service types, including services that are working well, services that are needed, and issues about cultural competence in service delivery. Continuity and levels of care (24 statements), financing issues (24 statements), consumer empowerment (18), and access to services (15) were also major themes. Additional categories included employment, education and training, and collaboration between systems. Finally, there were seven statements that discussed desired outcomes for homeless individuals with mental health problems. A summary of these results is presented below.

Services that were recommended, other than general use of evidence-based practices, were peer-based services, drop in day centers, community services (as opposed to meeting in an office), and street outreach programs. There should be greater funding available for all of these services, as well as funds for training consumers to participate in peer-based services. More broadly advocated for was an overall **continuity of services** between systems, specifically the criminal justice system. Participants often felt that individuals who were released from jail and/or state hospitals were left with no financial or employment resources, which perpetuates the cycle of homelessness. Participants also voiced a need for the mental health system to be more closely linked with housing and employment resources.

Housing and employment services were specifically focused on, with specific attention paid to the lack of affordable housing, strict time limits which impeded any real progress, and additional services for specialized populations (i.e., youth, Native Americans, families, veterans). Additional feedback was given regarding a lack of housing with no clinical strings attached; a homeless person must already be doing "well" in order to receive services. **Ongoing support** was specifically mentioned, as participants felt as though they were being terminated from services before they were able to function on their own.

Education for police officers and the general public about issues of homelessness, the prevalence of mental illness, and de-stigmatizing information was brought up consistently. People with mental illness, specifically homeless people, need to be treated with dignity and respect. Several people also spoke to the lack of information that they have about services and medications; there needs to be better communication between the service providers and the population that they are seeking to assist.

Respondents reported that the system in general seems to be set up for people to fail. **Lack of funding** for programs, elite requirements for participating, inappropriate expectations being placed on those accessing services, and many hoops to jump through for ineffective services are just several of the issues that deter homeless individuals from accessing the available services. One participant pointed out that homeless individuals with mental illness are often considered too "high risk" to be in a group home or transitional housing; the recommendation was that these resources be more prepared to handle mental health issues, as there is a high prevalence in the homeless community.

Overall there should be no wrong door for **accessing services**. Financial support should be provided not only to programs, but also to the individuals accessing those programs. One idea was that the money should follow the individual, rather than being given to the program. This would assist people in starting out with resources and continuing with ongoing support as they begin to rebuild their lives. There is a great need for housing, both shelters and transitional, as most organizations that provide shelter are currently overwhelmed and under-funded. This is also true for **professionals** in the field, who should invested in by organizations (i.e., paid a better wage, given reasons to stay at an organization) so that the faces of providers do not continue to change so quickly, which has a negative effect on those accessing services.

A full summary of all themes and statements within each theme is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Homelessness Subcommittee (N=187 statements total).

Themes	N Statements
Types of Services	**71**
Recommendations for effective models	**40**
More shelters and subsidized housing with a shorter wait list	10
Street outreach, such as that provided by the PATH program	7
Halfway houses with access to medication and housing case managers	5
Shelters and subsidized housing should have better capacity to deal with mentally ill individuals	4
Safe Havens day treatment center, which provides basic services	3
The Clubhouse system provides a place to learn skills, find community and services	2
Pay more attention to evidence-based practices	2
Service providers need to focus on long-term aspects of treatment	2
Clinicians should work in the community instead of in their offices	2
Everyone should have access to an advocate to help them navigate the system	2
Assertive Community Treatment (ACT)	1
Services that are needed	**26**
Resources in rural areas	9
More housing for homeless men	4
Permanent housing for disabled homeless	3
Services for homeless youth	3
Healthcare programs that integrate mental, substance use, and physical health services	2
Services for families	2
Drop in day services	2
Homelessness prevention services to help consumers stay housed	1
Culturally specific services	**5**
The RSN system should be altered to encompass and specifically represent Native Americans	2
Not enough services for Native Americans	2
The system should address mental health and housing needs of Native Americans	1
Consumer empowerment	**18**
Consumer run programs, like SHARE, are very helpful and should be continued	6
Provide services that give homeless people a purpose and a goal	5
Commit to involving consumers at all levels of decision making, including policy	3
Some housing exists that does not have clinical strings attached	2
Homeless folks should be able to build their own homes and participate in the process	1
The MH system has been focusing on empowering developmentally disabled people	1
Continuity and levels of care	**24**
Need more crisis intervention and "in the moment" services	7
Need better continuity of care	5
Better communication of services to the target population	3

Living facilities need to match the type of person they are housing	3
Provide ongoing support	2
People placed in facilities with inappropriate level of care	1
Lower standards on how people can qualify for services	1
Providers able to assess and treat people at whatever level they are at	1
Respite care should be increased	1
Access to services	**15**
Problems	**15**
Services are often pulled away from people when they're doing well	4
Clients pushed off onto other professionals because social workers not paid well enough to go the extra mile	2
Caseloads are too high for professionals to be effective	2
Outreach workers blame the individual rather than the system	1
Provide assistance to the person, rather than the program; money follows the person	1
Lots of hoops to jump through for ineffective services or services that take too long	1
Fragmented system creates barriers for the most vulnerable	1
The MH system places inappropriate expectations on people who utilize the benefits.	1
People end up on the street because they are too "high risk" for group homes/housing.	1
Solutions	**1**
Track outcomes of people who leave services	1
Education	**10**
Educate police officers on mental health issues	5
More effort to educate the public and end discrimination against homeless people	4
Lack of information about medications	1
Financing issues	**24**
For individuals	**9**
Without Medicaid there are no available services	4
Need access to affordable medication	2
Money provided by the state is not enough to live on	1
Insurance does not cover all mental illness equally	1
Difficult to access Medicaid services	1
For providers	**1**
Pay service providers well so that they will stay in their jobs	1
For programs	**14**
Sufficient funding for all regions to provide adequate services	10
People should not be kicked out of subsidized housing b/c they run out of money	1
Increased funding for hospital alternative services	1
Funds would be available to train consumers in peer support services	1
Money for new housing developments	1
Interaction between systems	**8**
Mental health system should be better integrated with housing and employment services	4
The Dept of Corrections and Western State Hospital turn people out with no resources	2
Better mental health services should be provided in local and state jails	1
Felony convictions prevent consumers from accessing housing and employment	1

Employment	**10**
Create more job opportunities for homeless people that are accessible and appropriate	9
More help for veterans - allow them to go back to work and give back to their community	1
Desired mental health outcomes	**7**
Continuity of care	**5**
Homeless people with co-occurring disorders are often pushed from system to system	3
No wrong door for accessing services	2
Long-term changes	**2**
Everyone should have health insurance	1
Homeless folks would be treated with dignity and respect	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
HOMELESSNESS SUBCOMMITTEE

Selected Representative Quotes

Types of services: Recommendations for effective models
(2/17/06 Meeting – Homelessness)
"My point with that being is that one of the – you know, some of these very, very mentally ill people, they're going to have to go to, you know, into the emergency room. Like you're saying, they're going to have to be, you know, hospitalized and locked up and diagnosed and medicated and cost a lot of money to the system. Whereas if we could have – if we could intervene – perhaps, one idea that I think would be a good one . . . would be halfway houses, if there were places where people who have mental illness could go and be safe and live in a group situation and have caretakers there but not – you know, not ordering them around."

Consumer empowerment
(2/17/06 Meeting – Homelessness)
"I just turned 20 last month. I've been doing these meetings for about almost ten years now. Alright? So before I was in middle school, I had to come to these things. Alright? I have not heard one new single thing out of anybody here. I've been hearing these things since, you know, before middle school . . . We don't need new programs. We need to have the consumers teach all the legal people the way we want it to be done, the way it needs to be done, because obviously, it's not working."

Types of services: Services that are needed
(3/10/06 Meeting – Homelessness)
"I tried mental health [treatment], but I had no affordable housing. That's what you've got to do; is get them off the streets in housing first. The problem that I see arising with [outreach workers] is that they have nowhere to put anybody."

Employment
(3/10/06 Meeting – Homelessness)
"[I]t's really tough to go out there and find a job when the last job that you have on an application is nine years ago. And the employer asks you, 'Hey, man, what have you been doing for the last nine years?', 'Oh, living under a tarp down by the river.' It doesn't go over very good, you know, unless you're applying for a survival instructor position or something like that."

Access to services: Problems
(3/10/06 Meeting – Homelessness)
"But, you know, there's problems because a person that's homeless is made to feel like they don't matter at all, like they're not even a human being . . . then the only thing I've got left, the only response I've got left is anger to that. Because I don't have any of the regular means that a person might have to be able to go and try and solve this problem with this state agency. Here's this powerful friggin' agency that's supposed to be there to help us, and is walking all over me,

and here's me, a homeless guy, and I can't afford a lawyer and stuff, if I could find one who would take the case.

Types of services: Services that are needed
(3/10/06 Meeting – Homelessness)
"I think we all, as social workers, I think sometimes we just get lost. We get lost in the pain and suffering you see, you get lost in the bureaucracy, you get lost in the frustration. But if the community can do anything, I think it's simply that supported housing continue, housing for people who have no money."

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

CO-OCCURRING DISORDERS SUBCOMMITTEE
April 3, 2006

Introduction

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Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

21. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
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The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony for each of the 4 Mental Health Transformation questions, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

Suzanne E. Kerns, PhD ABD, Eric J. Bruns, Ph.D., Phoebe Mulligan, and Justin D. Smith, University of Washington Division of Public Behavioral Health and Justice Policy

Maria Monroe-DeVita, Behavioral Tech Research, Inc.

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WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CO-OCCURRING DISORDERS SUBCOMMITTEE

Data sources:

26. Transcript of subcommittee hearing #1: February 10th, 2006 (Lakewood)
27. Transcript of subcommittee hearing #2: February 17th, 2006 (Vancouver)
28. Transcript of subcommittee meeting #3: March 9th, 2006 (Seattle)
29. Transcript of subcommittee meeting #4: March 16th, 2006 (Moses Lake)
30. Relevant statements from Adult Consumers Subcommittee and Children, Youth, and Families Subcommittee meetings
31. RSN responses to the 4 Transformation Questions that specifically address this sub-committee's population
32. Additional written submissions from individuals, agencies, and organizations statewide

Total Statements coded = 453

Summary of findings

Public testimony relevant to the Co-Occurring Disorders Subcommittee consisted of 453 unique statements coded from 40 individuals who gave testimony at public hearings (or written submissions) as well as additional documents submitted from individuals, RSNs, and other agencies and organizations. Seventy-five statements were coded from responses to the question "What is working well," 135 statements were coded from responses to the question "What is not working well," 196 statements were related to the question about what a transformed system will look like, and 47 comments were coded regarding proposed outcomes of a transformed mental health system.

A brief summary of the results across the four questions is provided below:

- The issue of **Collaboration and Integration of services** appeared often across respondents. When services collaborate and integrate, they work well. On the other hand, there is not enough cooperation between treatment services and treatment providers, which has been a source of strife for many consumers. This theme was further mentioned as an element of a transformed system. Collaboration seems central to this population since they are being treated for multiple afflictions often by multiple sources. Also, having facilities that served COD clients would help to increase continuity of care.

- **Funding** is also an important issue for this group. Medicaid, although working very well for those that qualify and receive coupons, seems to be inflexible, difficult to qualify for, as well as not equal in quality of services provided. A recommendation for a transformed system would include funding options other than Medicaid that are also easy to access. A second factor of funding is flexibility. Funding that allows for treatment of MH and of SA works very well when available, but most funding sources are not flexible in

this way. Funding was listed as a barrier for many consumer respondents and would like to see funding not limit care availability or quality of care. The cost of medications, compartmentalized funding, and siloing of funds were also mentioned as barriers to effective treatment.

- **COD Specific Treatment** is seen as unavailable, particularly to those on government funding. Outpatient COD treatment was further stressed as being difficult to access, if it even exists. This point reflects the comments made about lacking integration of services and also about the inflexible funding issues that do not allow for these types of programs.

- **Treatment Service Access** is a major problem for this population. Testimonies about seeking COD treatment overwhelmingly illustrated a "ping-pong" effect. For example, the consumer seeks treatment for MH and SA issues and is continually referred back and forth between programs that deal with only one issue. The client is often denied treatment by both providers because of the co-morbid issue. This illustration is also true of co-occurring medical and developmental issues as well. This is a further reflection of the lack of integration of services.

- Issues around **Treatment Professionals** were: a shortage of professionals trained in the COD field in general, and more specifically, a shortage of psychiatrists.

- Two service needs that were stressed were stable **housing and employment programs**.

- Access to care, flexible funding options, and integration of services would be indicators of a transformed system. Reduction of stigma, reduction of homeless mentally ill, as well as evidence-based outcome studies in general were mentioned as outcomes of a transformed system.

A full summary of all themes and statements for each of the four questions is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Co-Occurring Disorders Subcommittee (N=453 statements total).

Themes	N Statements
What IS working well?	**75**
Mental Health System (General)	**64**
Integration/Collaboration/Partnerships btw Programs	7
Access to care is increasing	2
Awareness of changing needs/adaptive	1
Accountability within the system	1
System as whole getting better at COD	1
Mental Health Services (Specific Examples)	**26**
Clubhouses (work because they are peer-to-peer)	6
Rose House	4
PACT	3
COMET	2
WA Medicaid Integrated Project in Snohomish County	1
Pathways	1
Lifeline Connections	1
NAMI	1
PALS at WSH	1
Seattle MH's deaf program - Gordon House	1
Adoptions Support Programs	1
CODI	1
Ridgefield Living	1
Mental Health Courts	1
Integrated Crisis Center	1
Treatment Practice Approach/Focus	**18**
Evidence-Based Treatments	3
Outreach	3
Recovery-Focused	2
Early COD Assessment	2
Wraparound approach	2
Employment-Focused	1
Family involvement	1
Grassroots efforts	1
Holistic Approach to COD	1
Best Practices Emphasis	1
Cultural Awareness	1
Treatment Professionals	**8**
Dedicated Professionals	4
Cross-trained staff	2
CDP's in Assessment Centers	1
Low Employees Turnover Rates	1

Funding	**8**
From Legislation	3
Funds that are Flexible	1
Medicaid Funding for Axis	1
Non-medicaid Funded Programs/Services	1
Excellent pay and benefits for employees at WSH	1
System works If you have Coupons	1
Training/Education Programs about COD	**3**

What is NOT working well?	**135**
Treatment Practices	**94**
Treatment Providers	**25**
Shortage of professionals in COD field	**8**
Not enough Psychiatrists	7
System of who gets employed - too rigid of requirements	3
Not educated about COD	2
Not enough time with patient/family	2
Lack of Quality Assurance	1
Assessment but no recommendation for care	1
Don't Assess both COD conditions	1
Programs	**21**
Lack of integration and cooperation between services/programs	**11**
Lack of Services for specific clients/disorders	5
Length of stay too short	2
Not enough peer-to-peer (approach) programs	1
Treatment services for incarcerated	1
Can't get involuntary treatment if needed	1
Consumers	**18**
Access to Services/Care	**12**
Takes too long to get treatment after initial attempt	4
Lack of options	2
Hospitals (State, VA, general)	**9**
Don't have competent treatment	4
Not enough psychiatric beds	3
People stuck there - lack of alternatives	2
Medications	**4**
Overmedication w/o monitoring of side effects	3
Medications prescribed w/o checking records	1
Other things that are not working well	**4**
Receiving treatment barriers (general)	5
Lack of COD outpatient treatment	5

Unmanageable Paperwork	3
No uniform COD treatment philosophy	2
Continuity of Care	2
Funding	**35**
Consumer	**20**
Compartmentalized Funding (MH and SA separate)	12
Not enough Funding for Medications	4
Lack of resources keep people out who need services	3
No Funding for Evidence-based practices	1
System	**14**
Lack of flexible funds	8
Treatment by Medicare/Medicaid	6
Services/Programs/Treatment	**1**
Too much financial decision-making	1
Education/ Training	**6**
System is not educated about its components	2
Consumers don't know the services/no one to tell them	2
Clinician training in MH and SA issues	1
Justice System gets MH and COD training	1

What will a *transformed* system look like?	**196**
Treatment Practices	**78**
Additional Programs	**31**
Housing	11
Employment Programs	6
Improved Diversion	4
Post-treatment programs	4
Residential Treatment Centers	3
Transportation	2
Inpatient Facilities	1
Services	**29**
Regional access to MH services	5
Facilities for COD specifically	4
Wraparound approach	4
Improve Retention Practices	3
Add Recovery Programs	2
Continuity of Care	2
Benefits of Hospitalization	2
Individualized/Tailored Care	2
Hospitalization length too long	1

Peer to peer treatment	1
Expansion of Treatment	1
Needs Assessment for COD	1
Options other than medications	1
Consumers	**14**
Customer has access to COD services	8
Consumer involvement in delivery of services	4
access to appropriate medications	2
Treatment Professionals	**4**
Employ trained, certified	1
Difficult to get registered counselor status	1
smaller case loads	1
Contact with Psychiatrists	1
New State MH Model Components	**73**
Must be Adaptive/Creative/Flexible	5
Reduction of Stigma	5
Streamlined and Simple Access and Procedures	4
Aim for availability of services throughout state	3
Consumer Advocacy	3
Recognize COD	3
Use a known model - don't need to create new one	2
Comprehensive treatment plan	2
Integration/ Cooperation	**29**
btw services and treatment staff	15
Involving Medical community	8
btw clients and their treatment staff	6
Treatment Focus	**17**
Outcomes Focused	6
Recovery Focused	3
Consumer-Driven	3
Prevention-Focused	2
Evidence-Based Treatments	2
Early Intervention Focus	1
Funding/ Use of Funds	**29**
Consumers	**17**
Individual accountability for client's own funding	6
Funding needs to not limit care availability	4
Funding not tied to Medicare/Medicaid	4
Support People instead of Program	3
Services	**10**
More Support for clubhouses	3
Evidence-based treatment	2
DVR needs funding	2

For long-term inpatient care	2
Support for psychosocial rehab models	1
Providers	**2**
Staff Training Funds	1
Increase Staff Salaries	1
Educational and Training Programs	**16**
Providers	**10**
Regarding treatment of certain populations	3
Information Sharing	3
Treatment Methods and Practices for COD	2
Research while treatment	2
Consumers	**6**
Educate Consumers and their families	3
Medications	2
mental health clients in DVR	1

Themes	Number of Statements
What are the OUTCOMES of a *transformed* system.	**47**
Consumers	**23**
decrease in homelessness	4
Increased Customer satisfaction	3
increase in workforce participation (clients)	3
easier access to services	3
decreased time spent in formal MH system	2
decrease in family dysfunction	2
decreased need for acute services	1
decrease in dependency on the MH system	1
increase in lifespan of client's	1
study of what happens to clients who lose services	1
measures of physical health	1
go to school?	1
Services	**17**
Diversion from Jails	3
Time delays in service delivery	3
Places to go after discharge from hospitals	2
medication side-effect monitoring	2
availability of medication	1
Access to hospitals when necessary	1
WSH downsized - serving fewer people	1
Entire Treatment Spectrum at one facility	1
Equality for COD clients	1

decrease in ER being primary access to care	1
having a larger network of services	1
Evidence-based outcome studies	**5**
System overall	**2**
flexible, adaptive responding system	1
cost-benefit analysis	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CO-OCCURRING DISORDERS SUBCOMMITTEE

Selected Representative Quotes

Rose House, Working Well – collaboration/Communication

"And we could have been a help, in that we could have -- if his case manager had called us back when we saw some problems happening, we might have been able to stop him from actually going out there and trying to medicate himself. So our biggest thing is that circle of support that surrounding all of our different colleagues at Rose House actually coming together and being a team rather than separate entities."

Transformed System – State MH Model - Recognize COD's

"If you do not approach a chemical dependency and the psychiatric disorder as a concurrent treatment modality, you will lose that patient."

Need More Collaboration/Communication; Need Education regarding COD

"Doctors prescribing mental health medications without accessing mental health evaluations/ history from clients. Thus the client who is co-occurring ends up with multiple medications from multiple doctors. This in turn costs more money from the tax payers to take care of medical and/or addiction problems exacerbated by the medication mismanagement."

Not working – Lack of Flexibility; Access to Care

"When they do show up to DSHS, often they have a hard time finding the appropriate place. Often they'll show up to say, oh, it looks behavioral so go to mental health division. Mental health division will often say, well, you've got a brain injury so, you know, it's not a mental health disorder, go talk to -- as a -- and they'll tell you this happened before you were 18, maybe it's a mental health disability, go talk to DDD."

Not working – Access to Care; No Treatment for Specific Disorders

"It's just not working. It's just not working for folks with brain injuries and unfortunately for folks with brain injuries, the no wrong door whole policy is missing some punctuation. It's no, wrong door, and that's really unfortunate."

Lack of Options for those without Medicaid or Private Insurances; Access to Care Barriers

"The other way we're serving them is for families that have to give up custody to the state in order to access residential care. My husband and I had to do that. We had to take -- we tried to work with the system. It didn't work. They wouldn't tell us the truth about the services that were available and I finally went down and when I took my 16 year old son to DSHS and I told that little 13 year old woman that was at the door, cute little blond thing, and I said I am not taking him home, and it nearly killed my husband and I to do that."

Lack of Integration/Collaboration; Education needed for Consumers seeking services

"And I was given the impression that all of this was support was working together and people were talking to each other and his probation officer had some idea of who he was

supposed to talk to, and actually, I was the only one that was talking to anybody, as I found out three weeks later. There was no connection."

Lack of Options; Access to Care

"That's pretty much what's wrong with the system, is that there's no coordination. In King County, it's especially frustrating what the lady just said about when I tried to get my son into the community mental health system, as soon as I brought up the fact that he's got chemical dependency programs, he cannot see a counselor until he gets into a drug treatment program. You know, we sort of don't do that. Our private health insurance helped out there more than anything in terms of that, but it wasn't until after he was released from inpatient treatment that he was able to access mental health services at Community Clinic."

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

CRIMINAL JUSTICE SUBCOMMITTEE
April 3, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Criminal Justice Subcommittee of the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements presented during the public testimony periods of Subcommittee meetings, as well as additional information received by the state MHT team determined by the research team to be relevant to this Subcommittee. These additional pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

The analysis presented here also includes information received from other sources during the course of the MHT planning process, such as Regional Support Network (RSN) reports of priorities and transcripts from statewide MHT "Listening Sessions." Finally, statements provided in other Subcommittees' public hearings that were determined to be relevant to the Criminal Justice Subcommittee were included in this analysis.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

25. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
26. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
27. What would a "transformed" mental health system look like?
28. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of transcripts from Subcommittee meetings (created by a legal transcription service), reports from RSNs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

Questions about this report can be directed to:
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To increase ease of use and interpretation, a single analysis of all statements was conducted. The information presented here combines responses to all four questions into a single summary of all testimony received. The purpose of the report is to provide Subcommittee members and others working on the MHT project a record of all the public feedback received that is relevant to this Subcommittee, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

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WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CRIMINAL JUSTICE SUBCOMMITTEE

Data sources:

33. Transcript of subcommittee hearing #1: February 7th, 2006 (Kent)
34. Transcript of subcommittee hearing #2: March 13th, 2006 (Yakima)
35. Relevant statements from Co-occurring Disorders and Children, Youth, and Families Subcommittee meetings
36. Feedback submitted from RSNs statewide
37. Additional written submissions from individuals, agencies, and organizations statewide

Total Statements coded = 179

Summary of findings

Public testimony relevant to the Criminal Justice Subcommittee consisted of 179 unique statements coded from 38 individuals who gave testimony at public hearings (or written submissions) as well as additional documents submitted from individuals, agencies, and organizations. These 179 statements were sorted into 10 main categories or themes. The two categories into which the most statements were coded was access to services (42 statements), including barriers to care and possible solutions; and commentary about existing services or service types (40 statements), including services that are working well for this population, services that are needed, and issues about cultural competence in service delivery. Input was also received about outcomes that should occur for this population and outcomes that should be tracked (28 statements). Testimony was also received about transitions (16 statements) and the cyclical nature of the criminal justice system and treatment within it (15 statements). Additional categories included financing issues, employment, education and training, and collaboration between systems. A summary of these results is presented below.

Services that were recommended included services that were evidence-based, peer support services, family focused services, and the continuation and development of Mental Health and Drug courts. For youth specifically, **prevention** programs were recommended. **Continuity between services** provided in the jail and ongoing and transition care is essential in helping individuals succeed out in the community. Support for family members and family preservation services was emphasized, as many people who are incarcerated lose contact with their children. Culturally specific services, such as bilingual/bicultural programs, were also recommended given the disproportionate confinement of people of color. Programs that work with dually diagnosed offenders are essential, as that is a group that has difficulty accessing services.

With specific regard to the **legal system**, it was indicated that the process of evaluating mentally ill people often kept them in jail longer than a guilty plea would have, which constitutes unfair treatment of mentally ill individuals. **Police officers** were also a large focus, with training on working with mentally ill offenders suggested, as well as training to work with juveniles more effectively. **Lawyers**, especially defense lawyers, should receive additional training in working with mentally ill defendants. **Service providers** of all types should be trained to recognize symptoms and make appropriate referrals. Additionally, participants suggested that there are

relatively few options for mentally ill individuals in **crisis** other than jail; this is unacceptable and services and supports should be expanded to meet the needs of a large population.

Education of police officers, those involved in the legal system, and the public in general regarding the actual risks posed by mentally ill offenders is necessary. This population needs greater access to **educational and employment opportunities**, which also speaks to the importance of assistance and discharge planning during the transition from jail or state hospitals to the community. **Housing** resources are necessary in order to facilitate this transition and provide offenders with the greatest chance of success. The nature of the mental health and criminal justice systems is very cyclical, as most offenders are only treated for their mental illness when they have reached a severe stage and committed a crime. All individuals should have access to mental health services early on, with competent assessment and evaluation procedures being in place within other systems (i.e., schools, community providers). Specifically, when children are assessed, the requirements for treatment are so high (with the new standard for eligible diagnoses) that most often they do not receive the necessary services.

Currently, there is no consistent set of measurable **outcomes** that is defined for evaluating the success of the criminal justice system. There were many proposals for how to evaluate systems, including **consumer satisfaction** surveys, a decline in the incarceration and **re-offending rates** of mentally ill youth and adults, reduction in suicide rates (both while incarcerated and in the community), and reduction or complete remission of symptoms. A specific concern in line with disproportionate confinement of people of color is that access to services would be equal across the board, regardless of race.

A full summary of all themes and statements within each theme is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony for the Criminal Justice Subcommittee (N=179 statements total).

Themes	N Statements
Types of Services	**40**
Recommendations for effective models	**22**
Drug and Mental Health courts	5
The Clubhouse system provides a place to learn skills, find community and services	4
Family Preservation Services	4
Use best practices or evidence-based models	4
Prevention programs for youth	3
Drug/Alcohol programs at Purdy Women's facility	1
Peer support teams	1
Services that are needed	**16**
Services (i.e., housing) for offenders, especially those who are dually diagnosed or are sex offenders	4
Services in rural areas, not spread evenly throughout the state	2
Support for family members	2
Improved mental health services in the jails	2
Community based services	2
There are not enough services for juveniles at any point in their system involvement	1
Special accommodations for clients with FAS/FAE	1
Crisis repsonse services	1
Adolescent psychiatric services	1
Culturally specific services	**2**
Bilingual/bicultural treatment providers	1
Treatment services would be strength-based and family-centered and would respect the patient's cultural heritage	1
Interaction with multiple systems	**5**
Common for first interaction with a system to be with the police	2
Lack of system integration	2
Prison is currently considered less restrictive than a psychiatric unit	1
Employment opportunities essential to recovery	**5**
Those who leave jail should be employed and moving toward their goals	3
Jobs are very difficult to find if someone has a felony record	2
Education	**9**
General public and professionals need to be educated on actual risks posed by mentally ill offenders	7
Need mandatory education for youth on neuroscience and stigmas	1

Increase educational access	1
Transitions	**15**
Gap between release from jail and community services	5
More housing/group homes for people transitioning out of jail or state hospitals	3
Better discharge planning	3
Each person would have an advocate to help them transition between systems	2
Healthy independence should be supported by the system	1
More people need to be in the recovery stage	1
Cyclical nature of the system	**16**
Address the cyclical nature of the MH and CJ systems by providing ongoing support	7
Need accessible and inexpensive screening to identify people who need services early on	4
The same people come through the system because they have to reach a serious stage to be noticed	2
Need an information management system so no one gets lost and progress can be measured	2
Agencies will begin referring clients back and forth	1
Financing issues	**11**
For individuals	**5**
Youth who are incarcerated for more than 30 days lose Medicaid benefits	2
Low-income people are most greatly affected by the funding cuts	1
Provide sliding scale fees for services	1
Kids without medical coupons have difficulty accessing services	1
For programs	**6**
Programs need more funding to provide sufficient services	2
Funding for mental health services is being directed toward the adult system, rather than the juvenile system	1
There is a constant ebb and flow of funding	1
Statewide RSN system where benefits do not change by region	1
Competition for funding between adult and juvenile systems	1
Access to services	**42**
Problems	**28**
The inability of providers to get timely evaluations of mentally ill offenders	12
Jails have become synonymous with "crisis intervention"	5
Police officers are often left with few options of where to take mentally ill people for services, especially after business hours	3
Individuals not receiving care in a timely manner	3
The diagnoses that qualify children for sufficient services are too limited and do not allow for early intervention	2
Insufficient staffing in jails and state hospitals may mean that mentally ill offenders receive a lower standard of treatment than non-mentally ill offenders	2

The traditional forms of services are not meeting the mental health needs of youth and their families	1
Solutions	**14**
Better continuity of care	6
Access to mental health care without having to go through the criminal justice system.	3
Focus on rehabilitation rather than punishment	2
Crisis intervention team made up of all necessary professionals	1
General services should be increased in order to have an effect on the criminal justice population	1
People who are in jail and are mentally ill would spend their time in the custody of a state hospital – rather than in jail – while they awaited trial and/or evaluation	1
Outcomes	**28**
Measurement of outcomes	**7**
Evaluations of systems should be conducted to determine consumer satisfaction	3
No current outcome that is defined and measurable	1
There is a measurable reduction in the level of stigmatization and irrational fear around mental illness as measured by objective surveys	1
Need to conduct an assessment to determine whether people can make their own decisions	1
Make sure the new process is sustainable	1
Statistical outcomes showing positive changes	**21**
Decline in incarceration and a reduction in re-offending rates of mentally ill youth and adults	14
Reduction in suicide rates	2
Lessen the disproportionate representation of minorities in the criminal justice system	1
Charges would be lower if the person was mentally ill	1
People would get out of prison sooner because they have received treatment	1
Provide people of color with the same opportunities to receive mental health services	1
Reduction or complete remission of symptoms	1
Training	**8**
Police officers would be trained to work with mentally ill offenders	5
More training for lawyers working with mentally ill offenders	1
Police officers specifically trained to work with juveniles	1
Service providers of all types are trained to recognize symptoms and appropriately refer clients to services	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
CRIMINAL JUSTICE SUBCOMMITTEE

Selected Representative Quotes

Education
(2/7/06 Meeting – Criminal Justice)
I think we need to have "a better understanding by the general public, advocates, consumers, and professionals of the actual risks posed by mentally ill offenders, which should hopefully ensure proper access to services based on facts rather than stigma."

Access to services: Solutions
(3/13/06 Meeting – Criminal Justice)
"[A transformed system] would be much more seamless. The whole corrections-based mental health would be a lot more seamless so that we could do a better job of possibly helping a kid before the adjudication takes place so that we don't ruin his or her criminal history forever."

Access to services: Problems
(3/13/06 Meeting – Criminal Justice)
"[Defense attorneys] don't want to advise their client to plead guilty, because perhaps they're not guilty under the law, or they can't communicate well enough with their attorney to be able to participate in their defense. Yet, if they sit in jail waiting for the evaluation to show that they're not guilty, they end up in jail longer than if they would have just plead guilty. So it's a very difficult situation that the defendants are in."

Access to services: Problems
(3/13/06 Meeting – Criminal Justice)
"A lot of the diagnoses that were brought down [based on the revisions to service access criteria] . . . like ADHD, Disruptive Behavior Disorder, Oppositional Defiance Disorder, Conduct Disorder. So if we have a child, or a teen, coming in with this screening who meets that criteria, but they're not at risk of being out in the street, they're not having to be hospitalized, they don't meet that criteria, they cannot be accessed for services."

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis

PUBLIC INPUT
April 6, 2006

Introduction

The current report represents an analysis of the content of public testimony related to the Washington State Mental Health Transformation (MHT) effort. The report provides a summary of statements received by the state MHT team. These pieces of information include public comments received via email, fax, web survey, or handwritten statements, and also relevant feedback submitted from entire agencies or organizations, some of which engaged in their own group processes before compiling and submitting their input.

Method

Across the many sources of data listed above, information received and analyzed typically were responses to a consistent set of 4 open-ended questions posed to individuals statewide:

29. Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of mental health consumers?
30. Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of mental health consumers?
31. What would a "transformed" mental health system look like?
32. What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Data were received from the state MHT team in the form of reports from agencies or programs, emails and web surveys forwarded from public constituents, and Adobe Acrobat "PDF" files of handwritten testimony. A team of PhD-level researchers then conducted qualitative analysis of these raw data using a technique described by Marshall & Rossman (1989). First, unique statements were isolated and summarized from all individual testimonials received. Next, categories were created and all statements sorted by these categories. Third, new categories were created for statements that did not fit the initial categories. Finally, small categories were sorted into primary categories.

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To increase ease of use and interpretation, a single analysis of all statements was conducted. However, this report also includes a Table with responses broken out by all four questions. The purpose of the report is to provide those working on the MHT project a record of all the public feedback received, organized in a way that allows for observation of the relative amount of testimony provided within each topic area, and discussion of priorities for action.

The current report

The current report consists of three main sections.

- The first section presents an **overview** of the analysis, including data sources and total number of unique statements coded. This section also includes a brief narrative summary of the findings.
- The second section presents the **results of qualitative analysis in detail**. This Table presents unique themes expressed in public testimony for each of the 4 Mental Health Transformation questions, organized by primary and secondary categories. For each unique theme, the number of statements that were found in the data related to that theme is presented. It is hoped that this Table will be a useful reference for the Subcommittee as it reviews the priorities presented by the public for action.
- The third section presents a selection of **direct statements and quotes** from the meeting transcripts and other information received, grouped by major themes.

Acknowledgments

Data analysis for the Mental Health Transformation Public Testimony Summary and Analysis Reports was conducted by:

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Maria Monroe-DeVita, Behavioral Tech Research, Inc.

Sabina Low Sadberry, Ph.D., University of Washington Evans School of Public Affairs

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
PUBLIC INPUT

Data sources:

38. Handwritten Statements in "PDF" format
39. Web Surveys
40. Faxes
41. Emails
42. Other forms submitted to the MHT team for analysis.

Total Statements coded = 2261

Summary of findings

Individual public testimony covering all populations in the mental health system consisted of 2261 unique statements coded from 248 individual sources of input. Raw data included submissions of testimony via hand-written submission, email, fax, as well as additional documents received from agencies and organizations that could not be present at specific Sub-committee meetings or other public hearings.

Three hundred and thirty-five statements were coded from responses to the question "What is working well," 751 statements were coded from responses to the question "What is not working well," 821 statements were related to the question about what a transformed system will look like, and 354 comments were coded regarding proposed outcomes of a transformed mental health system.

A brief summary of the results across the four questions is provided below:

- **Funding** in general was noted many times by consumers and providers. A general lack of funding exists in the mental health system. Providers do not have the funding to meet the needs of the consumers and many consumers in need do not qualify for Medicaid and do not have the ability to pay for services. Inflexibility is a key funding issue for consumers and providers. Consumers' treatment is often dictated by what funding they have rather than what treatment they need, while providers are forced to only provide treatment to those who qualify for that program's services and not based on the needs of the consumer. A transformed system would have more flexible funding options and the funding would follow the consumer not be restricted to the programs and services.

- **Medicaid funding** was a major topic of discussion. The system is works better for individuals who qualify for Medicaid, but the eligibility requirements for Medicaid are viewed as being too strict, which makes access for other consumers very difficult. Access to care for non-Medicaid eligible consumers is one of the major issues of the current system. One remedy suggested is to make access easier by having more flexible funding sources other than Medicaid.

- **Access to care** in general was noted as a barrier to care in the current system. Access for non-Medicaid and non-private pay, access to appropriate medications, access to a psychiatrist or other doctoral level therapist, and access to services in rural areas were the most mentioned. If a person does manage to qualify for services, receiving timely treatment was often difficult. The time from referral to assessment and then to treatment itself are often lengthy. For those who cannot access the system or those who do not receive timely treatment, the only option is often primary care physicians or the ER. This costs a lot of money and providers are not trained to handle mental health in these facilities, so need for treatment often is often supplanted with crisis de-escalation without follow-up or referral leading to a return to the ER. One major comment about access from is that there is never enough resources to meet the demands, thus, service providers are forced to turn away many people who are not in crisis. Consumers commented that crisis care was readily available but that follow-up often was not due to lack of resources.

- Providers and consumers alike mentioned that the system currently has too much **bureaucracy**, **unmanageable paperwork** requirements, and **too many regulations** that are constantly changing and often conflicting. Providers say that paperwork requirements cause them to spend less time with clients because of the time it takes to complete paperwork. Consumers also said that the paperwork at intake and when transferred to other programs was excessive. Consumers often opted out of services before they even began once they saw the amount of paperwork required to get in to the system. An MIS system for providers to share client information, a uniform policy and regulatory system, as well as less restriction on client privacy were all mentioned as ways to remedy this issue in the transformed system.

- **Integration and Collaboration** of services and between individual professionals was noted as not being done efficiently or often and was noted as a key component of a transformed system. Transfers and referrals were often not smooth, had immense paperwork demands on both the client and the provider, and often took very long to achieve while, in the mean time, the client was not receiving treatment. Integration in the transformed system would have much more integration between programs and services. Primary care and mental health would be in one facility, substance abuse treatment and mental health services would be combined, and different services, such as clubhouses and mental health programs would work together. There would also be increased communication between providers to streamline referrals and to aid in the treatment of clients being served in multiple settings for co-occurring afflictions.

- **Mental health in the education system** was mentioned often as a component needed in an integrated system. Ideally, educators would be trained to recognize mental health issues and would then have a network to refer these children for assessment and treatment if necessary. This prevention/early intervention approach was mentioned as a way to cut long-term costs in later mental health treatment if the problems could be identified and lessened early on.

- **Mental Health and the Justice System** was a common topic. Officers are often asked to make a judgment call about a mental health issue of a suspect often without proper knowledge of mental health and often without options for diversion even if they suspect mental illness. Once incarcerated, mentally ill offenders do not have much access to treatment. The offender either serves time or is released (often mentally ill offenders are released early because of their issue) and because there was no treatment or assessment, they return to the streets instead of a mental health program and more often than not, they become repeat offenders and the cycle continues. The education of diversion from prison and training on the part of the officers and the criminal justice system was noted as improving, but is still an area of concern that needs to change.

- **Services Needed.** Improvements and additional availability of specific services and program components were frequently cited. Housing was the most frequently mentioned. Day treatment centers and day programs, more clubhouses, drop-in centers, respite, employment services, and wraparound programs were also mentioned. Transportation for mentally ill consumers was seen as necessary so that they could get to appointments.

- **Treatment Focus.** The way to approach treatment and mental illness was a frequent focus of testimony. The order of frequency of nominations was as follows: Prevention-Focused, consumer-driven, family integration, recovery-focused, culturally aware services, early intervention approach, evidence-based treatments, strengths-based approach, and also a number of others that were less frequently mentioned.

- In regards to **Treatment Professionals**, there is an overall lack of quality providers especially psychologists, psychiatrists, and case managers. Reasons for these issues are the low pay for mental health staff, low job satisfaction, high case loads, and unmanageable "red tape" causing turnover that affects the overall quality of treatment.

- **Stigma** was mentioned often as a problem. Educational efforts directed at the community aimed at the reduction of stigma were mentioned as a needed component and was also considered a marker of a transformed system.

- **Regional Discrepancies** were mentioned many times. Consumers and providers in smaller, rural areas are experiencing a lack of options for treatment as well as the inequality of government funding to smaller areas that increases the lack of options. Consumers must travel great distances to get to treatment centers and then may have to go even further to get services that actually fit their need. Equality in all areas of the state would be an indicator of a transformed system.

- **Outcomes** The most often mentioned outcomes of a transformed system were: Fewer mental health issues encountered in the criminal justice system, fewer mental health in ER and in primary care facilities, reduced homelessness of mentally ill individuals, increased consumer satisfaction, easier access to care, higher employment rates for mentally ill, reduction of stigma, decreased recidivism, and reduction of crisis situations, as well as many others.

A full summary of all themes and statements for each of the four questions is presented in the Table on the following pages.

Table 1.
Results of qualitative analysis of public testimony included in the Additional Public Testimony report (N=2261 statements total).

Themes	N Statements
What is working well?	**335**
Mental Health Services	**152**
General Services/Program Types/Facilities	**110**
Clubhouses	21
Peer-to-Peer Programs	12
Immediate Crisis Services are Available When Needed	10
Community Mental Health Centers	9
Law Enforcement Can Easily Transfer Mental Health Issues to a MHP	6
Residences/Housing/Transitional Housing	6
Access to Care is Improving but Not Necessarily "Working Well"	6
Mental Health Services in Jails is Better	6
Vocational and Educational Programs	5
Triage Centers	5
Mental Health System and Services in General	5
Transitional Services after Leaving Jail	4
Private Mental Health Services are Great but Very Costly to the Consumer	4
Quality of Care Continues to Improve	3
Outreach in Smaller Communities	2
Vocational Services	2
Involuntary Treatment Act	2
Smooth Transitions to Hospitals When Beds are Available	1
Co-Located Mental Health and Primary Care Facilities	1
Mental Health Services/Programs Specific Examples	**57**
Mental Health Court	6
NAMI	6
Crisis Hotlines	5
Harvest House	5

Themes	N Statements
Ombudsmen Program	4
Rainbow House	4
Catholic Family Services	3
State Hospital Access to Services	3
FPS	3
Dr. Court	3
MIKA	2
PCAP	2
EPIC	2
YAR	2
Safety Centers	1
PACT	1
Ridgefield Living	1
Purdy Women's Correctional Facility	1
DMIO	1
Day Treatment at WSH	1
Emergency Preparedness and Mental Health	1
Treatment Practices	**99**
Treatment Professionals	**48**
Dedicated and Committed People	17
Well-Trained and Knowledgeable Providers	9
Flexible and Willing to Work with Clients	6
Access to Psychiatrists for Consultation	5
Mental Health Professionals Available in Emergency Room to Assist Physicians	5
Positive Attitudes and Collaboration with Other Agencies	4
Culturally Diverse Service Providers	2
General Practices	**16**
Consumer-Driven Treatment	6
DBT Really Does Work	3
Access to Medications (if you can get to a psychiatrist)	2

Themes	N Statements
Transitional Services to Keep People from Being Homeless	2
Immediate Access to Care for Children in Foster Care Network	2
Increased Time Spent with Direct Care Providers	1
Integration and Collaboration of Resources	**11**
Improving	11
Integrated Programs (not just mental health issues)	3
Treatment Focus/Emphasis	**6**
Recovery-Based Approach	3
WRAPAROUND Approach	3
Funding	**36**
If you have Medicaid or Private Pay, Services Working Well	17
State Funding has Increased	10
Capitated Funding is Stable Stream for Agencies	6
Efforts to Find New, Flexible Funding Streams	3
Nothing Is Working	**25**
Miscellaneous Comments	**12**
Ads About Mental Health in Newspapers	3
Depression Ads on TV	3
State has Begun to Show Support for Mental Health	2
Complaints Resolved at Lowest Possible Levels	1
Ombuds and Providers Work Well Together	1
Facilities at State Hospitals are Adequate (libraries, meals, activities)	2
Education/Training Programs	**11**
Substance Abuse Education in Justice System	4
Police Getting Better at Identifying Mental Health Issues	4
Consumer Networking	2
Consumers Need to Know How to Contact Ombuds with Concerns	1

Themes	N Statements

Themes	N Statements
What is NOT working well?	**751**
Treatment Practices and Delivery of Service	**285**
Programs and Services	**127**
Not Enough Child/Adolescent Specific Treatment Options	11
Poor Case Management	10
Lack of Hospital Beds	12
Only Manage on a Crisis Basis	8
Community Mental Health Centers Resources Don't Meet Needs	8
Not Enough Safe Places to House Patients During Crisis	8
Lack of Follow-Through Services	7
Lack of Early Intervention	7
Poor Medication Follow-Up and Tracking of Side-Effects	6
Services for Homeless Not Working	6
Too Much Use of Medications Solely	6
Lack of Counseling for Youth, Young Couples, Families	5
Lack of Prevention-Based Approach	5
Health and Wellness Based Programs Not Available	5
Cannot be Individualized/Tailored	4
Poor Retention Rates	4
Always Changing Because of Unpredictable Funding	3
Value-Based Instead of Scientifically-Based Treatments	3
Commitment Procedures and Practices Do Not Work	2
Treatment in State Hospitals Not Quality	2
Discharge Process Too Difficult and Takes Too Long	2
Not Enough Relapse Prevention for Offenders - Revolving Door	1
Not Enough Options for Long-Term Care	1
State Wants Outreach/In-Home Treatment but Doesn't Recognize Associated Costs	1

Themes	N Statements
Treatment Providers	**103**
Not Enough Clinicians (Psychiatrists and Psychologists)	24
Unmanageable Case Loads	20
Treatment Providers Not Trained Very Well	17
High Staff Turnover	15
Not Enough Case Workers	12
Burned Out Staff	10
Don't Treat the Consumers Well (like human beings)	4
Can't Bill for Services	1
Integration/Collaboration	**55**
Lack of Integration and Collaboration of Services and Programs	23
Not Enough Communication Between Providers	12
Poor Practices for Co-Occurring Conditions	12
Ping-Pong Effect to Clients	8
Mental Health System (general)	**247**
Barriers to Care	**165**
Access to Care Difficult	39
Takes Too Long to Get Services	29
Need To Address Rural Areas and Their Limitations/Lack of Facilities	25
Bureaucracy/Too Many Regulations - Conflicting and Constantly Changing	20
Unmanageable Paperwork Requirements	19
Too Many Mentally Ill Using Hospitals and Prisons for Treatment	12
Too Many Mentally Ill Having to get Treatment From Primary Care	9
Too Many Gaps – People Get No Services	8
Eligibility for VA Housing is too Strict/Unrealistic	3
SSL Applications are Discriminatory	1
General	**82**
Resources Do Not Meet Demand	23
Too Much Stigma	20
System Not Sensitive to Children - Based on Adult Mental Health Model	15

Themes	N Statements
Whole System Working Poorly	12
HIPAA	7
County System Doesn't Care About the Consumers	4
State Has Not Provided Clear Direction for the System's Development	1
Funding	**171**
Consumer Related	**85**
Lack of Services for Non-Medicaid and Non-Private Pay Clients	39
Access to Medications and Funding for Medications	18
Inflexibility of Use for Consumers	12
Treatment Access Because of Increased Diagnostic Criteria Strictness	8
Medicaid D Cuts Medications and Coverage	5
Private Mental Health Service is Inaccessible to Many Consumers	2
Insurance System for Longer-Term Care Situations	1
System (General or as a Whole)	**54**
Lack of Funding Across the Board	19
State Fails to Recognize Rural Areas/Funding Issues	13
Bureaucracy Costs Taking Funds from Treatment	11
Money-Driven System instead of Need-Driven	9
Inadequate Distribution	2
Program and Provider Related	**32**
Instability of Programs Due to Funding Being Unstable	15
Treatment Staff Not Paid Well	12
Funding Cuts to Outpatient Treatment Centers	5
Requirements Too Rigid to Tailor to Needs of Consumer	4
Consumer-Related Issues	**44**
Consumers Don't Know What is Available or How to Access It	10
Limited Access to a Psychiatrist	8
Not Enough Support for Family Members Trying to Help Mentally Ill	7
Consumers Don't Know Their Rights	5
Not Working Well With Minority Consumers	5

Themes	N Statements
Don't Have Enough Time with Therapists (non-MA level)	3
Children and Families Have the Hardest Time Getting Treatment	3
No Options Besides Behavioral Health Office	2
Some Consumers Don't Know How to Contact Ombuds	1

Themes	N Statements
What will a *transformed* system look like?	**821**
Treatment Services and Programs	**394**
Integration and Collaboration	**116**
More Integration and Collaboration of Services	44
Facilities for Co-Occurring Disorders - MH/SA and Primary Care in One Facility	30
Communication Between Professionals	17
Mental Health Community and Education System	13
Mental Health Treatment in the Justice System	12
Access To Care	**104**
Easier Access for All Consumers Seeking Care	31
Streamlined and Smooth Access to Care	27
Better Access for Non-Medicaid	19
Access for Everyone	15
Easier Access to Medications	12
Treatment Practices	**43**
Continuity of Care	18
Individualized and Tailored	11
Screening for Maternal Depression	4
Increased Flexibility/Adaptability	4
Stop Forcing Medications and Psychiatry on People	3
Ongoing Review and Case Management	2
All Agencies Have Access to SAHMSA Resources	1
Treatment Professionals	**55**
More Counselors/Case Workers	15

Themes	N Statements
More Psychiatrists	11
Lower Case Loads	9
MIS System for RSN's and Other Providers to Streamline Transitions	8
Need for Bilingual/Multicultural Counselors and Professionals	4
Professionals Trained to Treat Co-Occurring Disorders	4
Crisis Intervention Teams	2
In-Home Treatments	2
Bureaucracy and Regulations	**25**
Less Paperwork	14
Less Bureaucracy - Revise the WAC's	11
Additional Services Needed or Improved	**201**
Housing	29
Employment Services	16
Day Treatment Centers/Day Programs	14
More Clubhouses	12
More Mental Health Services in Jails	12
Drop-In Centers/Respite Centers	11
Transportation	10
Social and Recreational Activities for Consumers in Treatment Centers	10
Outreach and Engagement Efforts	10
Transitional Services in Place	8
Places to Go Other Than ER and Jail	7
Wraparound Services Needed	7
Hospitalizations (Beds) Available When Needed	6
Greater Array of Services/Choices	6
Foster Homes (Therapeutic)	6
Diversion Facility to Keep People With Mental Illness Out of Jails/Hospitals	6
Mental Health Awareness and Programs in the Educational System	5
Educational Services	4
In-Home Treatments	3

Themes	N Statements
Group Living Situations Not Individuals Alone	3
Veterans Homes and Other Services for Veterans Specifically	3
Catalog of Services With Criteria and Contacts	2
Crisis Lines Better	2
Emergency Mental Health Care Facilities Not the Hospital ER's	2
Community Outpatient Facilities	2
More Counseling Services	2
Parenting Education	1
Assisted Living	1
Follow-Up Services	1
Treatment Focus	**102**
Prevention-Focused	16
Consumer-Driven	13
Family Counseling Services/Family Integration	10
Recovery-Based	9
Cultural Awareness Emphasis	9
Early Intervention Approach	9
Evidence-Based Treatment	9
Strength-Based Approach	6
Age Awareness/No Neglecting of Younger or Older Populations	6
Client-Focused Approach	5
Community Treatment Approach	4
Peer-to-Peer Consumer-Driven Treatments	3
Holistic Approach to Treatment	2
Trauma-Centered Care	1
Funding/ Use of Funds	**76**
Non-Medicaid Funding	17
Increased Pay for Mental Health Staff	13
More Funding Across the Board	11
Flexible and Integrated Funding Options	11

Themes	N Statements
Money Follows the Client Not the Agency/Programs	6
Stable	5
Do Not Lose Funding in Jail	5
Medication Support	2
College Campus Mental Health Centers	1
More Informed Provider Network	1
Funding for Post-Partum Depression Extended	1
Go Beyond the Medicaid Minimum and Provide What is Actually Needed for Success	1
Funding for Immigrants to Get Mental Health Services	1
More Funding for Special Education Program In Schools	1
Training and Education	**65**
Consumer-Focused Education Efforts/Integrated Education into Existing Programs	13
Educate the Community (general public, schools, etc.)	11
Educate Police Officers About Mental Illness to Aid Diversion	11
Staff Trainings	11
Treatment Professionals in General	7
Social Skills Training for Consumers	5
Medications, How to Get Them, Side Effects (to the consumer)	3
Train the Families About Mental Health and How to Help	2
Mental Health Professionals About Chemical Dependency and Vice-Versa	1
Conferences About Holistic/Other Alternatives to Current Treatment	1
Entire MH System	**34**
Consistent Policies and Procedures (not different for each RSN)	11
Stability	8
Regional Services - Closer to Home, More Accessible	6
No RSN Network	5
Evaluations Before Crisis	2
State Would Actually Support Mental Health System	2

Themes	N Statements

Themes	N Statements
Outcomes of a *transformed* system	**354**
Outcome Measures	**354**
Consumer-Related	**255**
Fewer Mental Health Cases in Justice System/Less Jail Time for Mental Illness Issue	40
Fewer Mental Health Hospital Visits/Hospital stays	33
Reduced Homelessness	27
Consumer Satisfaction Increased	25
Increased Access to Care	22
Employment Rates Following Treatment	19
Reduction of Stigma	18
Decreased Recidivism	11
Greater Access to Medications and How to Pay for Them	9
Reduce Crisis Situations	7
Home and Social Stability After Release	6
Fewer Involuntary Commitments/Incarcerations for Mental Health Issues	6
Consumers Set Their Own Goals	5
Use the GAF as a Result Assessment	5
Reduction of Suicide Rates	5
Consumer Representation in Government	4
More Interaction with Psychiatrist	4
Returning to/Seeking Further Education After Treatment	3
Fewer People in Acute Care Situations	2
School Children are Less Disruptive and Attend School More Often	2
Better Educational Performance After Treatment (mainly children)	1
Decreased Deaths for Homeless Mental Illness	1
Services and Treatment	**68**
Timely Treatment	13
Higher Provider Job Satisfaction	9

Themes	N Statements
Housing	8
Well-Trained Workforce	8
Smaller Case Loads	7
Better Retention rate	6
At-Home Treatment Services	6
24 Hour Availability	3
Strength-Based	2
More Regular Mental Health Treatment	2
Better Assessments	1
Less Diagnosis Handed Out	1
Transitional Services and Supervision of Transitions	1
Need for Services is Met Not Higher Than Those Provided	1
Funding	**31**
Treatment for those non-Medicaid	9
Flexible funding	6
Adequate stable funding	6
If you qualify, you get quality, timely treatment	5
Reduced Administrative Overhead	3
Clients do not lose funding if they go to jail	1
Decreased Cost per Client/Cost per Service Hour	1

WASHINGTON STATE MENTAL HEALTH TRANSFORMATION GRANT
Public Testimony Summary and Analysis
ADDITIONAL PUBLIC INPUT

Selected Representative Quotes

System as a Whole Working Poorly

"As hinted in the president's commission report, there is something fundamentally wrong with a system that takes the most complicated medical conditions such as schizophrenia, borderline personality disorder, bipolar affective disorder, addictions, etc. out of the health system and puts them in state or local government bureaucracies with very limited budgets. It is hard to imagine a Division of Cancer Treatment in DSHS where patients diagnosed with cancer have to leave their medical centers and enroll in special cancer agencies in order to get their cancer care staffed by providers with less training and for drastically less money than they would have gotten if they had been diagnosed with heart disease and stayed in the medical system."

Access to Care – Quality of Care

"What is not working in our community is lack of access for people needing services, lack of services, lack of services that properly address mental illness. We have seen emphasis on behavioral changes for individuals, behavioral changes for family, behavioral changes for children without in some cases adequate diagnosis, treatment plan, case management, medication management. And what this translates to is less than adequate treatment of a significant biochemical imbalance of the brain."

Access for Non-Medicaid Qualifiers

"Access to services and treatment for those without Medicaid is very difficult and not equal – some RSN (KingCo in particular) has virtually no capacity to provide outpatient health services if the person does not have Medicaid."

Too Many People Receiving Treatment by Primary Care Physicians and ER

"Many low-income people end up seeking and receiving mental health services through their primary care providers at community health centers, because that is the only avenue available to them. Family practice physicians, nurse practitioners and physician assistants are stretched beyond their scope of practice to prescribe and monitor psychiatric medications, because there is no where else for patients to receive this service."

Treatment Providers in Jails – Transitions Out of Prison in Place

"If there were ADATSA counselors at the prisons, then the offenders could go directly from prison to inpatient treatment centers. Maybe the CD treatment center has a discharge planner. The folks who need inpatient CD treatment the most are the mentally ill offenders who continue to re-offend. These offenders are homeless, do not have SSI or a medical coupon, are committing crimes to continue their drug habits. Why doesn't someone stop this awful cycle by allowing ADATSA counselors into the prisons?"

Treatment Providers in Jails

"How someone becomes mentally disabled creates the structure and method in which they are treated. Crime caused by mental disability is still crime and clearly must be addressed. Corrections facilities should consider being treatment facilities as well as part of total corrections and education programs."

Integration and Collaboration

"The RSN and non-RSN parts of the mental health service structure would be well integrated. Mental health issues are very interrelated. Homeless mental health is tied to chemical dependency, life skills, and Veterans issues – they cannot be looked at in isolation. The structure of service delivery is not nearly as well integrated as the nature of the problems."

Integration and Collaboration – Communication between Providers

"There is no commonly accepted framework or language for describing mental health services delivery structure that efficiently and effectively communicates what is available and where their are gaps."

Integration and Collaboration

"I see the need for the state funded mental health team to be integrated with the local health care teams. I do not think that having only a freestanding mental health facility is going to be adequate. Most of the patients that are seen for mental health disorders are seen because of co-morbidities, preventive health measures, or other reasons that they come to a health care provider. Unless there is a significant amount of integration and coordination of this care, we will always be battling inadequate access, inadequate supply due to the lack of capacity planning, therefore running the risk of either inadequate capacity, which we have now, or duplication of services elevating the direct cost of care unnecessarily."

Too Much Bureaucracy – Administrative Costs Detract from Treatment

"The state and federal governments continue to increase administrative burden in managing the system, much of which does not contribute of more or better care for consumers. These increased costs have not been covered by increased revenue, but instead there is pressure to reduce administrative expenses."

Unmanageable Paperwork Requirements

"In addition, the paperwork requirements for therapists providing services are so daunting that they cannot see many clients. The face-to-face percentage requirements at our agency are kept at 50% specifically because of the paperwork. Having worked in other states, I know that I could see many more clients than 20 out of a 40 hour work week. So, we could provide services to more people if the paperwork was less. What happens is that therapists get burned out quickly because of the paper demands and then the low pay. This agency has difficulty maintaining quality counselors due to the extremely low pay. I, myself, could qualify for this county's sliding fee scale because of my low income."

Unmanageable Paperwork – Only Serve in Crisis – Staff Wages – Staff Turnover

"Given the limited funding of public mental health services, caseloads (at least in King County) are incredibly high and the paperwork work load so overwhelming that many patients with severe illnesses are seen as little as monthly and often only to complete needed paperwork. Clinical care is often provided only when a client calls in crisis leading to chaotic schedules for clinicians and chaotic treatment ebbing and flowing for clients. Case managers are paid very little money. With the above job stress and lack of training there is such frequent turnover that it appears that many provider agencies don't even try and invest in training as their staff are likely to leave in 4-12 months. Such turnover for clients with severe illnesses lasting years to decades is unconscionable."

Increased Treatment Staff Wages

"Funding would be consistent with the desired educational levels of service providers and staff members would be treated as professionals, in terms of financial compensation and basic respect. The federal government and the state would stop treating providers of social and human services as second class citizens."

Funding Causes Program Instability – Need Stable Funding Streams

"There continues to be a fickle system of funding which ensures instability in programs that provide critical services. Programs are forced to continually shift and change due to an unpredictable funding base."

Lack of Funding and Resources

"Lack of adequate funding for public services. In outpatient work this means frequency & duration of treatment is not based truly on client needs and clinical assessment but on level of care guidelines geared to manage scarce resources. It means that a population who have experienced trauma of many kinds, but particularly around human attachment, are re-traumatized again and again because they can be provided only with crisis services, and no durable trustworthy bonds. It means therapists are stressed by doing harm to already vulnerable clients."

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

AUGUST 2006

DSHS|RDA Report Number 3.31

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

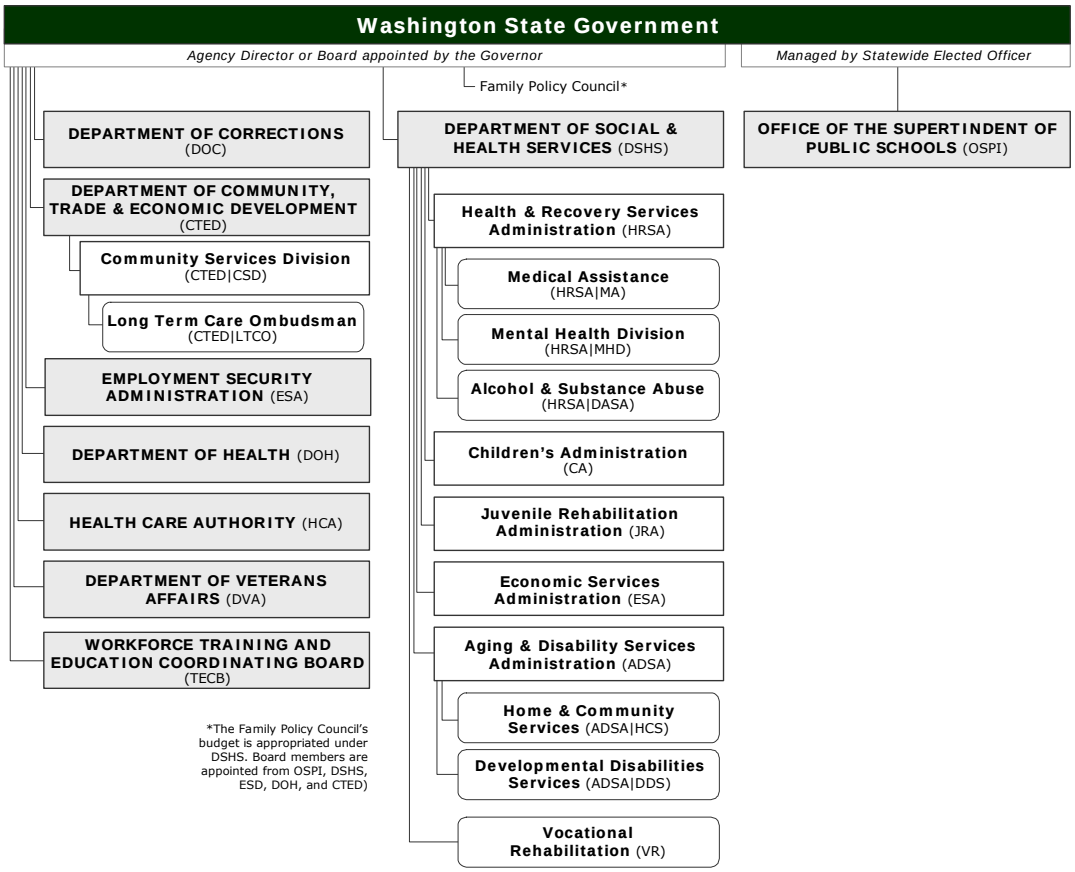
Sources: Tribal Lands – 2000 US Census Bureau and Washington State Department of Ecology. Major Highways – Washington Department of Transportation. County Boundaries - US Census Bureau 2000

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

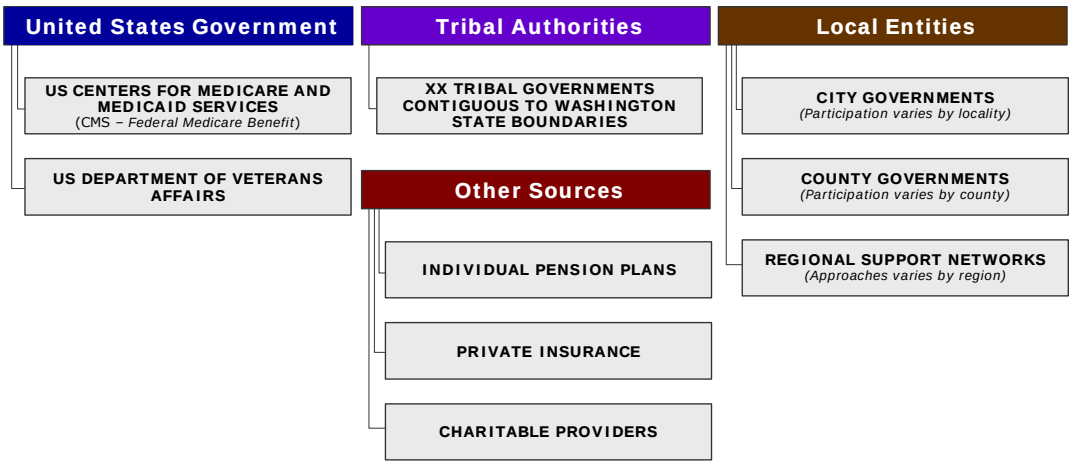
Chehalis • **Colville Council** (Colville, Chelan, Entiat, Methow, Okanogan, San Poil, Lake Nespelem, Nez Perce, Palouse, Moses, Sinkiuse, Wenatchee) • **Hoh** • **Jamestown S'Klallam** • **Kalispel** • **Lower Elwha** • **Lummi** • **Makah** • **Muckleshoot** • **Nisqually** • **Nooksack** • **Port 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.



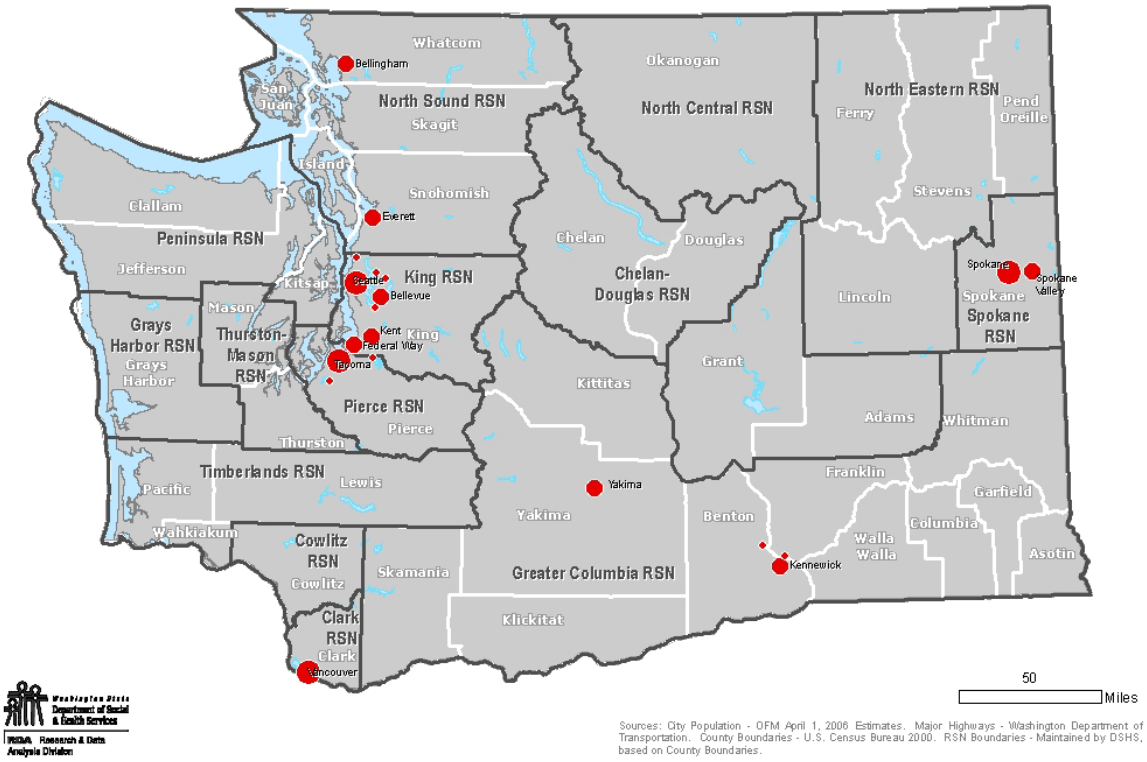
Local Government Mental Health Services

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.

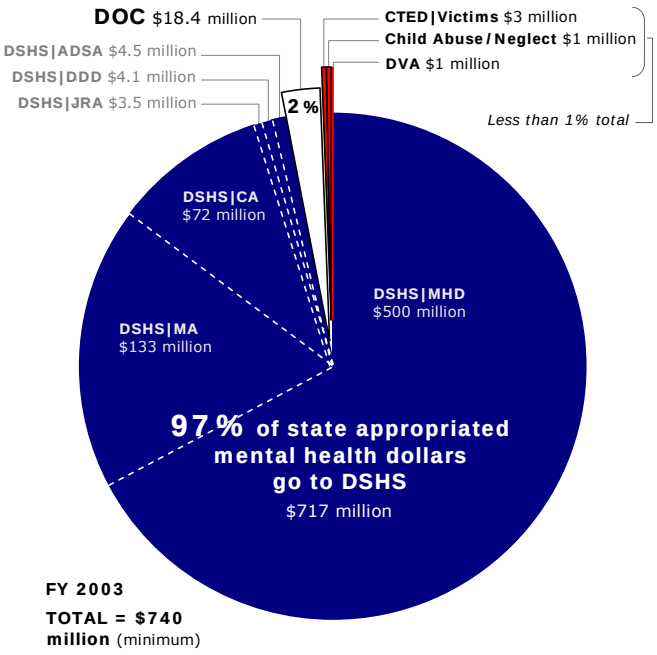
97 percent ($717 million) flowed through DSHS.

- **$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.

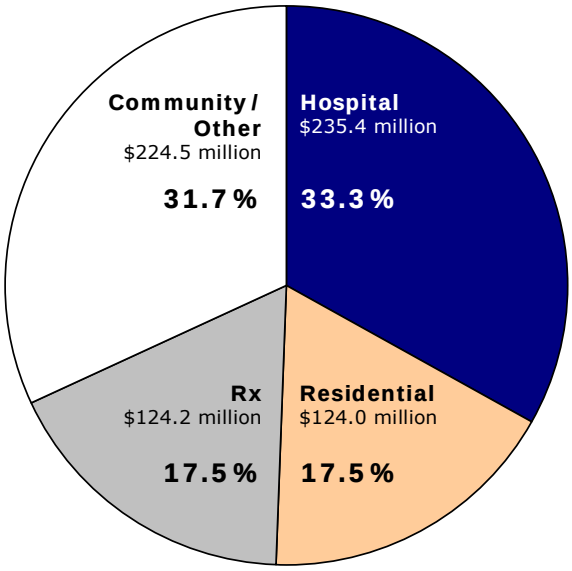
In FY 2003, DSHS spent $708 million* on fee-for-service clients for mental health services

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)

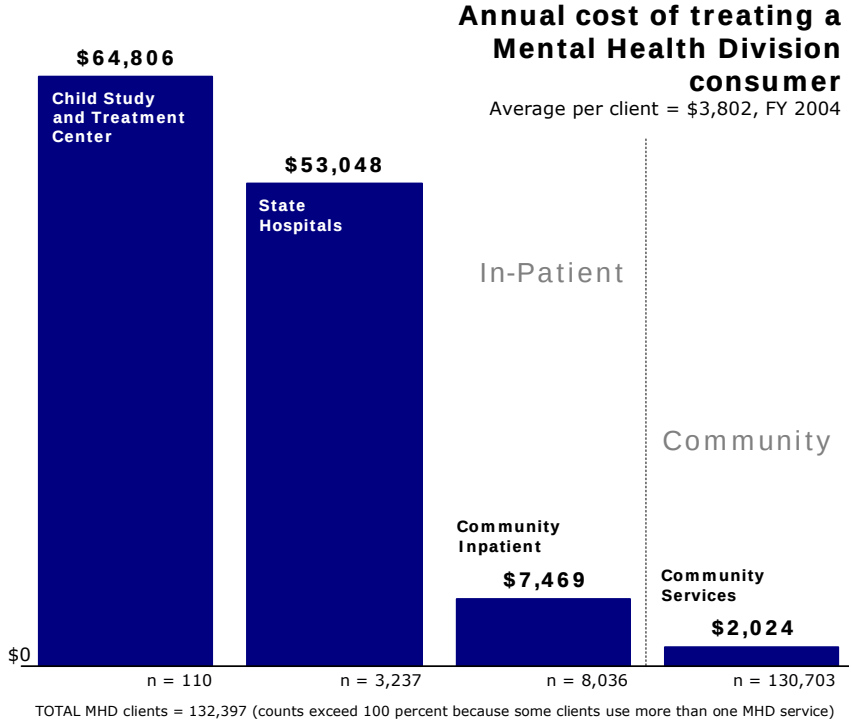
Community outpatient services include case management, medication management, group and individual treatment, psychological education for consumers and families, clubhouses, and other community-based services.

- **$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

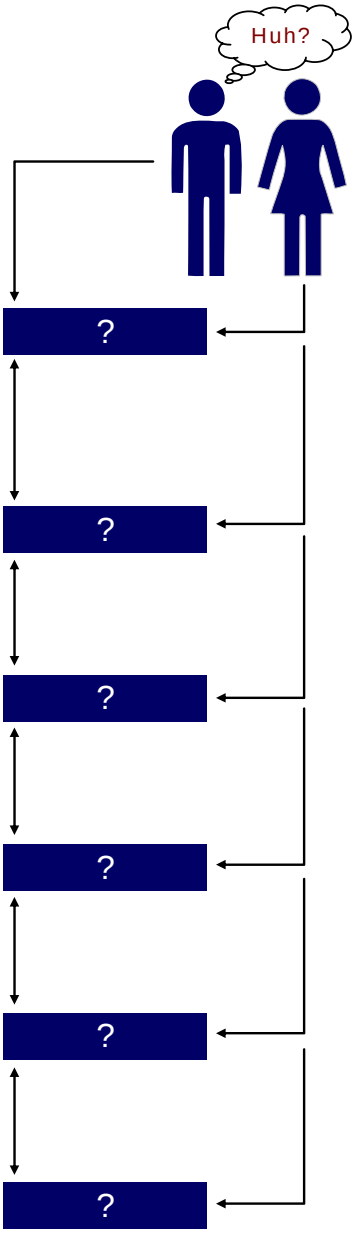
RSN Level 2 *DSHS Mental Health Division Entry*
Those with more severe functional impairment caused by the right diagnoses can receive more RSN services.
Must have a serious functional impairment means GAF of 50 or below for adults, CGAS of 50 or below for children except those under 6

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

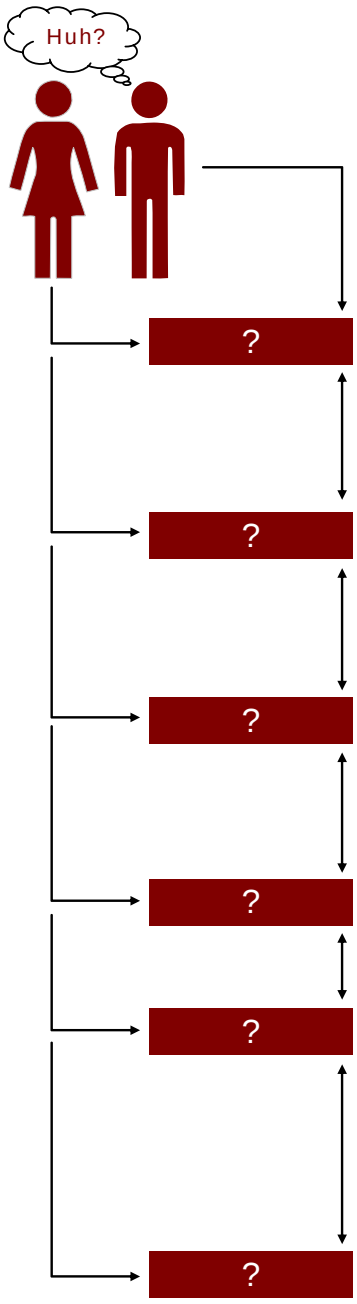
Other Medical Coverage *HCA Basic Health Plan Care Entry*
Basic Health Plan Enrollees can receive some mental health services through their doctor
Children under 19 ("Basic Health Plus" – non-TANF, non-DSHS) and Adults not eligible for free or purchased Medicaid and persons not living in state institutions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

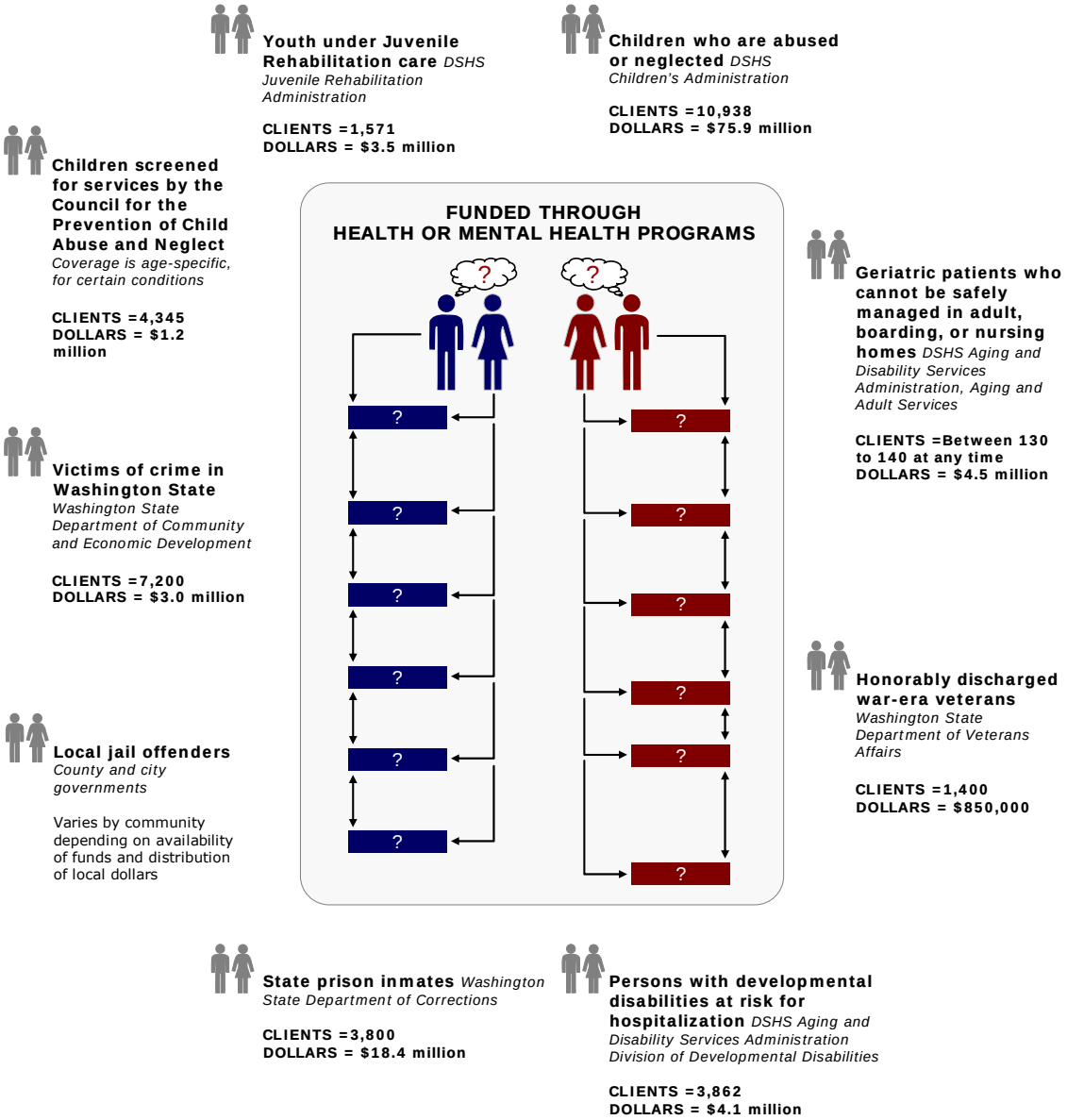
- Medication management and monitoring
- Inpatient care (up to 10 days per year)
- Individual and family counseling (up to 12 visits per year, with co-pay)

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

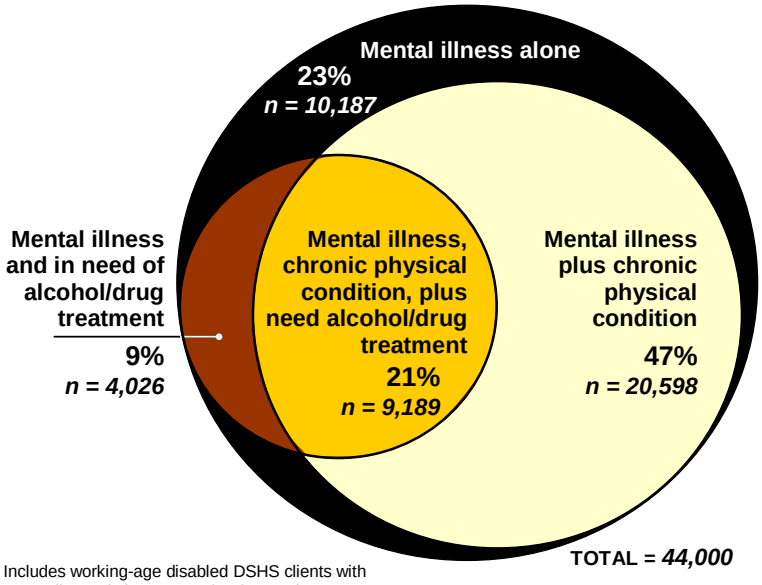
Treatment and recovery are more complicated when a person has multiple physical and mental health conditions, behavioral health issues, and family issues affecting their lives and their ability to concentrate on recovery. Such people are likely to be deeply functionally limited by their combined problems, 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

Beverly Miller, MSW
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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.

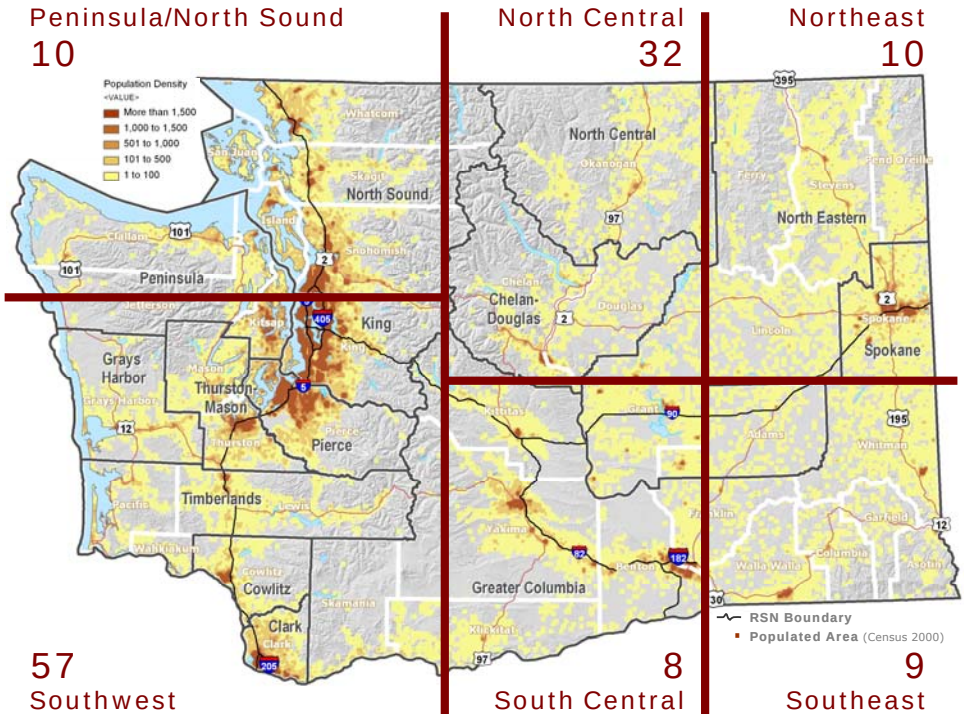
In addition, consumer leaders from WIMIRT and consumer, youth, and family member interviewers reviewed interview records to extract major themes of responses from specific demographic groups with adequate response rates to support such analyses. Such separate analyses were ultimately conducted for five 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

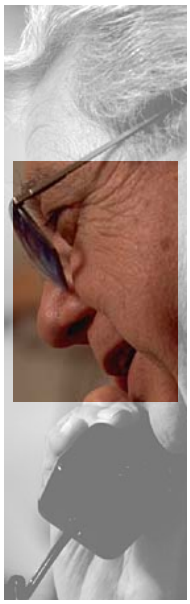
However, there were also themes that were specific to certain groups. Not surprisingly, **homeless individuals** were unanimously insistent that support for their mental health issues required assistance with jobs and housing. All 33 homeless individuals that were interviewed had an experience similar 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
Western Branch, Tacoma, Washington
University of Washington School of Medicine, Division of Psychiatry
and Behavioral Sciences

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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.

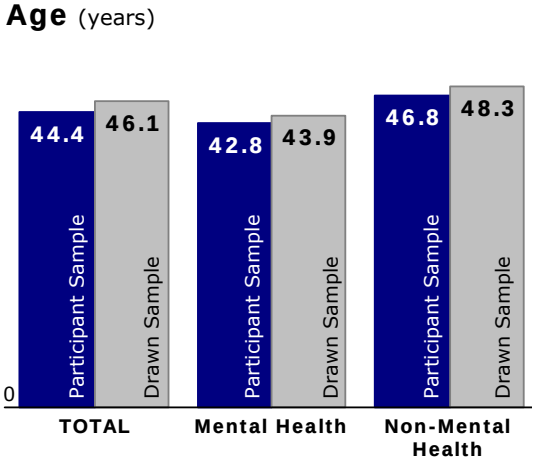
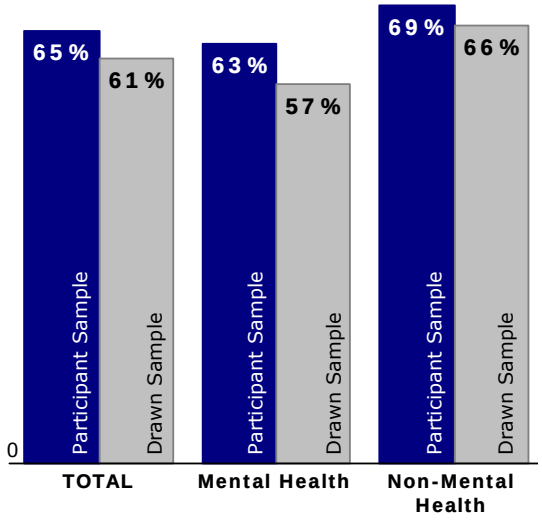


Figure 1 shows that those participating in the survey are younger than those in the drawn sample. This is the case for the total, mental health (MH), and non-mental health (Non-MH) groups. This is typical of survey data in that those that are younger are more likely to be able to participate in the survey; 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.

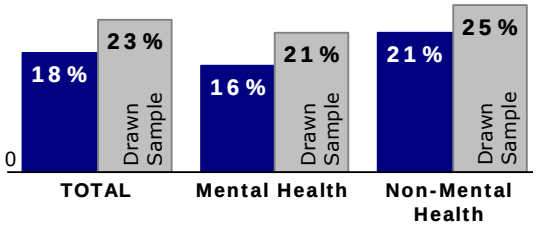
Gender (Percent Female)



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)



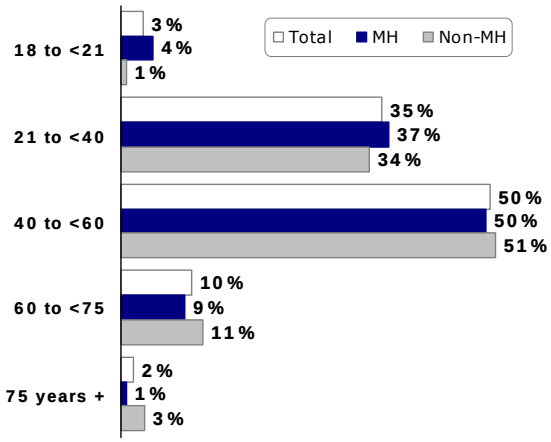
The total percentage of survey participants who identified themselves as belonging to a minority group is lower than that found in the drawn sample (18 percent vs. 23 percent).

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)

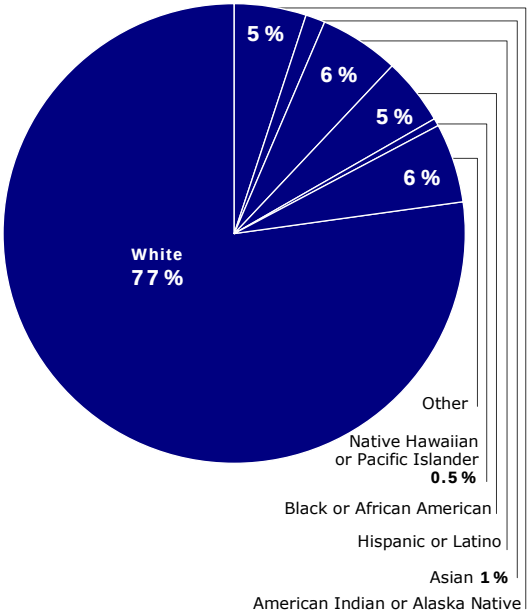


Figure 5 shows that approximately three quarters (77.2 percent) of the participants indicated that their race or ethnicity was White. Participants who identified themselves as "Other," (5.6 percent) or who said they were Black or African American (5.6 percent) made up the next largest categories, followed 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)

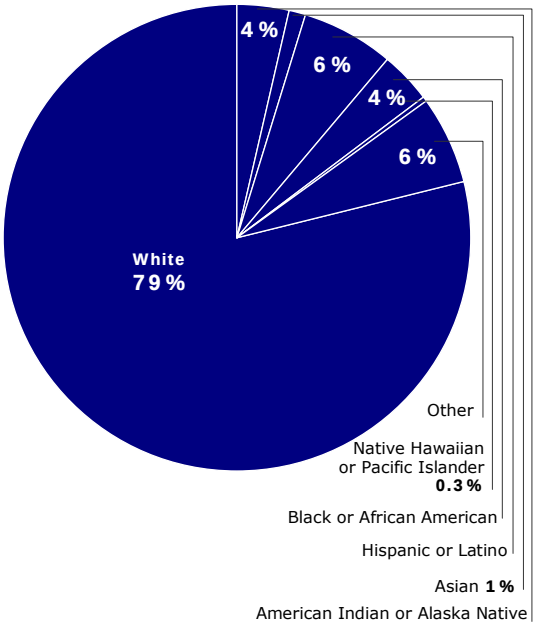


FIGURE 7.

Race / Ethnicity (Non-Mental Health Agencies)

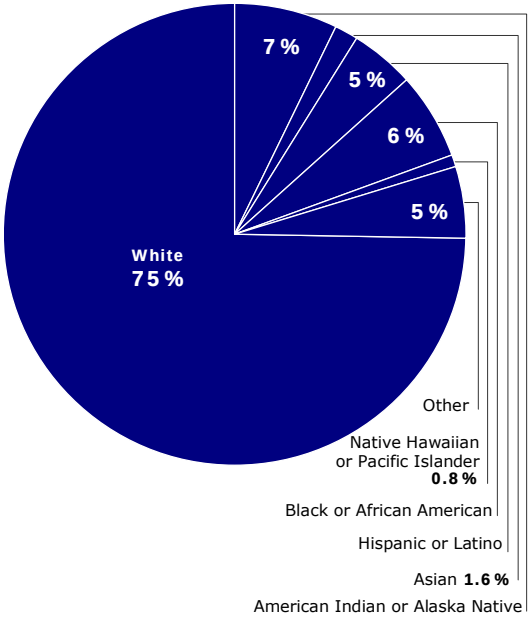


FIGURE 8.

Employment Status (TOTAL)

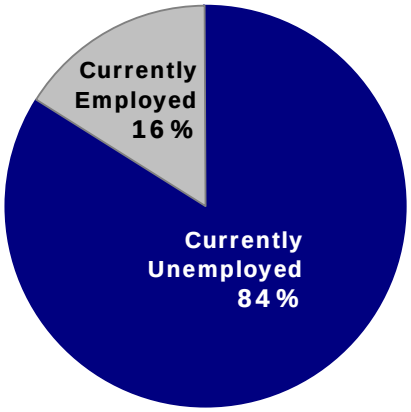


Figure 8 shows that most of the people who completed the survey from either mental health or non-mental health agencies were not currently employed. A larger number were employed from mental health agencies (18 percent) than were employed from non-mental health agencies (11 percent), Figures 9 and 10.

FIGURE 9.

Employment Status (Mental Health Agencies)

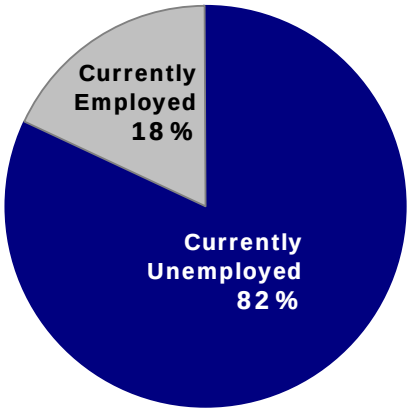
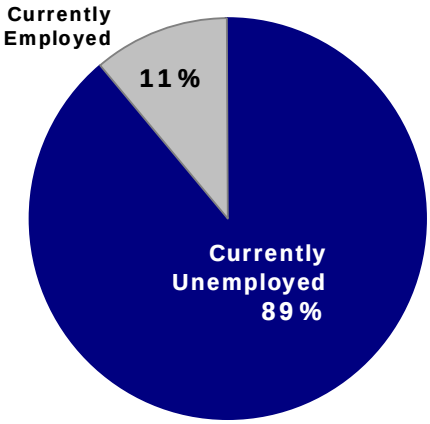


FIGURE 10.

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.

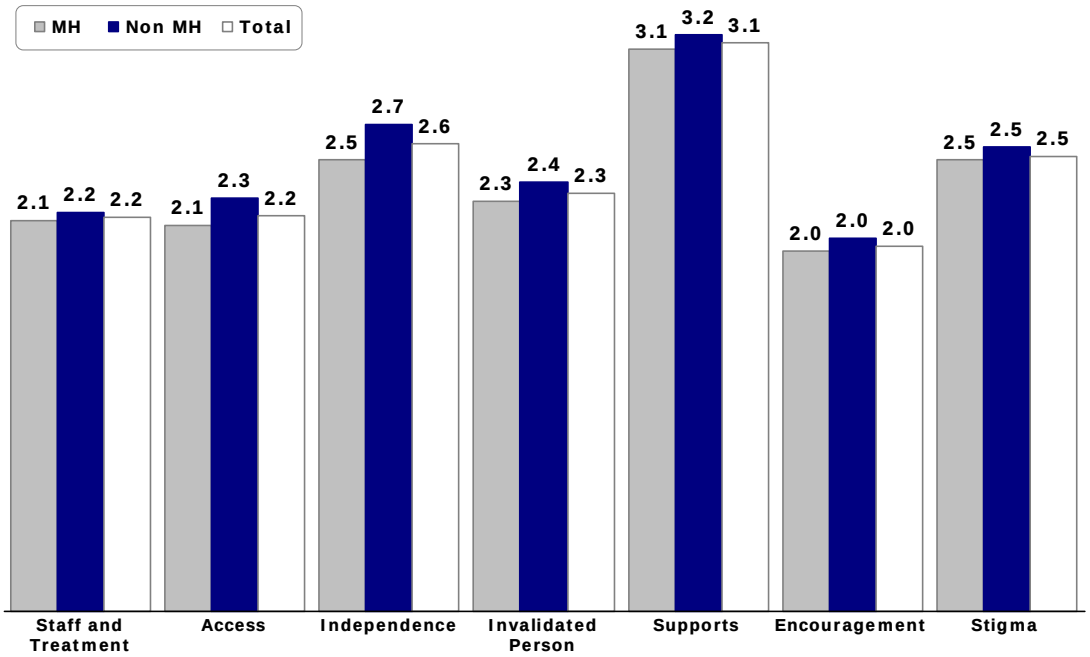
In Figures 12 through 17 the average scale scores were collapsed into categories so that the approximate percentage of scores falling into each of the categories can be observed. There are two response categories for the scales (Strongly agree (1- 1.49), Agree (1.5-2.49), Disagree (2.5-3.49), Strongly 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**

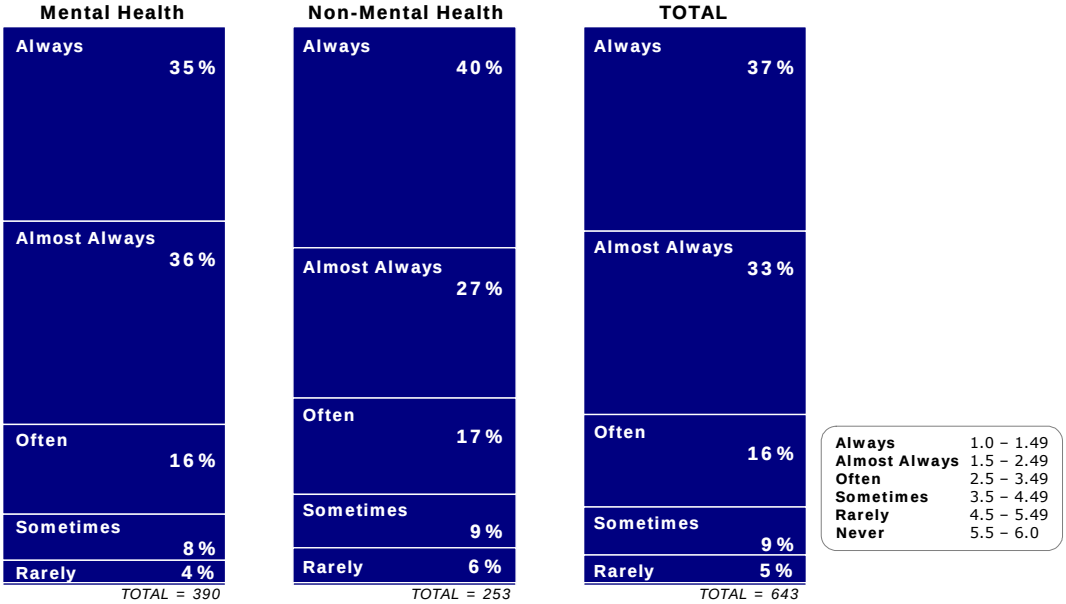


Staff and Treatment Satisfaction

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

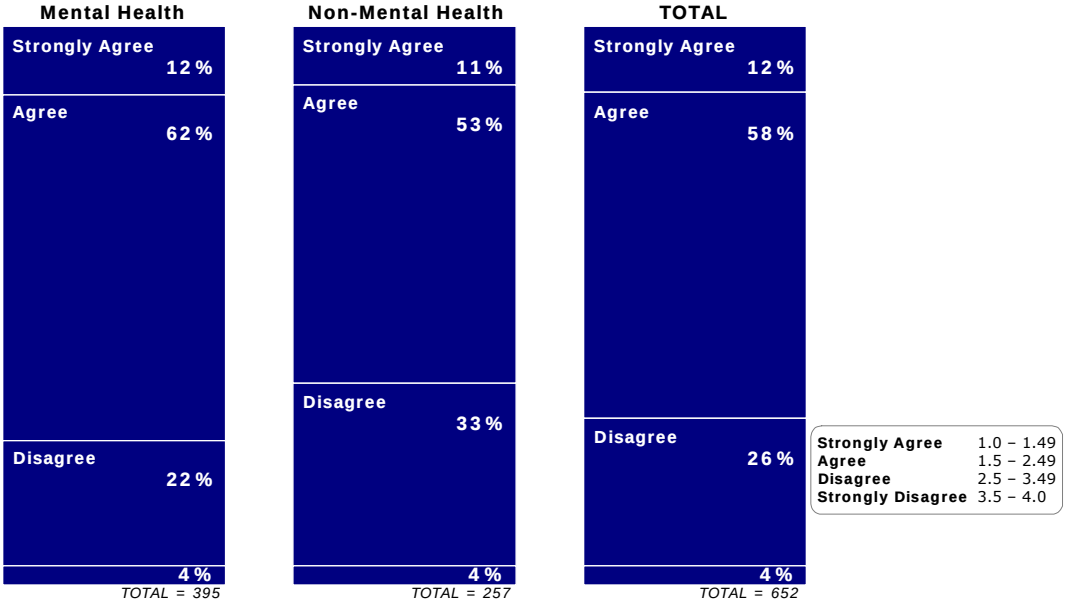


Access to Services

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



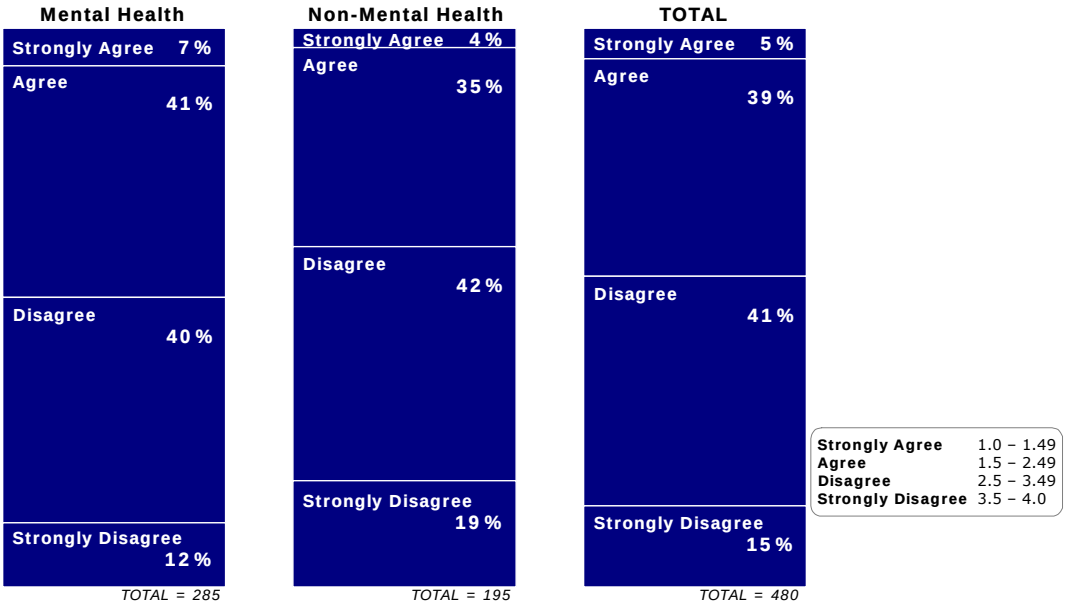
Perceived Independence

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

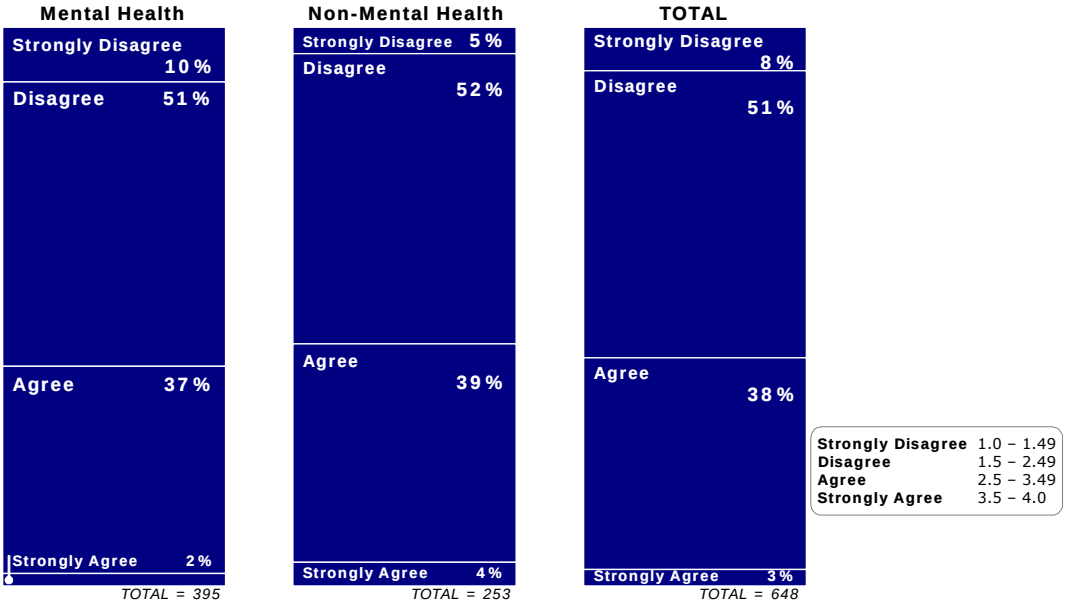


Invalidated Personhood

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

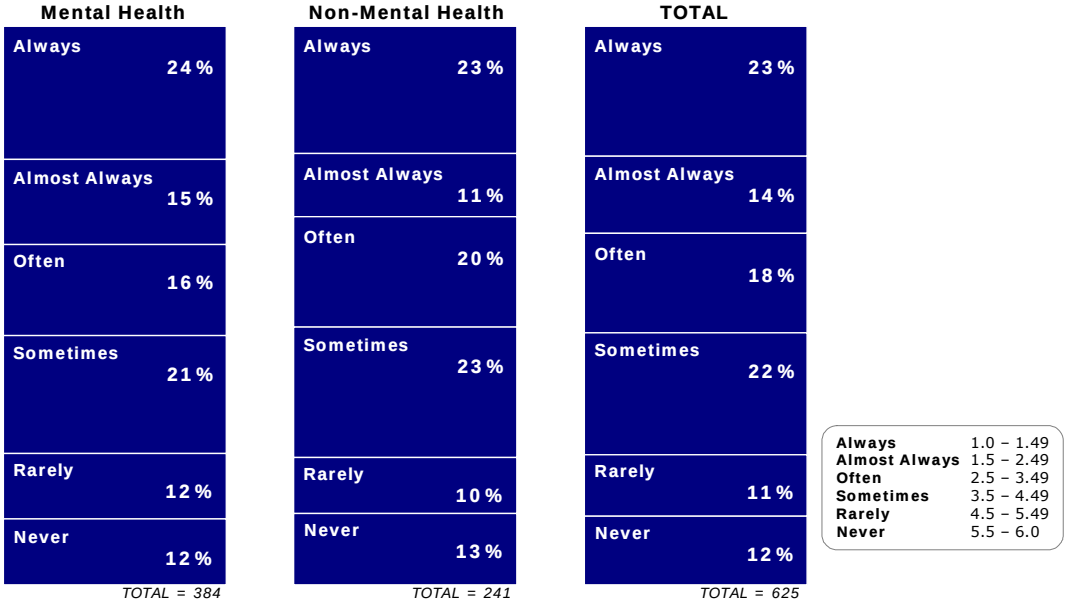


Support

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

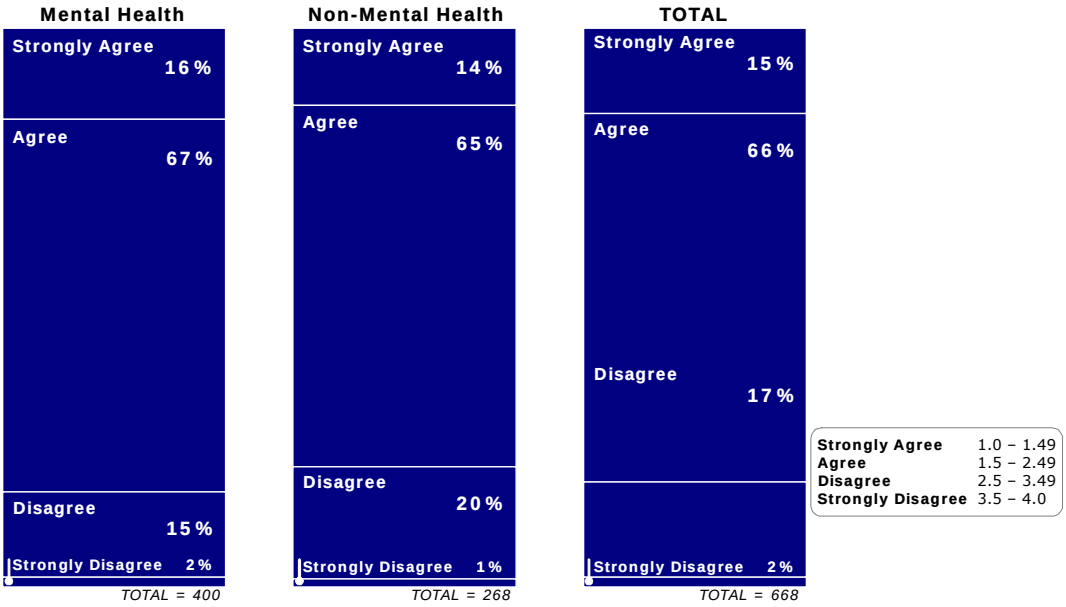


Encouragement

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.

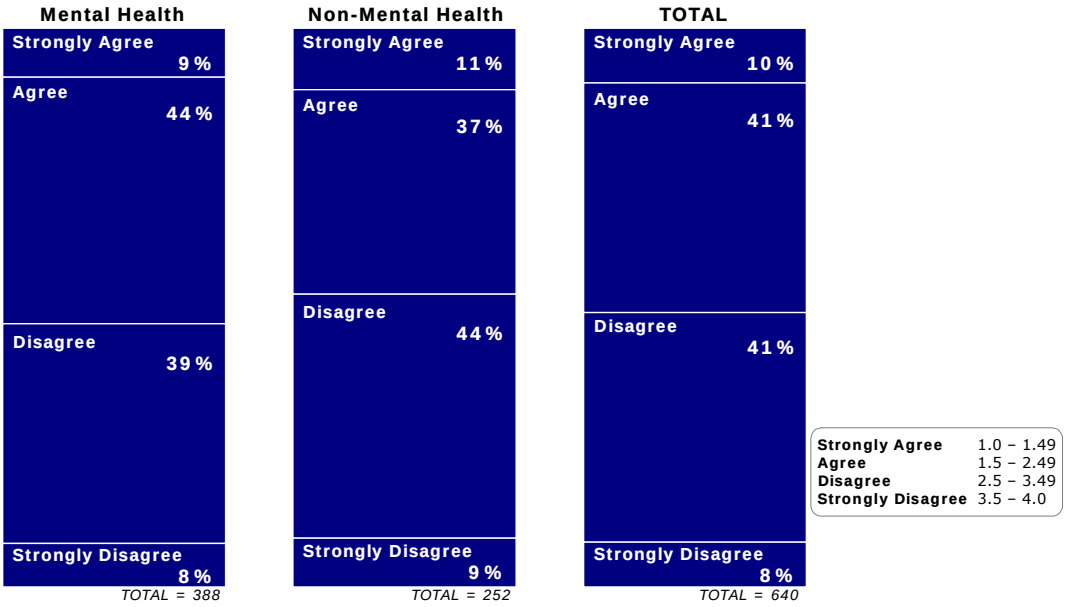
Discrimination Experience Scale	Reliability ALPHA
Discrimination Experience Scale	**.852**
People discriminate against me because I have a mental illness. (Strongly Agree…Strongly Disagree) Others think I can't achieve much in life because I have a mental illness. (Strongly Agree…Strongly Disagree) People 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

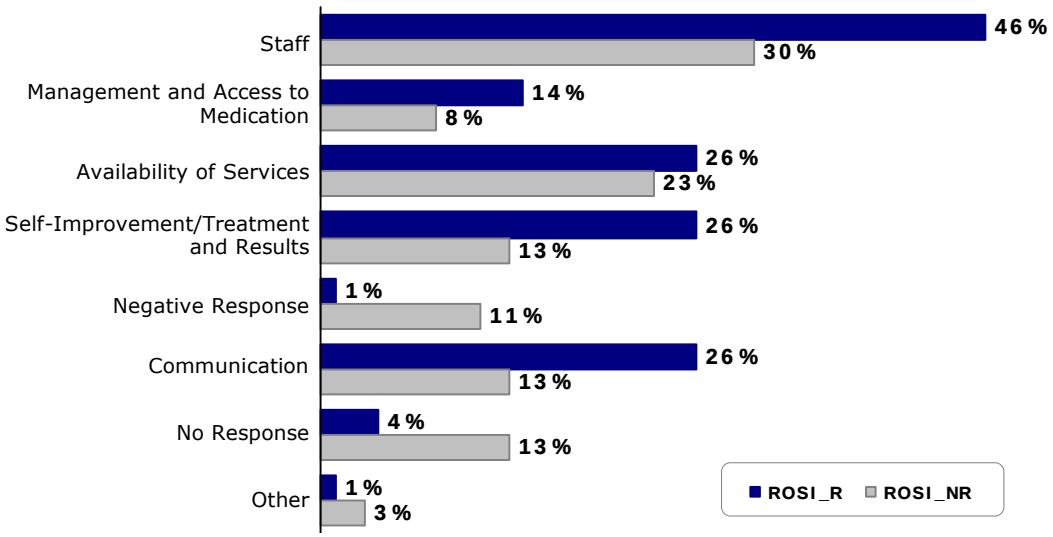
No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

'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.'

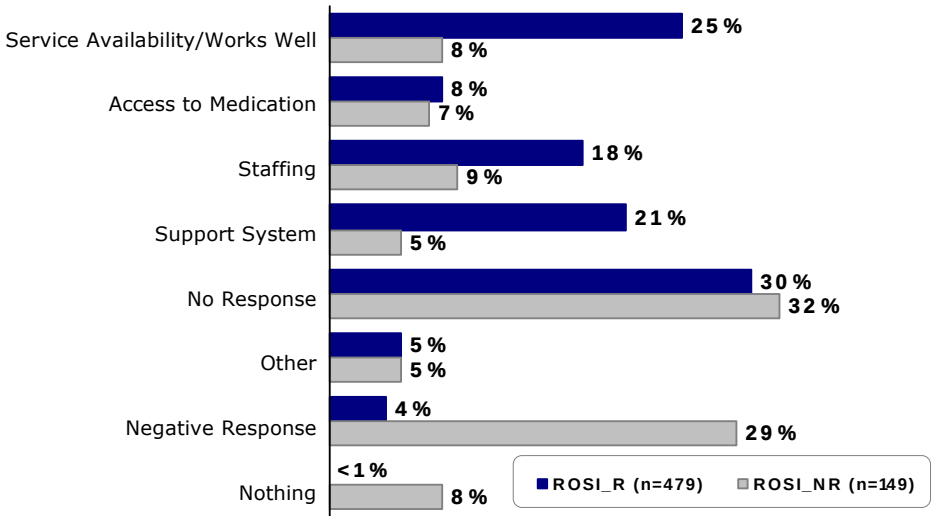
Other—Includes other responses that don't fall into the categories listed

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)

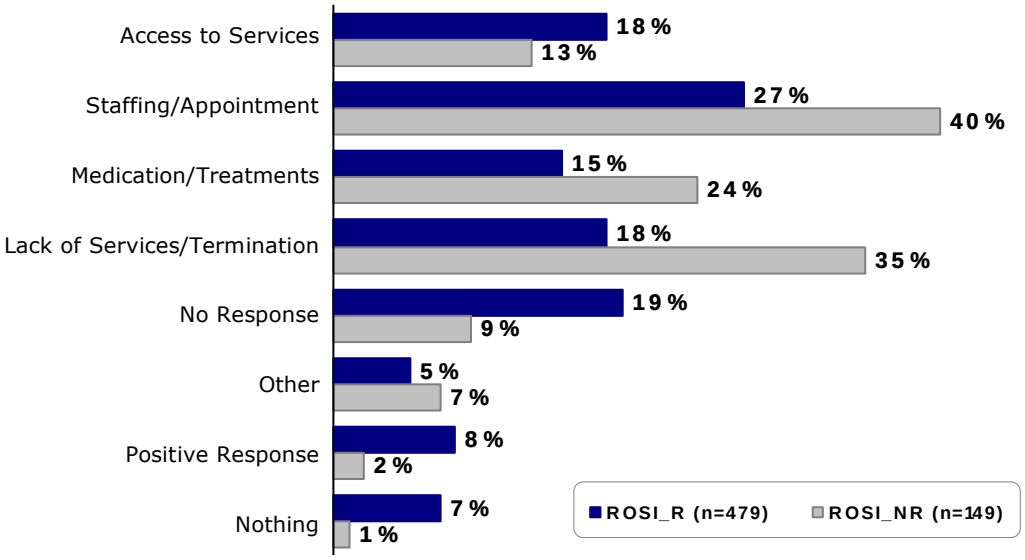
Other—Includes other responses that don't fall into the categories listed

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)

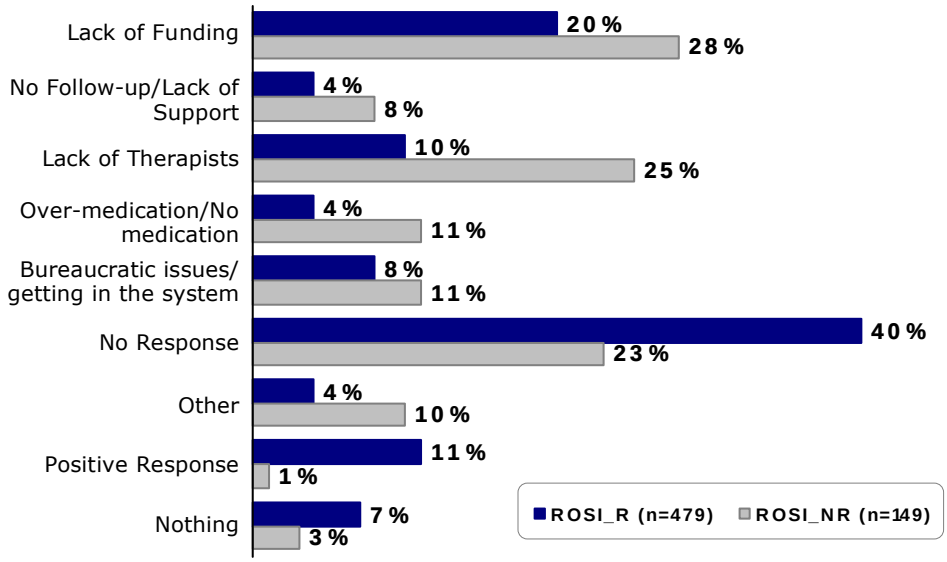
Other—Includes other responses that don't fall into the categories listed

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

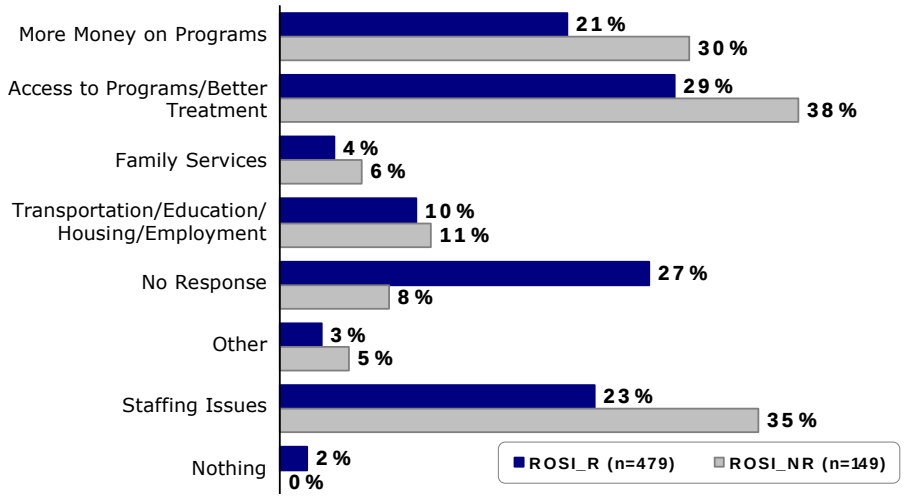
'Nothing'—Refers to the specific response, 'Nothing.' (As this response can be interpreted in several different ways even as a lack of response, a separate category has been created)

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.

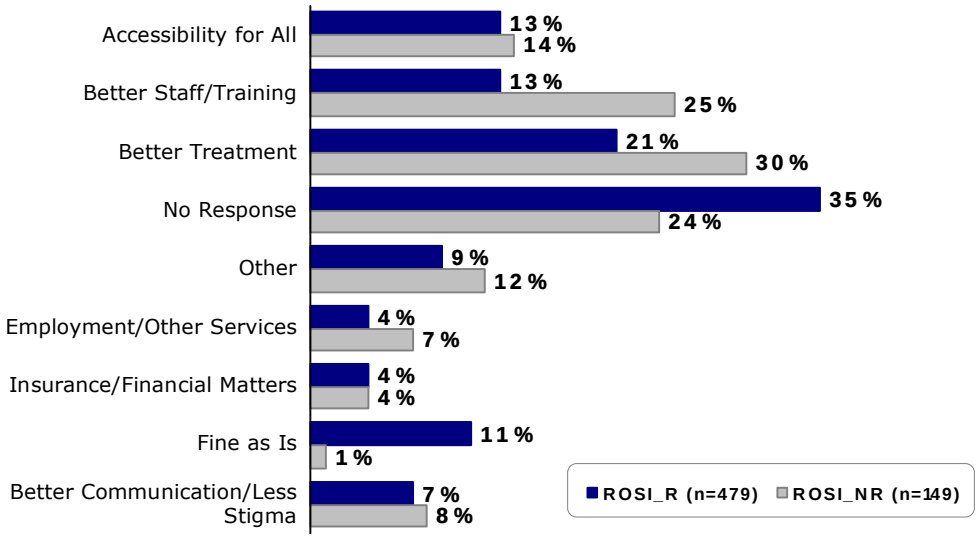
Other—Includes other responses that don't fall into the categories listed

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

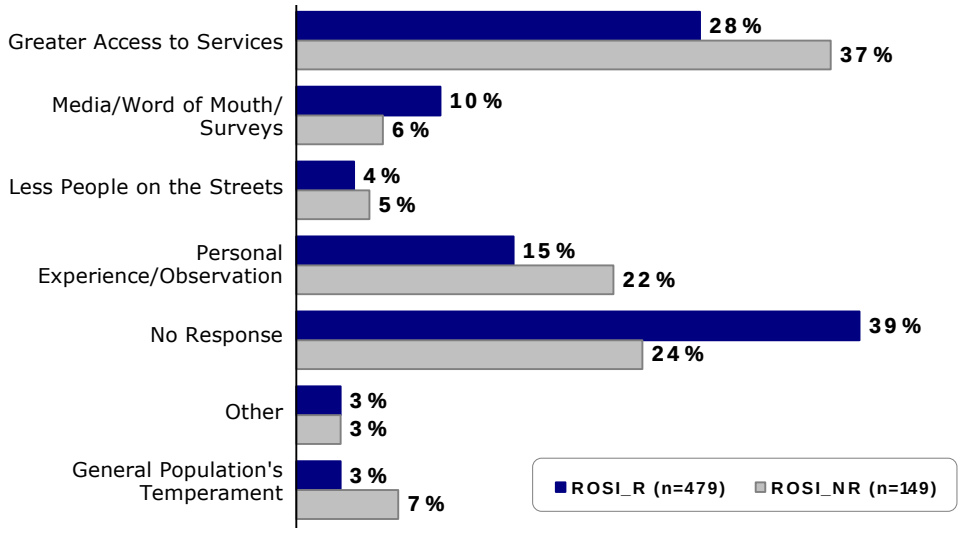
No Response—Respondent did not have a response to the question (field either left blank or respondent simply said 'don't know')

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:

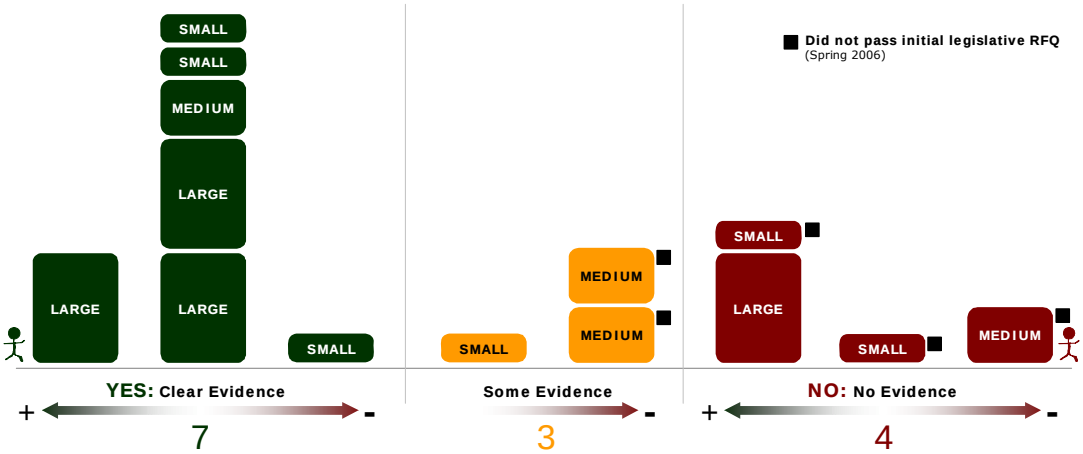
- There is clear evidence that half of the RSNS (7 out of 14) are driving program and counseling activities through transformative goals. While these regions represent half the RSNs, they represent two-thirds of the state's MHD consumers.
- For three RSNs, there is some evidence of transformation, but 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.

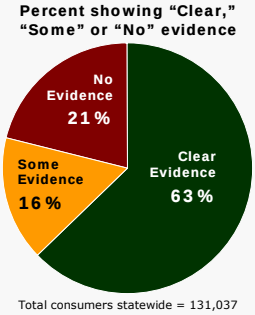
RSNs tell us WHAT WORKS from their perspective

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.*

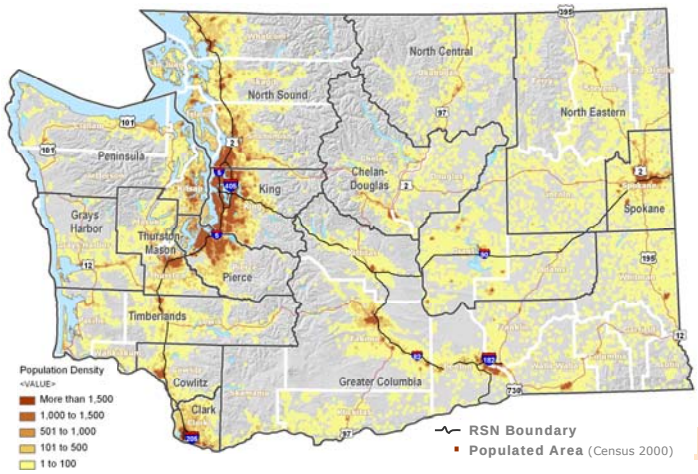
They operate under statute as well—RCW 71.24.045 (Regional support network powers and duties). Among the duties embodied in this law are:

- 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)

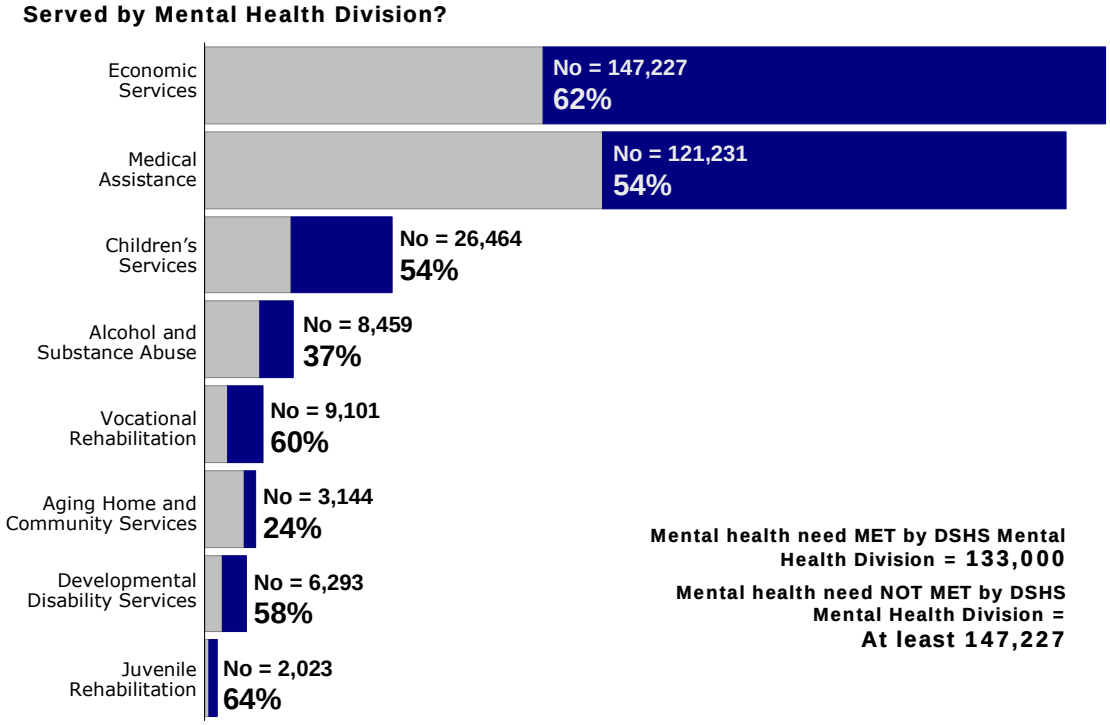
"We see attachment disorders, conduct disorders, and depression in kids all the time." (Department of Community, Trade, and Economic Development – Early Childhood Education Assistance Program)

"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?)

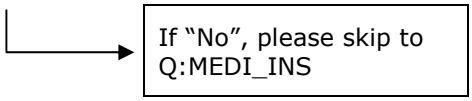
77. Don't Know
99. Refused

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:

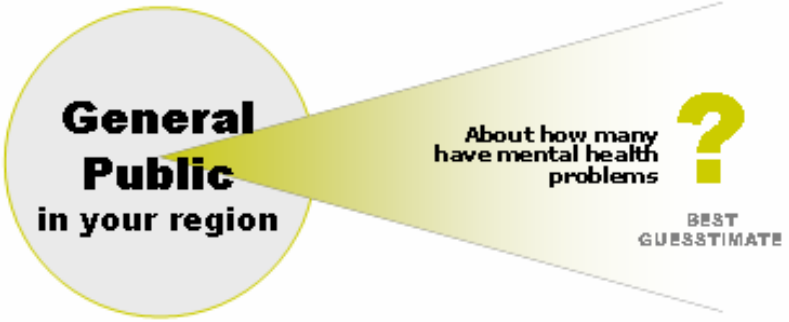
- Thought disorders like schizophrenia, paranoia, multiple personality
- Mood disorders like depression, anxiety, bi-polar, phobias, suicidal ideas
- Personality disorders like ADHD, borderline personality, aggressive
- Childhood personality diagnoses such as oppositional defiant disorder
- Family problems, 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.

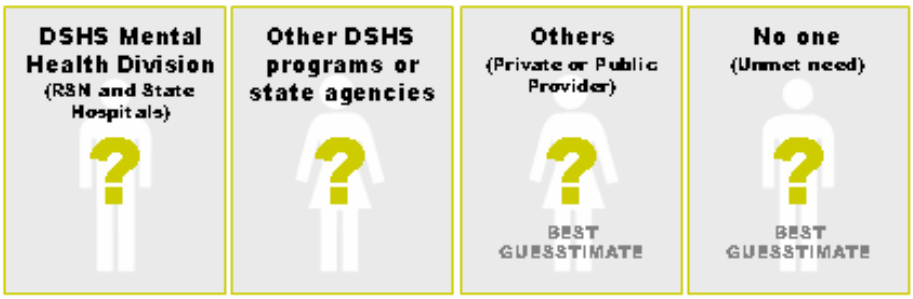
DSHS often serves sub-populations that are more likely to experience mental health disorders than the general population.

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?

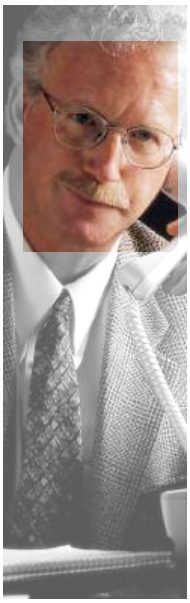
15. For your clients, what doesn't seem to be working?

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?

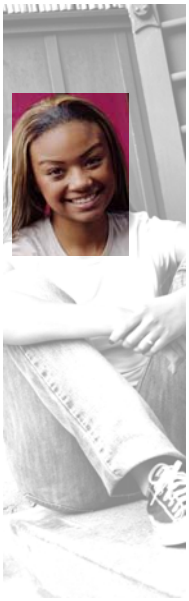
PROGRAMMING
DATA COLLECTION
FINANCIAL MANAGEMENT

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
Rick Bacon	DSHS, Assistant Director, Aging and Disability Services Administration
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
Cindy Ellingson	DSHS, Children's Administration
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Tammi Erickson	DSHS, Children's Administration
Mark Freedman	Thurston-Mason Regional Support Network
Rosa Giberson	DSHS, Economic Services Administration, Community Services Division
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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
Jann Hoppler	DSHS, Children's Administration
Jacalyn Hurn	North Eastern Regional Support Network
Kary Hyre	Community, Trade and Economic Development, Community Services Division, Long Term Care Ombudsman
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Gaye Jensen	DSHS, Juvenile Rehabilitation Administration
Carrie Yetzer	Department of Corrections
Mona Johnson	Office of Superintendent of Public Instruction
Gary Kamimura	Employment Security Department
Mickey Kander	Washington State Department of Health
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Richard Kellogg	DSHS, Health and Recovery Services Administration, Mental Health Division
Rebecca Kelly	DSHS, Juvenile Rehabilitation Administration
Judy King	Community, Trade and Economic Development, Community Services Division
Vicki Kirkpatrick	Washington Association of State and Local Public Health Officials
Greg Kline	DSHS, Health and Recovery Services Administration, Mental Health Division
Lance Krull	Community, Trade and Economic Development, Community Services Division
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Michael Langer	DSHS, Health and Recovery Services Administration, Division of Alcohol and Substance Abuse
Kathy Leitch	DSHS, Assistant Secretary, Aging and Disability Services Administration
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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
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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
Cheryl Stephani	DSHS, Children's Administration
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

APPENDIX 3 MHTP Outcomes, Principles and Strategies

INTRODUCTION

Appendix 3 provides a summary of the outcomes, principles, and strategies as defined by the subcommittees and task groups.

Section 1 – Subcommittee Outcomes

The following information contains the list of outcomes defined by the subcommittees. The corresponding Federal Goal associated with the outcome is identified in the right hand column.

Criminal Justice Subcommittee

1. Decreased number of people with mental illness from entering into the criminal justice system. — 5
2. Increased access to mental health and substance abuse services for those within the criminal justice system. — 5
3. Decreased number of people with mental health illness re-entering the criminal justice system. — 5

Co-Occurring Disorders Subcommittee

1. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources. — 4
   - Services will be specific to the individual's needs
   - There will be access to sufficient treatment providers who trained and retained.
2. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy. — 4
   - Peer-to-peer support is available to all who want it.
   - Communication between and among the parties is critical to making this successful.
   - Law enforcement officers receive crisis intervention training to deal with co-occurring disorders
3. Increased system collaboration and service integration is prevalent across all allied systems and services. — 4
   - Reduction in silos across system boundaries
   - Increased holistic services
   - Increased cross-system treatment
4. Service Delivery is consumer driven and recovery focused. — 2
   - There are options available outside of the current standard options such as homeopathic services.

Children, Youth, Parents And Family Subcommittee

1. Greater availability of State-Only Funds 5

   This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:

   – State-only Funds for parent organizations, mentorships

   – State-only Funds to serve those who are not in the country legally, non-Medicaid children/youth and families.

   – State-only Funds to serve working poor and people who have exhausted their insurance benefits

2. Youth and Family Support (this includes any caregiver family including foster, adoptive and kinship families) 2

   Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

3. Training and Education 4

   This is inclusive of partnerships between professionals and parents/youth, cultural competence, which goes beyond linguistics and ethnicity, and professionals.

   – Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface.

   – Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to 3 issues.

4. A system that is more proactive than reactive 4

   Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. The continuum would include respite, wraparound services, day treatment, and evidenced based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services

	would be available to be delivered in the family home or other community location of family preference. • Revisit the Access to Care Standards and open the door to access.	
Youth In Transition Subcommittee	1. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.	2
	2. a) Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work.	4
	b) Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.	1
	3. Consistent access to quality services and supports available regardless of location or funding sources.	5
	4. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members.	4
Adult Consumers And Families Subcommittee	1. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers will have a choice of services in which they can become engaged that include at a minimum: – Consumer-run services of various types – Individual therapy with a qualified therapist – Clubhouse services – Case management services	2
	2. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services. – Within five years, these services will represent 25% of all mental health services in Washington State, and – Within five years, 20% of adult consumers are	2

	employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.	
	3. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.	5
	4. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).	5
	5. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality supported employment based on national standards. These programs work collaboratively with DVR to ensure employment for as many consumers as possible.	8
Older Adult Consumers Subcommittee	1. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.	4
	2. Mental Health services for Older Adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.	5
	3. There will be an increased number of service-providing individuals with professional expertise in mental health and aging.	5
	4. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.	4
Homelessness Subcommittee	1. Housing will be available immediately upon need for individuals/families.	5
	2. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are being applied for.	5
	3. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).	5

Section 2 – Task Group Principles

The following tables contain the list of principles defined by the Task Groups.

Fiscal System Task Group Principles

The TWG approved the approach proposed by the Fiscal Systems Task Group to defer detailed fiscal systems strategies and adopt the principles defined by the task group to help determine detailed strategies in Year 2 when more information is known. The Task Group defined seven principles to guide their work in Year 2.

Financing strategies require a comprehensive and integrated approach

1. Seek to reduce funding silos and increase/expand integration of funding streams, within behavioral health programs and resources as well as across systems. Seek waivers to expand integration.
   - Possible strategy is to consolidate or blend behavioral health funds into one funding stream.
     - For example blend Healthy Options behavioral health benefit and RSN Medicaid benefit. Create one Medicaid behavioral health benefit; could be either carve-in or carve-out model.
     - For example combine all funding for community hospitals, state hospitals and long-term care with community based services into single funding stream.
   - Possible strategy is to establish integrated networks across funding streams and have single contracting mechanism with providers.
2. Behavioral Health funding is a scarce resource. Every effort to maximize third party liabilities (Medicare, private insurance, etc) as well as other sources of funding (grants, matching funds, alternative resources) should be made.
   - Possible strategy is, similar to Healthy Options Plans, provide RSNs an eligibility file with other member coverage identified. Require RSNs to implement coordination of benefit procedures for claims payment.
3. Service equality should be reflected in the distribution of resources and the reimbursement for services across the state. There should be a consistent array of services across regions and populations.
   - Possible Strategy is to adopt statewide funding rates that apply to all regions. This has been a major political issue in this state for several years. There has not been a satisfactory solution proposed.
   - Possible strategy is to adopt statewide maximum provider reimbursement rates by procedure code.
   - Possible strategy is to adopt and fund a basic benefit design available to all members and establish minimum service array

requirements.

4. Expand availability of early intervention and assessment for all populations.
   - Possible strategy is to drop or revise Access to Care standards for Medicaid members and require/establish that all members have same basic benefit, which includes at least an assessment/evaluation.
5. Reimbursement should be outcome based with incentives for adopting evidence-based practices.
   - Possible strategy is to adopt a process by which the state can approve alternative treatments, non-traditional service models and service innovations that are in addition to basic benefit. Some states call these value-add services. Should be cost neutral to the state.
   - Possible strategy is to adopt recovery and resilience based outcome measures for the system.
6. Consumers and families should have greater responsibility/opportunity to direct services and expenditures.
   - Possible strategies are Self-Directed Care Models and Money Follows the Person Program.
   - The Centers for Medicare and Medicaid Management (CMS) has issued a request for proposal for Self-Directed Care Programs as well as working on a Money Follows the Person Program. The state should pursue these programs and funding.
7. Efforts should be undertaken to reduce or simplify administrative burden for all components of system.

In addition to approving the above principles, the TWG directed the Task Group to ensure it addresses the importance of funding stability in its financing plan. Further, the TWG recommended to the Task Group that they expand the membership to include representation from other organizations as well, such as the Office of the Superintendent of Public Instruction (OSPI), the Department of Community, Trade and Economic Development (CTED), and the Employment Security Department (ESD).

Fiscal Systems Task Group Next Steps

The Fiscal Systems Task Group will be developing their financing plan over the next few months, in time for agencies to submit decision packages for priority budget changes to Washington's Legislature for the 2007-2009 biennial budget cycle. Upcoming activities will include:

- An assessment of current funding strategies.
- A review and documentation of best practices and "pockets of success."

- An exploration of Consumer Driven Service Models.
- An exploration of Integration Initiatives:
  - Behavioral/Mental Health and Physical Health;
  - Substance Abuse/Chemical Dependency and Mental Health; and
  - Encourage better coordination of services e.g., criminal justice/MH; schools/MH; Long-term care/MH.
- A feasibility study of Home and Community-Based Waivers.
- An exploration of opportunities to increase flexibility and choice of services.
- An assessment of ways to potentially decrease costs:
  - Explore unified paperwork, administrative outcomes; and
  - Improved benefit coordination.

Cultural Competence will be braided into all Transformation Activities

The TWG accepted several detailed strategies put forth by the Cultural Competence Task Group and recognized the need for a broader discussion of effective approaches to achieving greater levels of cultural competence in Washington's mental health system. The Cultural Competence Task Group identified guiding principles it will use to improve current competency levels and attitudes.

- Consumers, families and youth are members of the group that establishes the social marketing plan, providing guidance about plan feasibility for various communities.
- Consumers, families and youth will contribute to the development of intake and assessment procedures by being part of the workgroups charged with the development of the instruments.
- Consumers, families and youth will contribute by becoming part of the treatment team planning.
- Consumers, families and youth will contribute to the establishment of standards, accountability measures and financial incentive provisions.
- Consumers, families and youth will participate in curriculum development and act as consultants during the implementation process.
- Consumers, family and youth will participate as speakers in cultural competency trainings and help with curriculum design.
- Consumers, family and youth will participate by being part of hiring panels and committees that actively help recruit from their communities.

The task group will continue during Year 2 to refine the existing strategies, and develop new strategies that seek to infuse cultural competence

throughout the systems that provide mental health services.

Evidence-Based/ Promising/Emerging Practices

The Evidence-Based/Promising/Emerging Practices (EBPEP) Task Group members included a diverse mix of individuals comprised of consumers, advocates, clinicians, administrators, and researchers all committed to transformation of the mental health system of Washington State. Informed by the evolution of the concept of evidence-based practice in the scientific literature and the philosophy developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) the types of strategies included 1) evidence based, 2) promising, 3) emerging practices and 4) system strategies.

Necessary Elements for the Successful Implementation of Training

There are a variety of steps necessary to ensure the successful implementation of training into a new program or treatment practice. Past typical methods have been to offer training and then expect the staff trained in the new methods to go forth and implement. Rarely is this successful. Because of competing demands and expectations, new programs may not be a priority for everyone in the organization. Often, good intentions and verbal support may not be accompanied by practical support. Frequently, line staff, supervisors, and administrative staff are not fully aware nor do they appreciate the extra work required to handle a new program. As well, the sustainability of any new practice or treatment method takes continued support and encouragement over time to integrate the new, required skills and tasks into the operations of the organization. The following briefly outlines what is required for successful implementation.

Begin with Administrative Staff

Top administrative and supervisory support is critical. This is especially true when there are staff role changes, increased demands on time, the need for internal referrals or when supplies and equipment need to be purchased. Educating and obtaining support from key people in the organization greatly helps in the implementation of the project. Therefore, begin by meeting with administrative staff and mid-management staff to elicit their support in the new program. Provide them with information supported by data regarding what the costs and benefits will be to the clients and the organization. Provide an overview of the program goals and outcomes. Define the amounts of time for training and supervision that will be required. Define the general costs financially to the organization as well as emphasizing the possible gains.

Training Opportunities

It is best to create collaboration between mid-management staff and line staff when considering who in the organization will be trained to implement a new program. The collaboration assists an open communication related to the changes in staff responsibilities and roles as well as what resources may be necessary to ensure that line staff has the time to commit to the new program. Current staff skills and abilities need to be considered as well as how the new skills may enhance their competence. These issues need to be delineated prior to any training to diminish potential confusion and frustration. Training should be done in a

time sensitive manner in which the logistics of implementation have been defined and organized so that shortly after the training is completed, the program is actually implemented. Training tends to be most successful when it is skill specific, offering as much "hands on" and practice opportunities to the participants to demonstrate the skills needed. Supporting materials and readings that can be accomplished by staff prior to the formal training also enhances their readiness to learn.

Supervision and Follow-up

Implementation of a new program is more successful when training is followed up with supervision from expert staff that has experience with the program. Supervision should focus on assisting staff in skill acquisition by providing specific recommendations in behavioral terms. The use of video can be a very helpful tool in teaching new skills. Follow-up in the form of "booster" trainings to reinforce learning has also been helpful to anchor the new learning for staff. The sustainability of most new programs is increased with supervisory support of at least 6-9 months.

Consumer and Family Member Feedback

The above is predicated on the idea that a program will not receive training for a strategy or practice that does not resonate with consumer and family values. We believe it is important to actively solicit consumer and family feedback once a new program is running in order to make sure it continues to resonate with their needs and expectations.

Quality Assurance Methods and Approaches

Quality Assurance is a set of methods adopted to insure the highest quality of service delivery across a variety of disciplines, from business to medicine to mental health. In general, it focuses on improving both the process of delivering the service and the outcome of that service delivery.

In mental health, there has been much focus on improving process, especially for the delivery of psychosocial treatments. This has been accomplished by focusing first on training practitioners to deliver a given service competently. This requires specific nuts and bolts training in all the aspects of a treatment. Competence might be assessed by tape-recording or observing actual delivery of the treatment and assessing whether specific components or aspects of it were covered. Next, adherence/fidelity to the treatment over time would be assessed by periodic monitoring to assure that the treatment is being adhered to faithfully. There is a range of comprehensiveness in how meticulously competence and adherence are monitored, with procedures for research studies being far more detailed than procedures for routine clinical care.

A neglected part of quality assurance has been that of outcome. It has been shown that, if outcome is sequentially monitored over time and results are immediately fed back to those delivering treatment, that ongoing process monitoring is unnecessary once training is completed and initial competence is assessed and thought to be satisfactory. This innovative and more importantly easy to implement suggestion should be strongly considered. It only requires a carefully specified outcome or set of outcomes, and a method of easily measuring them over time.

Proposed System Outcomes Measurements

The task group encourages data collection methods that will further the effort to identify practices that are most effective in achieving consumer recovery. This data shall then be utilized to guide system-wide continuous quality improvement. The ultimate goal is to promote those programs and practices that are backed by evidence to be those that are most efficient and efficacious in achieving consumer recovery. To the extent that not all programs work as originally conceived and implemented, it is important to evaluate the actual outcomes of programs so that ineffective programs can be reconsidered and limited resources can be most effectively used. To achieve this goal, the transformation grant EBPEP subcommittee proposes a number of outcomes principles:

Principle #1

The Transformed Mental Health system shall emphasize outcomes data collection that identifies programs and practices that are most efficient and efficacious in achieving recovery for consumers who reside in our communities, including identified subpopulations

Principle #2

Outcomes data collection shall emphasize naturalistic data collection, be trended over time, analyzed with appropriate statistical methods, and compared against realistic and achievable benchmarks. Outcomes shall avoid "status quo" styles of benchmarking such as community standard and previous performance comparisons – and rather emphasize what is possible and achievable.

Principle #3

Outcomes data collection shall emphasize HOLISTIC assessments of service outcomes, including but not necessarily limited to:

- Symptom reduction,
- Family and social role improvement,
- Vocational educational function,
- Reduction in homelessness,
- Increase in independence,
- Decrease in criminal/justice involvement,
- Reduction of voluntary and involuntary hospitalization, and
- Subjective quality of life measures.

Criteria for Selecting Evidence-Based Practices

The following criteria are suggested as starting points in considering adoption of any given practice:

- Level of scientific support,
- Degree of patient centered choice recovery,
- Costs and costs effectiveness,
- Feasibility of the intervention,
- Availability of funding, and
- Ability to monitor and evaluate the effectiveness of the interventions.

Section 3 – Task Group Strategies

The following information contains the list of strategies defined by the Task Groups. The corresponding Federal Goal associated with the strategy is identified in the right hand column.

Fiscal Systems Task Group	1.	Seek to reduce funding silos and increase/expand integration of funding streams, within behavioral health programs and resources as well as across systems. Seek waivers to expand integration.	Goal Intro, 5
	2.	Behavioral Health funding is a scarce resource. Every effort to maximize third party liabilities (Medicare, private insurance, etc) as well as other sources of funding (grants, matching funds, alternative resources) should be made.	Goal Intro
	3.	Service equality should be reflected in the distribution of resources and the reimbursement for services across state. Should be a consistent array of services across regions and populations.	Goal Intro, 3
	4.	Expand availability of early intervention and assessment for all populations.	Goal Intro, 4
	5.	Reimbursement should be outcome based with incentives for adopting evidence-based practices.	Goal Intro, 5
	6.	Consumers and families should have greater responsibility/opportunity to direct services and expenditures.	Goal Intro, 2
	7.	Efforts should be undertaken to reduce or simplify administrative burden for all components of system.	Goal Intro
Cultural Competence Task Group Strategy	1.	Require participation of all mental health employees in an initial and ongoing annual training in cultural	3
	2.	Recruit and hire employees and leaders that reflect the population they are responsible to serve.	3
	3.	Develop and implement a training curriculum for cultural competency in collaboration with institutions of higher education, in particular Schools of Social work and psychology, Public Health, Medicine and Law in order for students and agency personnel to become certified as specialists and future trainers.	3
	4.	Revise WAC or MHD-RSN contract terms to afford opportunities for MH Specialists to be available to contracting agencies.	3

	5. Create roundtables to discuss and review cultural competency issues routinely with RSNs, Tribes, mental health providers, and state agency personnel	3
	6. Provide technical assistance and support to mainstream and specialty MH provider agencies to promote increased capacity to serve special populations, resulting in development of CC teams that will provide ongoing TA.	2, 3
	7. Identify, document, validate implement, and support promising programs and practices that currently exist in the community.	2, 3, 5
	8. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.	2
	9. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide	2, 5
	10. Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.	3
	11. Require outreach workers for diverse communities and cultural competence Specialists to become a part of the treatment team planning.	3
	12. Provide social marketing methods as a means to promote and increase cultural competence awareness.	1, 3
	13. Promote the development of linguistically and culturally specific intake and assessment procedures.	3
	14. Provide certified interpreters for deaf/hard of hearing and for limited to non-speaking consumers and family members that are qualified in mental health settings. Done in compliance and alignment with appropriate federal and/or state laws. Provide mental health,	3
	15. Develop Cultural and Linguistic standards and accountability measures.	3
	16. State and local government service agencies and their contractors and Tribes will be responsible for the achievement of Cultural/Linguistic standards and accountability measures.	3
Evidence-Based/Promising/ Emerging Practices	1. EBPEP 1a. Identify early childhood aggression and implement evidence-based practices around responding to early childhood aggression and conduct problems (e.g.,	5

	the Incredible Years program)	
2.	EBPEP 1b. Work with the schools to increase early identification of emerging aggression, conduct problems, and delinquency and implement evidence-based interventions (e.g., MST, FFT; see Appendix A for examples)	5
3.	EBPEP 1c. Establish treatment courts and court-based-interventions for youth and parents/caregivers with MH or SA disorders resulting in child abuse or neglect. (e.g. Family Treatment/ Dependency Court, or the Miami-Dade Infant Mental Health Court)	5
4.	EBPEP 1d. Establish treatment courts and court-based interventions for adult offenders with mental illness.	5
5.	EBPEP 1e. Jointly Establish procedures and policies for identifying youth who are appropriate for diversion	5
6.	EBPEP 1f. Institute and evaluate diversion mechanisms at every key decision-making point within the JJ continuum (see attachment for sample programs)	5
7.	EBPEP 1g. Provide Crisis Intervention Training to Police Officers	5
8.	EBPEP 2a. Develop mechanism for supporting relationship development maintenance between incarcerated parents and their children (e.g., TAMAR's children model)	5
9.	EBPEP 2b. Adopt a comprehensive collaborative MH-juvenile justice strategy for intervening at critical points in juvenile justice processing (initial contact, intake, detention, judicial processing, placement, probation, aftercare)	5
10.	EBPEP 2c. Perform MH screening and assessment routinely as youths move from point to point in the JJ system.	5
11.	EBPEP 2d. Provide evidence-based treatment models while within the JJ system (see Appendix B for sample programs)	5
12.	EBPEP 3a. Arrange for continued access to evidence-based care upon release including models such as Multi Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions. (See attachment A for model aftercare programs).	5
13.	EBPEP 4a. Utilize models incorporating aspects of	4

cognitive behavioral therapy and Motivational Enhancement Therapy for integrated treatment for co-occurring mental health and substance abuse disorders.	
14. EBPEP 4b. Utilize contingency management strategies to support recovery.	4
15. EBPEP 4c. Utilize integrated group therapy.	4
16. EBPEP 5a. Treatment for parents in particular should incorporate trauma treatment into substance treatment approaches.	4,5
17. EBPEP 5b. Screening and treatment should deliberately inquire into if clients are parenting and how these challenges impact their parenting and family relationships.	5
18. EBPEP 5c. Implement Crisis Intervention Team (CIT) model for law enforcement officials	4
19. EBPEP 5d. Use peer support models such as dual recovery, double trouble.	2, 4
20. EBPEP 6a. Integrate systematic screening for mental health and substance use.	4
21. EBPEP 6b. Co-treatment oriented courts (such as Family Treatment Court, Drug Court, Mental Health Court)	4
22. EBPEP 8a. Mobilize Youth Empowerment and Engagement curricula (examples MOVE, TARGET-T)	2
23. EBPEP 8b. Identify and mobilize mentors, navigators, peer advocates and other supports for family members, youth and young adults	2
24. EBPEP 8c. Wraparound (specified model with quality monitoring)	5
25. EBPEP 8d. Consistent statewide mechanism to ensure that the philosophy/value of family and youth involvement is taught in certification, university, and other training programs	2
26. EBPEP 8e. Develop a mechanism to ensure funds are available to support family and youth participation in the planning, implementation, evaluation, and policy of programs and practices (i.e., stipends, transportation, childcare, etc.)	2,5
27. EBPEP 9a. Use Life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T)	5

28. EBPEP 9b. Use navigators and peer advocates 5
29. EBPEP 9c. Integrate centers for health, mental health and life skills support (example school health clinics) 1, 5
30. EBPEP 9d. Use Transition centers 5
31. EBPEP 9e. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade 5
32. EBPEP 9f. Use Empowerment and Engagement curricula (examples MOVE, TARGET-T) 2, 5
33. EBPEP 9g. Use social marketing campaigns aimed at reducing stigma (example - Speak Up When You're Down is a social marketing campaign around normalizing PPD responses and reducing stigma already funded by the WA State Legislature) 1
34. EBPEP: 10a. Develop institutionalized consumer advisory boards. 5
35. EBPEP 11a. Develop institutionalized consumer advisory boards. 5
36. EBPEP 12a. MHD will pilot 2 Self-Directed Care Programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model (please see above narrative for #12 regarding specifics of SDC model). 5
    - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans
    - Consumers in this program will be eligible to purchase services for the purpose of accessing:
    - Clinical Recovery Services
        - Psychological Assessment
        - Medical Services(Psychiatric Evaluation, Medication Management)
        - PACT
        - Individual and Group Therapy provided by a licensed mental health professional
        - Supported Employment
    - Recovery Support Services(services that are alternative to traditional mental health services) such as:
        - Massage Therapy as a form of touch therapy to assist an individual overcome issues

documented by a licensed mental health professional
    - Forms of Art Therapy
    - Smoking cessation activities Occupational, speech, and physical therapy when recommended by a licensed mental health professional
    - Services related to developing employability and/or productivity that will lead to employability
  - Recovery Enhancements (tangible items for consumption that relate to employment or other productivity such as volunteer work or training/education)
    - Transportation
    - Non-cosmetic dental work
    - Hearing Aids
    - Non-cosmetic eye glasses and non-disposable contacts
    - Hair Cuts from a professional
    - Facial cosmetic and make-up products for the purposes of camouflaging medical conditions, such as facial scars, burns, etc., and for the purposes of seeking or participating in employment and/or other meaningful activities
    - Tutoring
    - Face-to face and distance learning educational classes
    - The initial costs of pet ownership(a maintenance plan must be submitted with action plan that details the ability to have the pet in the current place of residence, food and health upkeep, and care for the animal in the event of the individual's absence
    - Time-limited assistance to secure or maintain a more independent living arrangement(a maintenance plan must be submitted with action plan that details long-term financial ability to maintain the living arrangement)
    - Time-limited assistance with vehicle repair for purposes of employment and/or transportation to access Clinical Recovery Services
    - Entertainment items(i.e., movie tickets) and restaurant dinners if recommended by a licensed mental health professional

- Consumers will be provided comprehensive informational supports about medication assistance, treatment options, and potential providers.
- Consumers will be required to complete their own L Analysis, which takes the place of a professional generated Treatment Plan. The Life Analysis identifies recovery goals, and what is needed to accomplish those goals.
- Consumers will be encouraged to complete an Advance Directive; Relapse Prevention Plan; Crisis Plan; Personal Safety Plan; and Post Crisis Plan. The goal is for participants to take control of their own lives, and not be controlled by their illness, circumstances, or others.

37. EBPEP 13a. Fund the development of a minimum of one independent Consumer-run Drop-In/Resource Center in each RSN 2

    - These resource centers will serve as each area's umbrella organization, where trained peer counselors will assist individuals in the recovery process, including goal setting, warmlines, developing mutual self-help groups, teaching problem-solving skills, providing vocational assistance, and developing plans for symptom management using the Wellness Recovery Action Plan (WRAP) model.

38. EBPEP 13b. Fund the development of a minimum of two Recovery Education Centers, to be run by consumers, one in Eastern Washington and one in Western Washington. 2

    - These centers will serve as the state's technical assistance centers offering TA around consumer run services; principles of recovery.

39. EBPEP 13c. Fund the development of a minimum of one Clubhouse Model psychiatric rehabilitation program in each RSN based on the Fountain House Model. 2

    - Free-standing Clubhouse programs should be allowed to become one version of a "consumer-run entity."
    - The definition of a clubhouse should be the definition of a clubhouse program as articulated by the International Center for Clubhouse Development (ICCD).

- Clubhouse programs in the State of Washington should be required to be certified by the ICCD.
- Clubhouses should be funded in such a manner that makes it possible for the program to operate in complete fidelity to an ICCD defined clubhouse.
- Clubhouse funding must be flexible enough to ensure that clubhouse services are consumer-directed, and that the clubhouse's overarching focus is vocational rehabilitation and job and educational placement.
- Clubhouses are not clinical programs – admission criteria and service planning is not based on diagnosis, level of functioning or medical necessity. Clubhouses are adjunctive to clinical services and focus on people's strengths.

40. EBPEP 13d. Expand Personal Assistance Services (PAS) for people with psychiatric disabilities. PAS is a method which already has a long and successful track record for serving people with disabilities in a self-determined manner, and for which Medicaid funding is already available.	2
41. EBPEP 14a. Use 4 year and 2 year colleges to train professionals and para-professionals in psychiatric rehabilitation.	5
42. EBPEP 14b. Encourage reinstatement of psychiatric rehabilitation programs at WSU and in the EWU Social Work departments and in additional undergraduate schools	5
43. EBPEP 14c. Develop certificate and AA programs at community colleges in alignment with USPRA program requirements	5
44. EBPEP 14d. Establish a Recovery Education Center School which would be licensed by the State of Washington degree in behavioral health recovery	5
45. EBPEP 14e. Establish Recovery Schools as a post-secondary educational institution.	5
46. EBPEP 16a. Use Individual placement and support (IPS)	4, 8
47. EBPEP 16b. Use Assertive community treatment with employment component (ACT)	8
48. EBPEP 16c Provide supported employment (SE) and Clubhouse-based Transitional Employment (TE).	8

49. EBPEP 16d. Use peer support (PS), WRAP, Club House, and supported education as a way to maintain recovery and retain employment.	8
50. EBPEP 16e. Provide support for consumer-owned and operated businesses	8
51. EBPEP 16f. Cross train VR staff and clinical and vocational mental health staff to increase integration and communication.	8
52. EBPEP 17a.Use Depression Care Management (e.g. IMPACT, PROSPECT)	5
53. EBPEP 17b. Implement Gatekeeper programs	4
54. EBPEP 17c. Use the Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)	4
55. EBPEP 17d. Geriatric Regional Assessment Team (GRAT)	4
56. EBPEP 17e. Case Management	4
57. EBPEP 18a. Depression Care Management (e.g. IMPACT, PROSPECT)	5
58. EBPEP 18b. Include inquiry into provision of care giving to children.	5
59. EBPEP 19a. Continue Geriatric Mental Health Specialty Training	5
60. EBPEP 19b. Provide Co-occurring disorders training	5
61. EBPEP 20a. Elder Wrap Around	4
62. EBPEP 20b. Expanded Community Services (ECS)	4
63. EBPEP 21a. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples –Youth Care Model, Mockingbird Family Model programs)	5, 7
64. EBPEP 21b. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.	5, 7

65. EBPEP 21c. Establish some transitional housing options to provide for overflow need.	5, 7
66. EBPEP 22a. Implement a consistent statewide approach to ensuring that family mental health supports are available for all family members (Birth on up) during both periods of homelessness and transition.	5
67. EBPEP 22b. Use Multi-disciplinary teams including mental health and chemical dependency specialists, RN/ARNP, case managers, and peer supports are available at drop in centers and shelters to provide assessment, services and supports	5
68. EBPEP 22c. Make available Medical Respite for youth and young adults	5
69. EBPEP 22d. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued	5
70. EBPEP 22e. Implement PACT teams	5
71. EBPEP 22f. Establish a medication initiation and maintenance service that can be quickly and easily accessed by people without Medicaid or those with Medicaid who have not been able to get enrolled in community mental health services.	5
72. EBPEP 22g. Create an ample supply of outreach and engagement teams aimed at identifying, engaging and stabilizing homeless persons with mental disorders	5
73. EBPEP 24a. Undertake a comprehensive, cross-system financing strategy for child, youth, and family mental health that aims to maximize federal entitlements, increase flexibility, and fit state-only funds to state and local needs.	5
74. EBPEP 24b. Collaborate with Insurance Commissioner around options for ensuring EBTs are reimbursable through private insurance plans.	5
75. EBPEP 24c. Programs working effectively with immigrant families (regardless of legal status) with young children – See examples in Appendix D.	3
76. EBPEP 25a. Develop a state-wide Youth and Family Engagement Academy to mobilize funding, develop training, and match family and/or youth involvement models to community needs (See Appendix C for example family support models)	5

77. EBPEP 25b. Designate funding specifically to create/support/ maintain Family and Youth Organizations and support programs — 2

78. EBPEP 25c. Review statutory & administrative constraints to funding/reimbursement of parent/ youth partners and minimize barriers — 2

79. EBPEP 26a. Create a statewide Mental Health Technical Assistance, Training and Resource Center that is modeled off of the national technical assistance centers. — 4

80. EBPEP 26b. Ensure that a specific component of the statewide training and TA center is directed at education for Primary Health Care Providers (PHCP) — 4

81. EBPEP 26c. Implement a statewide approach to supporting school staff to help stabilize children and youth experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports (PBIS). — 4, 5

82. EBPEP 27a. Create an Evidence-Consensus Based/Promising/Emerging Practice (EBPEP) Institute to provide mechanisms to — 5

    (A) oversight and direction toward the implementation of EBPs including consumers, parents, and youth;

    (B) review, monitor, and disseminate information on evidence-based practices and current research;

    (C) assisting communities to identify local needs, select evidence-based approaches and provide technical assistance for implementation; and

    (D) evaluate and maintain strategies including evaluating current and new practices and monitoring for fidelity, outcomes

83. EBPEP 27b. Ensure that promising family-centered processes and support services voiced as needs by communities that are not focal treatments (e.g., Youth and Family Supports/Parent Partners, including parent organizations, support organizations, peer support, parent partners, Mentoring, Respite Care services, the Wraparound process, Day treatment programs) are supported and included as options for communities — 2

84. EBPEP 27c. Restructure the Access to Care Standards to ensure treatment can easily be provided: — 4

    - in a non-clinic setting (home, childcare center)

- to caregiver-child dyads and other family constellations
- for disordered relationships even without a presenting primary diagnosis in the adult or child
- for caregivers with mild to moderate mental health challenges with a specific focus on mitigating the impact of their mental health challenges on parenting
- for children at-risk of developing severe emotional-behavioral disorders
- for children exposed to trauma or violence regardless of presenting diagnosis
- for drug-exposed infants and their caregivers regardless of presenting diagnosis

85. EBPEP 27d. Specifically address provision of appropriate infant, toddler and early childhood mental health services 4

    - Statewide adoption of the DC:0-3R for children Birth through 5 years of age.
    - B. Provision of appropriate relationship-based services when possible and appropriate (see Appendix C – 4 for examples).

APPENDIX 4 Community Transformation Partnership Membership

COMMUNITY TRANSFORMATION PARTNERSHIP (CTP) MEMBERSHIP

(as of 7-17-06)

Name	**Organization**
Anderson, Karen	PAVE –Parents are Vital in Education
Buchanan, Ardith	Youth 'N Action! (youth alternate)
Butts, Joe	PAVE
Devries, Jocie	FASE/PAVE
Dickerson, Curtis	Youth 'N Action!
Fentress, La Dale	A Common Voice/SAFE-WA
Freidmund, JoAnne	MPAC Mental Health Advisory and Planning Committee
Glover, Carolyn	Pierce Co Ombuds
Hutchins, Trova	Thurston Mason QRT
Jaussaud, Fay	SAFE-WA – State-wide Action for Family Empowerment
Jemelka, Ron	Transformation Grant
Johnson, Tamara	Youth 'N Action!
Jose, Frank	NAMI Greater Seattle
Lane, Stephanie	Transformation Grant
Lord, David	WA Protection and Advocacy System
Owen, Eleanor	MHPAC/NAMI-WA
Perry, Monique	TWG (youth alternate)
Petershchick, Erin	MHTP (alternate staff liaison to CTP)
Stark, Ken	Transformation Grant
Teeter, Laurie	TACID
Thurston, Clifford	New Century Coalition
Waters, Bill	Rose House

APPENDIX 5 Mental Health Transformation Project Prevention Advisory Group Members

Mental Health Transformation Project
Prevention Advisory Group Members

Kathy Barnard	Center on Infant Mental Health & Development, School of Nursing, University of Washington
Walt Bowen	Infant Toddler Early Intervention Program, Department of Early Learning
Kathleen Boyle	Citizen
David Brenna	Mental Health Transformation Project
David Brown	Citizen
Rico Catalano	Social Development Research Group, School of Social Work, University of Washington
TJ Cosgrove	Public Health - Seattle & King County
Victoria Crescenzi	Naval Hospital Bremerton
David Crump	Spokane School District
Sharon Doyle	Human Services Policy Center, Evans School of Public Affairs, University of Washington
Joann Freimund	Mental Health Planning and Advisory Committee
David Hawkins	Social Development Research Group, School of Social Work, University of Washington
Tory Henderson	Department of Health & Washington Council for the Prevention of Child Abuse and Neglect
Sheri L. Hill	Center on Infant Mental Health & Development, School of Nursing, University of Washington
Ron Jemelka	Mental Health Transformation Project
Lonnie Johns-Brown	Washington Coalition of Sexual Assault Programs, Washington Society for Clinical Social Work, Washington Association for the Education of Young Children
Doug Johnson	Greater Columbia Behavioral Health, Mental Health Planning and Advisory Council
Mickey Kander	Department of Health
Rebecca Kelly	Juvenile Rehabilitation Administration
Mike Krebs	Citizen
Michael Langer	Division of Alcohol and Substance Abuse
Laurie Lippold	Children's Home Society of Washington
Sandy Loerch Morris	Infant Toddler Early Intervention Program, Department of Early Learning
Sabina Low Sadberry	Center for Children
Robin McIlvaine	Mental Health Division
Craig McLaughlin	State Board of Health
Steve Norsen	Mental Health Division
Daisye Orr	Department of Health, Office of Health Promotion
Jennifer Pariseau	Citizen
Erin Peterschick	Mental Health Transformation Project
Laura Porter	Family Policy Council
Barb Putnam	Children's Administration
Deborah Ruggles	Department of Health
Jill Sells, MD	Docs For Tots Washington State
Cheryl Strange	Division of Developmental Disability
Bronwyn Vincent	Mental Health Division

APPENDIX 6 MHTP EVALUATION TEAM AND TASK GROUP MEMBERS

Members of the MHTP Evaluation Team and Task Group

Here is a short story and comments that a Washington State consumer recently shared with us:

> *You've probably heard the story about the drunken man who lost his wallet and was discovered by a passerby searching for it under a light post.*
>
> *'Are you sure this is where you dropped it?" asked the passerby.*
>
> *'Oh, no mate', replied the drunk, 'I dropped it in the gutter, but I can see much better over here.'*
>
> *I suspect that sometimes mental health researchers are a little like this misguided man. However, instead of a wallet, they have misplaced something called 'the right questions' and 'relevant research'. Unlike the drunken man, they do not know they are focusing their search in the wrong area.*
>
> *However, just as the inebriated man would be aided by a torch, the researchers would benefit from the illumination that could be provided by working in partnership with consumers with lived experience of a mental disorder.*

It is in this spirit that the following individuals are working to ensure that our evaluation efforts are consistent with Transformation goals. The list does not indicate who are researchers and who are consumers; we are learning be partners in this process.

Beverly Miller
Cindy Willey
Dario Longhi
Debra Flanagan
Dennis McBride
Eric Bruns
Erin Peterschick
Faye Jaussaud
Gary Cuddeback
James Mead
Jeanette Barnes
Jill San Jule
Joe Morrissey
Judy Hall
Karen Laughlin
Katie Weaver-Randall
Liz Kohlenberg
Ron Jemelka
Ryan Oelrich
Sandy Gregoire
Trova Hutchins