Washington State

Systems of Care Expansion Planning Grant Strategic Plan

Grant Number: SM60634

October 1, 2011 - September 28, 2012

Division of Behavioral Health and Recovery
Department of Social and Health Services

Table of Contents

Acknowledgments

The Washington State Systems of Care (SOC) Strategic Plan was the result of family, youth and system partner efforts to infuse SOC values in all systems for children, youth and families. The individual, institutional, and system wide SOC commitment and efforts are represented in the plan detailed in this document. The success achieved thus far was possible through the efforts of SOC contributors, technical support specialists, and reviewers. THANK YOU!

Contributors
Tamara Johnson, SOC Youth Lead, Youth 'N Action
Jeanette Barnes, SOC Family Lead, Division of Behavioral Health and Recovery (DBHR)
Tina Burrell, Chemical Dependency, DBHR
Christie Seligman, Division of Developmental Disabilities, DBHR
Barb Putnam, Children's Administration (CA)
Dan Schaub, Juvenile Rehabilitation Administration (JRA)
Ron Hertel, Office of Superintendent of Public Instruction (OSPI)
Sarah Butzine, OSPI
Maria Nardella, Department of Health (DOH)
Carol Miller, DOH
Eric Bruns, University of Washington
Lin Payton, Children's Mental Health DBHR
Mark Nelson, Children's Mental Health DBHR
Rebecca Kelly, Children's Mental Health DBHR
Jeannie D'Amato, DBHR
Andrea Parish, SOC Project Director
Kathy Smith-DiJulio, SOC Research Manager
Margarita Mendoza de Sugiyama, SOC Project Manager
Alice Huber, SOC Principle Investigator
Regional FYSPRT Leaders
Family and Youth Organizations
Washington Eastside & Westside Lessons Leaned Leads and participants
SOC Workforce Development Work Groups Leads and participants

Technical Support
Sybil Goldman, Washington State SOC Coach
National Technical Assistance Center for Children's Mental Health, Georgetown University
Pedro Garcia, DBHR
Beverly Smith, DBHR
Keri Waterland, Aging and Disability Services Administration (ADSA)
Denise Gaither, ADSA
Bill Baney, Portland State University (PSU)
Dan Embree, PSU

Reviewers
Statewide Family, Youth & System Partners Round Table (FYSPRT)
Division of Behavioral Health and Recovery (DBHR)
Chris Imhoff, DBHR Director
Michael Paulson, Behavioral Health and Managed Care Chief
Rebecca Kelly, Children's Mental Health Supervisor

Strategic Plan Overview

Vision:
The Washington State System of Care Project will expand systems of care statewide with family-driven, youth-guided core values fully integrated in all parts of the SOC Governance Structure , the Statewide Family, Youth and System Partners Round Table (FYSPRT), that reviews and approves infrastructure for state-level funding, policy, program and practice changes. The SOC expansion will focus primarily on youth ages 13-18 with serious emotional disturbances (SED), out-of-home placement, and/or juvenile justice/child welfare histories.

Goals:
1. Infuse SOC values in all systems for children, youth and families
2. Ensure services are seamless for children and youth who are the population of focus
3. Build access and availability of home and community based services
4. Develop and strengthen workforce that operationalizes SOC values
5. Build strong data management systems to inform decision making and ensure outcomes

Matrix and Timeline:
The Matrix and Timeline provide a comprehensive overview of the SOC project goals and selected strategies, actions and timeframes for this work over the next 4 years. The detailed information is located in the Matrix and Timeline section of this document. Numerous documents as well as individual experiences and perseverance have informed this matrix. There are also many stories and supporting documents that provide the context and detail for this matrix.

Social Marketing Plan:
The Washington State Social Marketing Plan helps to implement the Vision and Mission: to expand systems of care statewide grounded in Family-Driven and Youth-Guided core values, and a Program Goal: to Infuse SOC values in all systems for children, youth and families. The annual Social Marketing Goals developed to move forward on implementation are:
(2012) Communication Plan for Decision Making Process
(2013) What's In It For Me? The benefit when families and youth are full partners in the process
(2014) Raising Awareness of Children's Mental Health from Local to State Level
(2015) Continue Full Engagement with Youth, Family & Community Partners in All Activities
(2016) Families and Youth are Full Partners in All Decision Making Processes and Activities.
The plan is detailed in the Social Marketing Plan section of this document.

Children's Mental Health Redesign:
At the same time the SOC plan was being developed, a consultant was hired by DBHR to develop a Children's Mental Health Redesign Plan. This plan is currently out to stakeholders for feedback. During the feedback process, it was decided the SOC plan would be the foundation plan for Washington State for children's mental health. Elements of the redesign plan are included in the SOC plan.

A detailed description and two diagrams that illustrate the Children's Mental Health Redesign Governance Integration Model provide an overview of the scope of the planning effort and the integration of the planning effort into a single, System of Care-based effort which are located in the Children's Mental Health Redesign section of this document.

Governance Structure:
The System of Care Project diagram illustrates the statewide leadership structure. Membership will expand as Regional Family, Youth, and System Partners Round Table FYSPRT events are held and a family, youth and system partner are selected as representatives to the Statewide Family, Youth & System Partners Round Table (FYSPRT) Leadership Team. Also, a revision from four to five Work Groups was made to accurately reflect significant SOC work activity. As the Work Groups are organized and increase their activities, additional family, youth and system partners are brought into the governing structure from their respective Regional FYSPRT areas.

The five Work Groups include: Policy & Practice, Finance, Cross System Initiative Team, Workforce Development, and Data/ Evaluation & Quality Assurance. The FYSPRTs and work groups were asked to develop a charter and logic model for their respective groups which are included in the SOC Infrastructure Organizing Documents section of this document. As SOC Work Groups complete phases of their respective activities a report-out to the Statewide FYSPRT Leadership Team takes place. It is anticipated that initial work for all the work groups will be completed in the SOC 4th Quarter reporting period. Regular status meetings are taking place between SOC Grant system partners with their respective executives; however, the Systems of Care Executive Team is in the process of being reconstituted because of executive staff turnover.

Cultural Competency:
Two significant cultural competency policies are now in force in the State of Washington. These policies impact all governmental agencies and services provided to citizens as directed by the Washington State Governor and the Secretary of the Washington State Department of Social and Health Services.

In August 2010 the Department of Social and Health Services began a process to develop a Cultural Competency Administrative Policy (No.7.22) and develop Guidelines to support each administration in the development of action plans for delivering DSHS services in a culturally competent manner. The policy and guidelines were finalized in June 2012. The Cultural Competency policy, key principles, and guidelines are included in the Appendix of this report.

"The Washington State Department of Social and Health Services (DSHS) is committed to creating and maintaining an environment that supports "Cultural Competence" by promoting respect and understanding of diverse cultures, social groups, and individuals. To achieve that commitment we develop and maintain a high performing workforce who provides meaningful service access that improves outcomes for all clients. We deliver culturally responsive services and our workforce reflects the diversity of the communities we serve. Each DSHS administration ensures Cultural Competency is integrated into the overall organizational culture and ongoing business". (Cultural Competency Guidelines –Effective September 16, 2011)

A Cultural Competency Work Group comprised of representatives from all DSHS Administrations met to develop Goals & Objectives for the agency's Cultural Competency Training and to draft an agency Cultural Competence Key Principles document for inclusion in all agency workforce training.

In June 2012 the Governor signed a Workforce Diversity and Inclusion Executive Order that directs all cabinet agencies, boards and commissions, and other agencies that report to the Governor responsiblity to develop and maintain a high performing workforce that improves outcomes for customers, delivers culturally responsive services, and reflects the diversity of the communities it serves.

SOC Integration into Mental Health Inpatient Care:
Several initiatives are underway to integrate SOC values into Washington's mental health inpatient program systems for youth, and to implement specific steps to link this important resource more fully to statewide SOC efforts.

- Children's Long Term Inpatient Program (CLIP) Improvement Team: The CLIP, Washington's 91 bed mental health inpatient system comprised of the 3 child units of the State Hospital and 3 contracted Psychiatric Residential Treatment Facilities. The CLIP Improvement Team is a joint effort of CLIP program managers, state and regional children's mental health coordinators, and parents on our CLIP Parent Steering Committee. This group for the past 20 months has focused on common concerns related to the admission process, discharge planning, family inclusion, implementation of components of the national "Building Bridges" initiative, transition to the community, and reduction in length of stay. Agreed recommendations are currently in the implementation phase. Youth voice has recently been added to this effort.
- CLIP Parent Steering Committee: This committee is composed of experienced parent partners whose youth have received treatment in our CLIP programs, members of CLIP administration and DBHR parent support staff, and active parent partner staff members of CLIP programs. This group provides ongoing technical assistance to CLIP programs and working parent advocates, and two weekend training events yearly for parents whose youth are in treatment. These parents are an invaluable resource in infusing SOC values in our most intensive and secure psychiatric care.
- Parent Initiated Treatment: DBHR and CLIP Administration have worked with our acute care hospital systems and statewide emergency rooms to more fully implement access to inpatient care for youth unwilling or unable to consent. Implementation of a recent law to inform parents fully of their treatment options is providing a more complete array of choices for youth in crisis.
- Roads to Community Living: In collaboration with our Home and Community Services section of our administration, we have added our CLIP and state hospital Medicaid populations to Washington's Money Follows the Person demonstration waiver. This initiative is a pioneering effort to apply the federal MFP program to assist in discharging youth (0 to 21) from our CLIP and state hospital programs.
- Multi-Dimensional Treatment Foster Care: DBHR continues to support our evidence-based treatment foster care pilot as an alternative to institutional care for youth disrupting from home and community family placements.

- Children's Acute Inpatient Care: DBHR is beginning a project to connect Washington's 3 children's psychiatric hospitals and 2 acute children's Evaluation and Treatment facilities more fully into our System of Care activities. Initial efforts include assistance in establishing parent partners in one of Seattle's acute hospital programs.
- Parents and Youth on review teams: DBHR has previously intermittently included parent advocates on Inspection of Care activities in our CLIP Programs. This current initiative will explore a more consistent and stable design for including youth and parent partners in our inpatient program reviews and funding support to include parents and youth peers as part of regulatory inspections in CLIP programs.

Legislation:

There are several specific pieces of Washington State legislation that are driving some of the changes in Children's Mental Health as well as for our system partners:

2SHB 1088 - Establish a process for monitoring cross-system success in addressing the mental health needs of children in Washington State. Meet the legislative intent of 2SHB1088 (passed 2007). Establish an ongoing method for evaluating success of Children's MH Redesign/system improvements.

In consultation with parents, caregivers, youth, Regional Support Networks, mental health services providers, health plans, primary care providers, tribes, and others, shall develop an outcome-based performance measurement system, including measures such as:

- Decreased emergency room utilization;
- Decreased psychiatric hospitalization;
- Lessening of symptoms, as measured by commonly used assessment tools;
- Decreased out-of-home placement, including residential, group, and foster care, and increased stability of such placements, when necessary;
- Decreased runaways from home or residential placements;
- Decreased rates of chemical dependency;
- Decreased involvement with the juvenile justice system;
- Improved school attendance and performance;
- Reductions in school or child care suspensions or expulsions;
- Reductions in use of prescribed medication where cognitive behavioral therapies are indicated;
- Improved rates of high school graduation and employment

Recently passed legislation:

E2SHB 2264 - Concerning performance-based contracting related to child welfare services. The legislature is supporting public child welfare in the development of performance based contracts which will refocus services and payments on positive outcomes for this vulnerable population.

E2SHB 2536 - Concerning the use of evidence-based practices for the delivery of services to children and juveniles. The bill builds on the past successes of using evidence-based practices in juvenile justice by applying similar practices to child welfare and children's mental health. The legislation also requires outreach to ethnic communities to identify promising programs that serve children of color that through state provided technical assistance to service providers, there is an opportunity to transition promising programs to evidence-based practices.

SSB 5459 - Relating to transition services for people with 2 developmental disabilities. The "RHC bill" prohibits persons under age 16 from admission to a RHC and allows short term crisis or respite admissions only for persons between age 16 and age 21. This bill designates the closure of Frances Haddon Morgan Center (FHMC) by December 31, 2011 and requires a person-centered approach to be used to transition residents out of the institution. It freezes admissions to Yakima Valley School (YVS) except for limited, short-term admissions for crisis and respite. When the resident population at YVS reaches 16 individuals, the institution may cease to exist as an RHC. It calls for a legislative task force to study the future of RHCs and make recommendations for efficient consolidation of institutional capacity and provide strategies for reframing the mission of YVS. The bill also invested in establishing three new types of community based services to be conducted by state employees. It expanded state operated living alternatives (residential supported living), created a new state service of crisis stabilization services for both children and adults, community clinical treatment teams that are available to assist with prevention and intervention services and enhanced respite, especially for children with complex needs.

The intention of the overview is to provide the contextual view for the following document. The SOC Strategic Plan has multiple components representing the work being done and a comprehensive and actionable plan based on SOC values that will guide us as we bring this plan to life in Washington State. The components of this plan as identified above comprise the major indicators that will continue to evolve and interact in a manner based on future demands and realities through a regional and state infrastructure that will remain accountable to SOC values and principles and the goals of the Washington State Systemsl of Care Plan.

Matrix and Timeline

Washington State
System of Care Expansion Planning Grant
Goals and Strategies Matrix/Timeline

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
1. Infuse SOC values in all systems for children, youth and families									
A governance structure established and put in policy based on SOC values that provides a process for local and regional state level decision making, with families, youth and system partners in leadership and decision making roles with state leaders	X				X	X	X	X	X
• Develop and maintain cross system, high level governance structure inclusive of executive leadership, family, youth, and other system leaders	X	X		X	X	X	X	X	X
• Develop and maintain: Finance, Cross System Initiatives, Workforce Development, Data Evaluation & Quality, and Governance workgroups associated W/Statewide and Regional FYSPRTs	X		X		X	X	X	X	X
• Financing strategy developed for projected increase utilization of intensive services based on improved screening		X	X	X		X			
• Aligning funding sources to strengthen interagency collaboration, improved long-term outcomes, and establish systems to develop funding mechanisms for youth and families involved in intensive cross system services		X	X			X			
• Certification for limited scope agencies	X	X			X	X	X		
SOC Values and Principles infused in all contract language	X	X			X	X	X	X	X
Establish SOC website linked to Children's Mental Health Division of Behavioral Health and Recovery Website and other family youth and system partners websites		X			X	X			
Support statewide and agency efforts to implement the Governor's Workforce Diversity and Inclusion Executive Order and DSHS Cultural Competence Policy and Key Principles	X			X	X	X	X	X	X
• Coordinate with tribal-centric planning and implementation efforts	X	X	X	X	X	X			
• Implement DSHS Administrations Cultural Competence Action Plans		X		X	X	X	X		
• Develop Cultural Competence Key Principles marketing plan		X		X	X	X			

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
• Implement SHB 2536 outreach to ethnic communities to identify promising metal health service programs		X	X	X	X	X			
Implement Children's Mental Health core practices (Wraparound)		X	X	X		X	X	X	X
CLIP Parent Steering Committee sponsors training and system technical assistance improvements for parents of youth in CLIP		X	X	X	X	X	X	X	X
Foster a statewide understanding of the value of family and youth peer-to-peer support partners, as well as family and youth advocacy organizations		X	X	X	X	X	X	X	X
Support and Expand the existing youth advocacy groups such as (Youth 'N Action) that are operating statewide		X	X		X	X	X	X	X
Coordinated School Health Team at OSPI will promote mental health inclusion in school wellness policies and health related goals in school improvement planning	X	X		X	X	X			
RSN Contract to support SOC values in service delivery	X	X			X	X	X	X	X
Screening and assessment for Intensive Services • Educate community and cross system partners in functional indicators that suggest a possible need for intensive mental health services.		X	X	X		X	X		
• Develop cross system protocols for referral, screening and assessment of youth possibly in need of intensive services.	X	X			X	X			
• CANS development for screening and assessment		X	X	X		X	X		
• CANS algorithm to inform need for intensive mental health services		X		X		X	X		
• Develop quality and accountability plan		X			X	X	X	X	X
Increase cross system planning to reduce duplication and increase integration of trauma and adverse childhood experiences (ACEs) training's and interventions		X		X	X	X			
Expand and support the development of local and regional Family, Youth and System Partner Roundtable (FYSPRT)		X			X	X	X	X	X
• Develop a SOC Community Learning Collaborative that supports and enriches family education and development		X	X	X		X	X		
• Work with regional and local FYSPRT's to leverage local funding such as Treatment Sales Tax and redirect resources to meet the needs of children, youth and families			X			X	X	X	X
Coordinate efforts with Medicaid providers and health plans to expand SOC philosophy and practice		X		X	X	X	X	X	X
• Increase service provision for consumer operated services that are Medicaid reimbursable	X	X	X	X	X	X	X	X	X
Provide training/education to leadership and staff from system partner and other child serving agencies on SOC		X		X	X	X	X	X	X

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
values									
2. Ensure services are seamless for children and youth and their families									
Develop Cross system agreements across DSHS and HCA to address care coordination	X				X	X			
Development of Child & Family Teams for coordinated care planning in a family driven and youth guided manner		X	X	X	X	X	X		
Build a framework of policy, funding and practice standards that remove barriers to services and supports			X		X	X	X	X	X
• Explore re-alignment of future state block grant, Medicaid and other fund sources to support the short-term and long-term strategic plan	X	X	X	X	X	X	X	X	X
• Information about current legislation effecting system partners that supports SOC values		X	X		X	X			
• Establish SOC as the mainstream delivery system to serve youth and their families	X	X			X	X	X	X	X
• Inform discussions regarding state plan modalities to ensure the EBPs, wraparound and intensive services are Medicaid "match able"	X	X	X	X	X	X			
• Examine alternative waiver strategies to develop a differential mental health benefit package for children co served by Children's Administration (CA)		X	X		X	X			
• Develop and maintain a cross system finance workgroup of the State wide FYSPRT with high level finance individuals from identified system partners	X	X	X	X	X	X	X	X	X
• Develop and implement MMIS changes that support SOC		X	X	X	X	X			
• DOH promotes inclusion of behavioral health into Health Home		X		X		X	X	X	X
• Develop multiple funding sources for Wraparound		X	X	X		X	X		
• Present *Measures of Statewide Performance for Children's Mental Health* to key legislators		X		X		X	X		
Implement Parent Initiated Treatment law to ensure parents are fully informed of psychiatric treatment options	X	X		X		X	X	X	X
Roads to Community Living program (money follows the person) provides funding RSN state share of RCL waiver, targeting youth in CLIP programs transitioning to home or family like settings			X	X		X	X	X	X
Children's Acute Inpatient Project will connect our 5 acute units to statewide system of care activities and improve care transitions and supports.	X	X					X	X	

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
Create cross system agreements related to education (accountable to the state level agreements)at the local and regional level that support SOC service delivery									
• Connecting with counselors and principals is key for successful SOC educator engagement		X		X		X	X	X	X
• Ensure IEP is current							X	X	
• Explore service co-location		X	X		X	X	X		
Families and youth partner with champion system representatives to educate and demonstrate the value of youth and families as equitable partners in the development, design and delivery of services and supports.	X	X					X	X	X
• Develop self-advocacy & system navigation training to be delivered through regional FYSPRT's		X				X	X		
• Partner with Health Care Authority to provide education to Non Community Mental Health Agencies private providers on how to enroll under fee for service Medicaid		X		X			X		
• Creation of systems navigators		X					X		
CANS Tool Development and implemented specific to Washington State and tied to management quality plan, workforce development plan and core practice model	X	X		X	X	X	X	X	
Develop cross system protocols, consistent process and quality management		X			X	X	X	X	X
Develop capacity throughout the state for provision of intensive home and community based services for those needing them to prevent out of home treatment.		X					X	X	X
• Develop capacity for Mobile Crisis response for youth involved in intensive mental health treatment	X	X	X	X		X	X	X	X
• Develop Intensive Care coordination capacity	X	X	X	X		X	X	X	X
Improving oversight and monitoring of psychotropic medication usage with youth.	X	X	X	X	X	X	X		
Continue cross agency/administration efforts to identify areas of improvement related to mental health and psychotropic medications and their impact on children in foster care. A few key focus areas are:									
• Communication, education, and collaboration with prescribing providers and stakeholder groups. This includes the development of training materials and expansion of the PAL and Second Opinion program services.		X	X	X		X	X		

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
• Make improvements to the existing data management system to support better tracking of information and enhance the quality improvement process.		X	X	X		X	X		
• Refine and update existing cross administration policies and guidelines based on evidence based diagnosis and treatment recommendations.	X	X		X		X	X		
Work across systems to explore Positive Behavioral Supports (PBS) as an intervention where culturally relevant	X	X	X	X	X	X			
Implement Child & Family Teams for youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more systems						X	X	X	
• Develop agreements across DSHS child-serving agencies requiring participation in CFTs			X			X	X	X	X
• Child and Family Teams are available throughout the state for youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more systems utilizing consistent processes and a quality management structure	X							X	
Agencies collaborate to align funding to develop sustainable financing for array of home and community based services and supports		X	X				X	X	X
Explore funding options for the creation of system navigators		X	X	X			X		
Expand Transitional services		X	X		X	X	X	X	X
• Transitions from child mental health to adult mental health System				X		X	X	X	X
• CLIP Improvement Team an ongoing effort to CLIP programs, system managers and parents to improve transitions in and out of psychiatric residential treatment and reduce length of stay		X				X	X	X	X
• Develop a workgroup of cross system partners to improve the transition between residential and to community care				X	X	X	X		
Develop a university, family and youth, and state co-led training institute to provide a sustainable training system to support SOC	X		X			X	X	X	X
3. Build Access and availability of home and community-based services									
Policy and procedures to create an intake process that is youth and family friendly.	X	X					X	X	
To bring forth more focused efforts for the creation and development of consumer operated services per HB 2654	X			X		X	X	X	X

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
• Regulatory changes to allow youth and family organizations to provide peer support without having to become a fully licensed Community Mental Health Agency.	X				X	X			
• Support the creation and development of family and youth organizations at the community level to meet the needs of youth and families.		X			X	X	X	X	X
Increase access for Rural & Frontier home and community based services in rural communities		X				X	X	X	X
• Support for development of training for Family/Youth Initiated Wraparound			X	X			X		
• More venues for families and youth to receive training to be their own Wraparound facilitators			X	X			X		
• Tele-Health education and training for rural and frontier youth and families		X	X	X	X	X	X	X	X
Increase the use of Evidence Based Practices (EBPs)					X	X	X	X	X
• Seek technical assistance for Medicaid financing of EBPs		X	X	X			X	X	
• Include language in RSN contracts requiring implementation of trauma informed care including AFCBT, TF-CBT and CBT+		X	X	X	X	X	X		
• Fidelity monitoring requirements for EBPs	X						X	X	
• Include recommendations for the reallocation of resources for EBPs and assessment of the use of evidence-based and research-based practices provided in a manner that is culturally competent			X	X			X	X	
• Engage Provider organizations: administrators, clinicians and supervisors to be part of implementation planning for EBPs		X		X	X	X			
• Implementation of SHB 2536 an act related to the use of EBPs for the delivery of services to children and juveniles within the context of SOC governance structure		X	X	X		X	X		
Support Multi-dimensional Treatment Foster Care Pilot to ensure family based alternate treatment for high needs mental health youth	X	X					X	X	X
Conduct asset mapping around the state to determine the existence of interest in building TimeBank resources to establish a greater network of natural community supports		X				X	X		
4. Develop and strengthen a workforce that operationalizes SOC values									
Develop a cross-system workforce inclusive of families and youth to enhance family driven, youth guided, person centered recovery resiliency services and supports		X					X	X	X
• Parent and Youth Peers on Review Teams: Provide structure and funding support to include parents and youth peers as part of regulatory		X	X	X		X			

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
inspections in CLIP programs.									
• Leverage United Block Grant Funding to support SOC training			X	X		X	X	X	X
• Reallocate funding to support the training of all members of the workforce in the philosophy, values and principles of Systems of Care and Wraparound.	X	X	X	X			X	X	X
• Families and youth are seen as equitable partners to provide quality training, technical assistance and coaching based on their lived experience		X		X			X	X	X
• Training for family initiated Wraparound		X	X	X		X	X	X	
• Provide a summer youth institute in collaboration with all system partners to bring youth advocacy/advisory groups together		X	X	X		X	X		
Support CBT and Trauma Focused Cognitive Behavioral Therapy training for broad array of state's mental health clinical workforce		X			X	X	X	X	X
Develop and implement policy and procedures for a trained workforce	X			X	X	X			
Develop a SOC training institute in partnership with and co-led by Family, Youth, University of Washington and Division of Behavioral Health and Recovery						X	X	X	X
• Inclusion of youth and families as equal partners in the development, design and delivery of training services and supports		X		X		X	X	X	X
• Develop and implement policy and procedures to ensure workforce is trained		X	X	X		X	X		
• Families and youth are seen and utilized as equal partners in workforce development decisions and ensuring quality training, technical assistance and coaching.		X	X	X		X	X		
Train staff to implement wraparound care coordination and Child and Family Teams				X		X	X	X	
Training for providers related to ACES diagnosis		X	X	X		X			
Implement training and coaching for family and youth peer counselors				X			X		
Develop an approach to address the needs of tier 2 and 3Response to Intervention students who may be struggling in school due to social/emotional challenges		X		X		X	X		
Develop training to recognize indicators for high risk scenarios: 1) out of home placement, 2) step down from hospital; 3) crisis intervention						X			
Develop a state wide training institute to provide a sustainable training system to support SOC expansion and implementation		X	X	X		X	X	X	

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
5. Build strong data management systems to inform decision- making and track outcomes									
Families and youth leaders and system partners are involved in the development of the evaluation and data collection method to ensure queries draw the information necessary to indicate whether services and supports are based in the philosophy and approach of System of Care			X	X	X	X	X	X	X
• Review existing methods of monitoring and reporting and begin alignment with SOC values		X				X	X		
• Evaluation and data collection training is provided for youth and families so they have the skills to effectively develop and administer evaluations as well as interpret the data		X	X	X		X	X	X	X
• Prioritizing funding to support the development of an evaluation and data collection process that is based on the System of Care values and principles		X	X				X	X	X
Utilize governance structure to provide oversight and input to data management workgroup		X				X	X	X	X
• All data system processes are grounded in System of Care Values		X					X	X	
• Develop a transparent process for the collection, interpretation and dissemination of data		X				X	X	X	
• Develop and implement a CFT quality tool for RSNs and Providers		X		X		X	X		
Develop family, youth and system accessible data system that supports performance assessment of SOC and other cross initiatives to improve children's mental health.						X	X	X	X
• Solicit feedback and input from end users to assure process is meeting SOC values and goals		X					X		
• Regular data reporting to FYSPRTs and RSNs to support CQI		X				X	X	X	X
• Identify cross system outcomes and performance indicators		X					X		
• Education re: data interpretation and quality improvement		X		X			X	X	X
• Opportunities for continuous quality improvement identified.		X						X	X
• Develop and implement a plan for multi-lateral training among provider/RSNs and family system partners regarding information exchange				X		X			
• Conduct assessment using rating tool for Community-Level Implementation of the Systems of Care Approach by Beth Stroul and Lan Le.		X				X	X		
Avoid duplication of data collection efforts –to maximize system efficiencies and minimize respondent burden.		X				X	X	X	X

Goals, Strategies and Activities	*Policy & Regulatory Changes*	*SOC Services & Supports*	*Financing Mechanisms*	*Training, TA & Coaching*	*2012*	*2013*	*2014*	*2015*	*2016*
• create effective data sharing agreements among system partners	X				X	X	X		
• Explore options for effective use and sharing of administrative data across systems to support SOC values and goals and CQI improvements.			X	X	X	X	X		
• Incorporate the work on *Measures of State Wide for Children's Mental Health* from HB 1088 into SOC data workgroup	X				X	X	X		
Link the OSPI Dropout Early Warning and Intervention System(DEWIS) work and the OSPI data base with other DSHS systems to determine students who may be at risk for dropping out of school due to a mental health need		X				X			

Legend Notes:

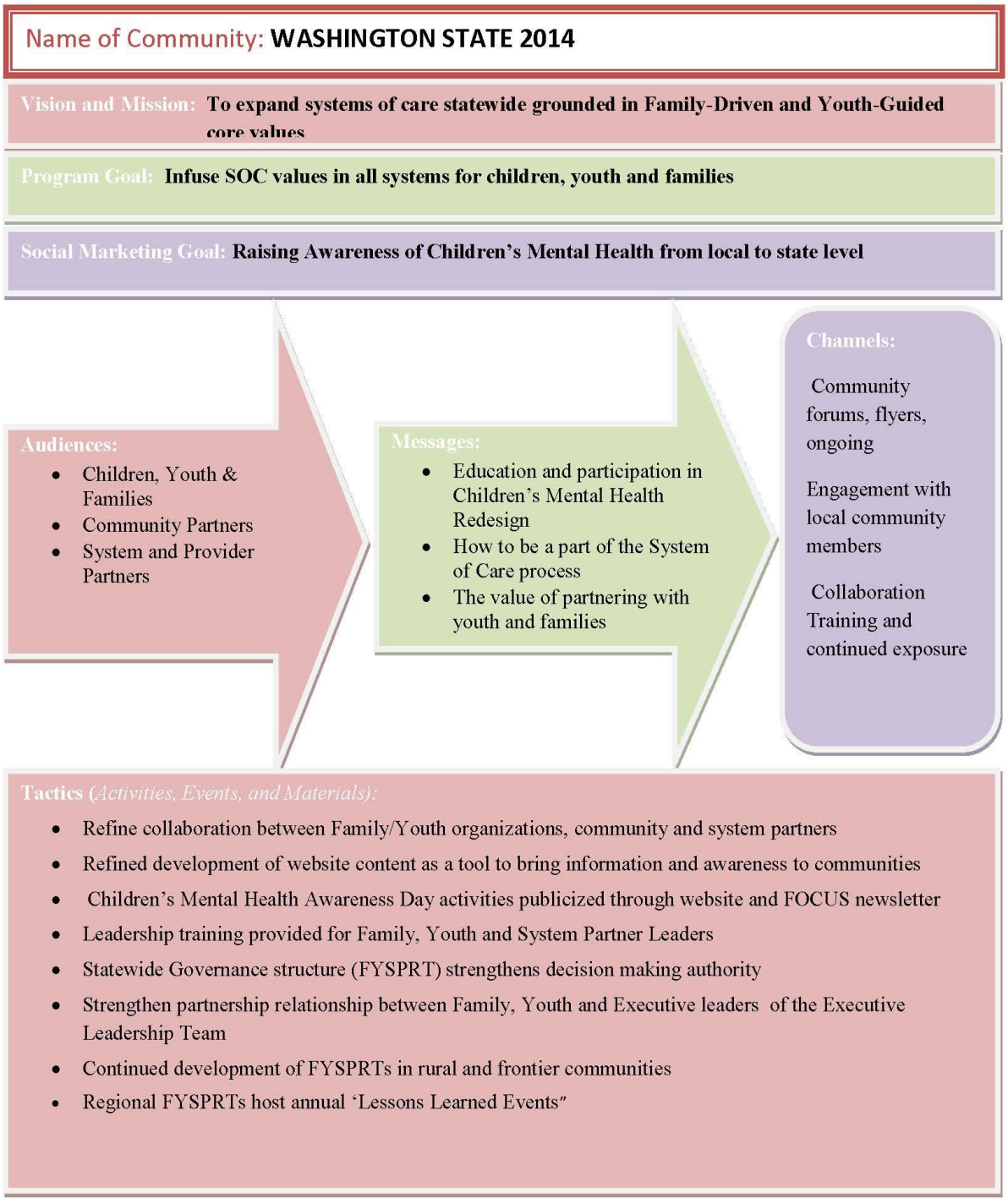
- The X's in the timeline represent the start of an action not that this action will be completed in the year an X is indicated.
- The Term "Family" used in this document is inclusive of adoptive, foster, biological and grandparents parenting a child or youth.
- Strategies that apply to more than one goal will appear in each goal section.
- Accountability for Matrix progress is through the Statewide FYSPRT. Responsibility for action steps within partner agencies and organizations will be led by FYSPRT Representatives.

Social Marketing Plan

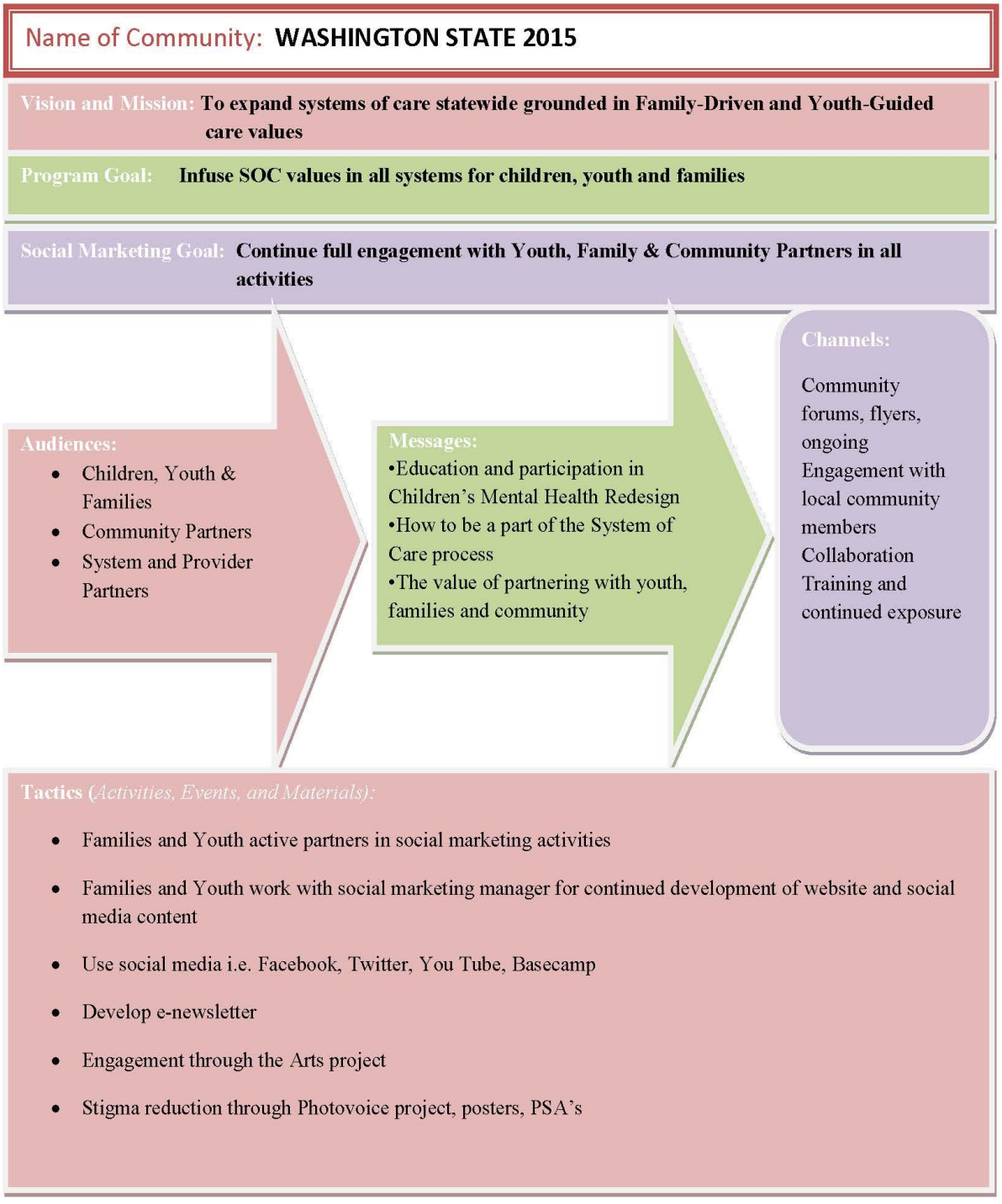
Our social marketing goals expand systems of care statewide grounded in Family-Driven and Youth-Guided care and infuse SOC values in all systems for children, youth and families.

Social Marketing Plan

Social Marketing Plan



Social Marketing Plan



Social Marketing Plan

Name of Community: **WASHINGTON STATE 2016**

Vision and Mission: **To expand systems of care statewide grounded in Family-Driven and Youth-Guided care values.**

Program Goal: **Infuse SOC values in all systems for children, youth and families**

Social Marketing Goal: **Families and Youth are Full Partner in all decision making processes and activities**

Audiences:

- Children, Youth & Families
- Community Partners
- System and Provider Partners

Messages:

- Education and participation in Children's Mental Health Redesign
- Active partners in the System of Care process
- Honor the value of partnering with youth, families and community

Channels:

Community forums, flyers, ongoing Engagement with local community members Utilization of FYSPRT communication plan

Tactics (*Activities, Events, and Materials):*

- Continued refinement of process to honor family driven and youth guided care
- Education for all partners about Communication Plan and purpose
- Lessons Learned Events held so communities across the state can share what's working in their respective communities and what changes have been made to continue the expansion of systems of care
- Carryover of activities from previous years continuing to raise awareness of children's mental health and the value of Families and Youth as full partners

Children's Mental Health Redesign

Children's Mental Health Redesign Governance Integration Model

The Division of Behavioral Health and Recovery (DBHR) is the lead agency for multiple children's mental health initiatives in Washington State. In conjunction with the System of Care planning effort a comprehensive children's mental health redesign plan was developed. From the beginning it has made sense to build upon the System of Care process rather than to create duplicative and uncoordinated processes. The diagram that follows demonstrates that integration effort at the governance level. The diagram reflects the Washington system of Care Governance structure at the center. It also depicts the traditional agency management of programs and the governance structure negotiated as a part of the completed interim agreement in the T.R. v. Dreyfus children's mental health lawsuit. Rather than create a parallel governance structure, the State has negotiated a structure that closely reflects the SOC structure and has moved to make the SOC governance the lawsuit governance. Already numerous activities described in the agreement are underway within the SOC governance process.

The redesign plan is intended to be dynamic. At present, it covers a period of 6 years. Six years is a very long time in a system such as this. It is expected this plan will change and be updated frequently as circumstances change and as it is incorporated into the SOC plan. A description of segments of the redesign plan follows:

Relationship to System of Care Activities

The Washington State System of Care is intended to be the foundation of the work to be completed in the context of this plan. SOC principles and governance is the core of the plan and the means by which the State will implement the plan. As a System of Care, Washington State seeks to build collaboration between youths, foster, adopted and biological families and organizations that will result in better access and an expanded range of integrated and culturally competent services and supports.

Relationship to the T.R. v. Dreyfus Lawsuit

The redesign plan incorporates the work contemplated under the Interim Agreement approved by the court on March 7, 2012. The activities under this agreement are integral to the overall plan and should be seen as steps along the way to the ultimate outcomes identified by the plan rather than as a separate plan implemented in parallel. The activities related to the Interim Agreement affect the other activities in a significant way in terms of timing and staff effort. Because the activities of the lawsuit have timelines imposed by the agreement, the work in many cases will take priority over other activities due to limitations of staffing.

Relationship to DBHR Activities

This plan is intended to bring together all of the activities of the Children's Mental Health Team at DBHR. While not every activity is specifically identified in the plan, it is expected that the System of Care and this plan will provide the framework and the

guideposts for all of the team activities. This plan represents the priorities, the strategic vision and the work plan for the team. This document provides an overview of the Children's Mental Health Plan and its relationships with other activities, including the Washington System of Care efforts and the work to implement the T.R. v. Dreyfus Interim Agreement. Further it summarizes the components of the plan and the development process that resulted in the Implementation Plan. The narrative also provides an outline of the major activities in the plan, the scope of the activities and the groups working on each element.

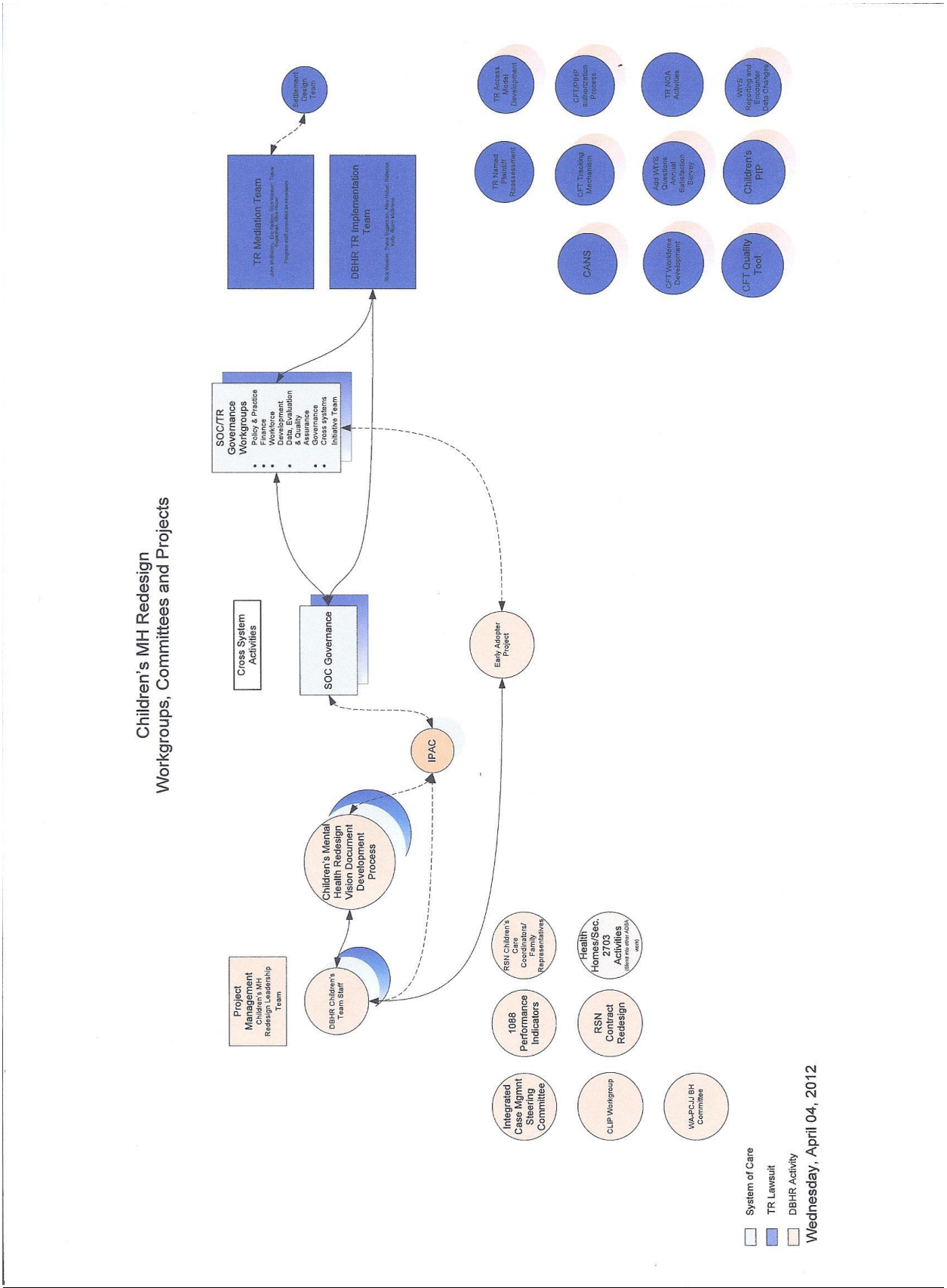
The diagram titled "Children's Mental Health Redesign Governance" that follows this narrative displays the governance/management structures for the DBHR Children's team, the System of Care effort and the governance structure described in the T.R. Interim Agreement. The placement of the System of Care Governance structure at the center is intended to highlight it as the intended governance structure to guide the system reform effort. It is expected that it will assume the governance functions of the T.R. Interim Agreement. As the Governance structure is fully operationalized, future versions of this document will depict the System of Care Structure as the sole Governance structure. The "*What Will a Re-designed Children's Mental Health System Look Like? (4/29/12)"* document further explains specifics of what needs to be accomplished for this integration effort. This document is included in the Appendix A.

Children's Mental Health Redesign Governance
System of Care
DBHR Management
Rick Weaver, Project Lead
Children's Mental Health Redesign Leadership Team
Rick Weaver, Robin McIlvaine, Chris Imhoff
Meeting Coordination TBD
Communications Management Rick Weaver
System of Care (SOC) Executive Team
Secretary, Assistant Secretaries and other Executive Leaders
Facilitation Team
Family Lead,
Youth Lead,
Project Manager,
Project Director
Statewide FYSPRT
SOC Family Lead & SOC Youth Lead
Governmental Partners, Tribal Representative, System Partners, CA, DOH, JRA, CD, OSPI, DDD, HCA, DBHR
1 to 3 representatives from the Regional FYSPRTs to be named
Community Collaboration Team
Temporary Team to merge into regional or Statewide FYSPRTs as representatives to the Statewide FYSPRT are selected
Policy & Practice
Finance
Workforce Develop.
Data, Evaluation & Quality Assurance
Governance
Cross Systems Initiatives Team
Family, Youth & System Partner Roundtable
Southwest Washington P.A.V.I.E.
Family, Youth & System Partner Roundtable
Northwest Sound MH Family Network Resource Group
Family, Youth & System Partner Roundtable
Northeast Passages Spokane
Family, Youth & System Partner Roundtable
Southeast NAMI Yakima
TR
(Wherever Possible SOC Governance Groups of like or similar name will be used to meet these functions)
DSHS Secretary & HCA Director
Executive Team
Secretary, Assistant Secretaries and other Executive Leaders
Steering Committee
CA, DBHR, DDD, ESA, JRA, HCA, OSPI, RDA, Community Board Representative
Input
OIP
IPAG
OJJ
Settlement Design Team
Plaintiff's Representatives, State Representatives, Mediator (as needed)
Community Board
Workgroups
Governance
Policy and Practice
Fiscal
Quality Mngmt.
Data and Evaluation
Local Coalition Workgroup
Wednesday, April 04, 2012

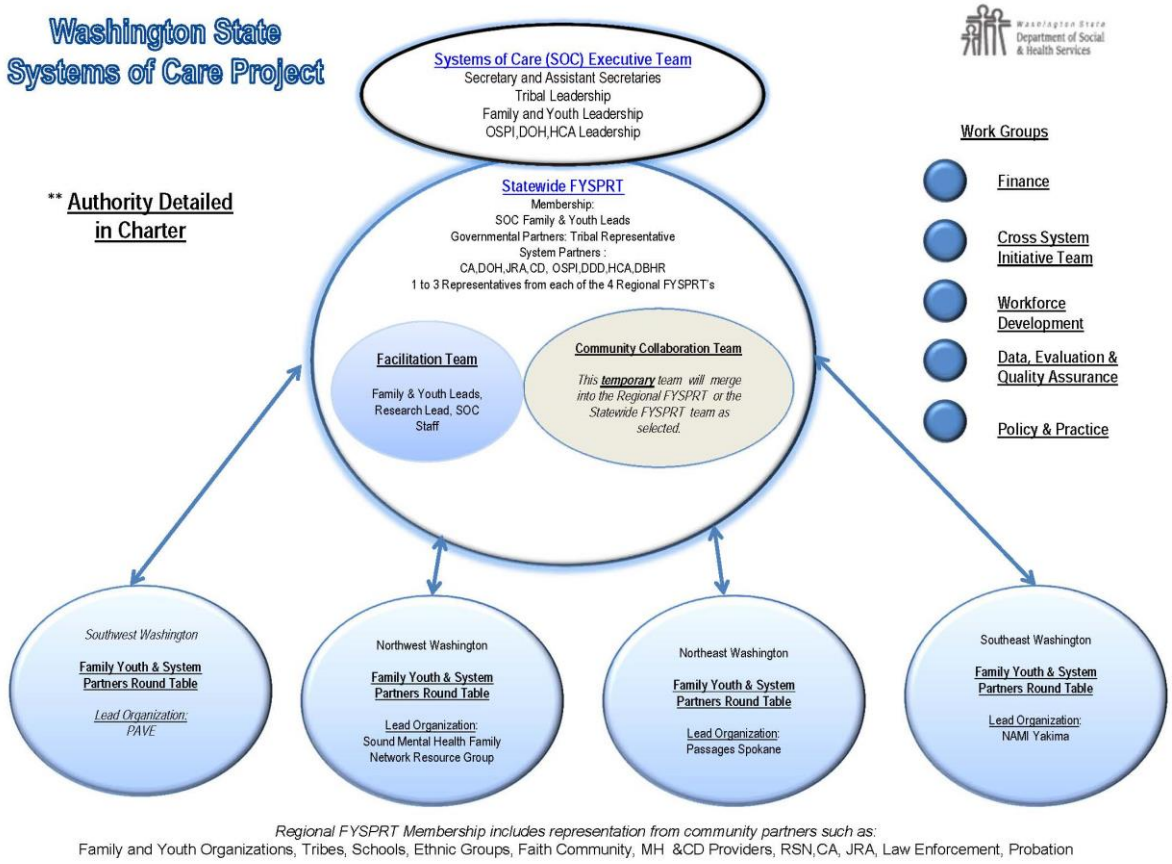
Children's MH Redesign – Workgroups, Committees and Projects Diagram

The Division of Behavioral Health and Recovery (DBHR) have pulled together many children's mental health redesign efforts under the auspices of its System of Care planning effort and Governance structure. The diagram that follows illustrates the interconnectivity of the various efforts. The lines represent communication and reporting relationships. The colored discs illustrate the interrelationships between the three largest efforts, DBHR responsibilities (legislative, contract, etc.), System of Care Planning and the T.R. lawsuit. It also reflects the central coordinating function of the SOC governance structure. The diagram follows:

The diagrams that illustrate the Children's Mental Health Redesign Governance Integration Model are intended to provide an overview of the scope of the planning effort and the integration of the planning effort into a single, System of Care-based effort. The diagram titled "Children's MH Redesign Workgroups, Committees and Projects" graphically depicts many of the major efforts across the Children's Mental Health System. While it depicts DBHR Children's Mental Health, System of Care and T.R. v. Dreyfus activities separately by color, it attempts to show the crossover between activities by layering color codes. It also depicts System of Care efforts as the coordinating glue that integrates all the many efforts. The System of Care Governance structure is depicted as the center of the effort. The Children's Mental Health Redesign Workgroups, Committees and Projects diagram follows:


Children's MH Redesign
Workgroups, Committees and Projects
Project Management Children's MH Redesign Leadership Team
DBHR Children's Team Staff
Children's Mental Health Redesign Vision Document Development Process
IPAC
Cross System Activities
SOC Governance
SOC/TR Governance Workgroups
Policy & Practice
Finance
Workforce Development
Data Evaluation & Quality Assurance
Governance
Cross systems Initiative Team
Early Adopter Project
TR Mediation Team
Settlement Design Team
DBHR TR Implementation Team
TR Named Plaintiff Reassessment
TR Access Model Development
CFT DMHP authorization Process
CANS
CFT Tracking Mechanism
TR NOA Activities
CFT Workforce Development
Add WYS Questions Annual Satisfaction Survey
WYS Reporting and Encounter Data Changes
CFT Quality Tool
Children's PIP
RSN Children's Care Coordinators/ Family Representatives
1088 Performance Indicators
RSN Contract Redesign
Health Homes/Sec. 2703 Activities
Integrated Case Mgmt Steering Committee
CLIP Workgroup
WA-PCJJ BH Committee
System of Care
TR Lawsuit
DBHR Activity
Wednesday, April 04, 2012

SOC Governance Structure



Systems of Care Executive Team

Executive oversight is provided by the SOC Executive Team. The team leads by executive leadership from DSHS, including Aging and Disabilities Services Administration (ADSA; which includes DBHR, CD and DDD), JRA, and CA, and OSPI, DOH, HCA, tribal, family and youth leaders. The System of Care Governance Structure diagram follows this narrative. Operational oversight is provided by the Statewide FYSPRT. They monitor and review grant activities, goal achievement, project status and deliverables based on SOC values. Statewide FYSPRT responsibilities include:

- Approval of objectives and outcomes, project management and quality assurance practices
- Workgroup oversight
- Timely progress reporting
- Communication with the Executive Team, workgroups and regional FYSPRTs.

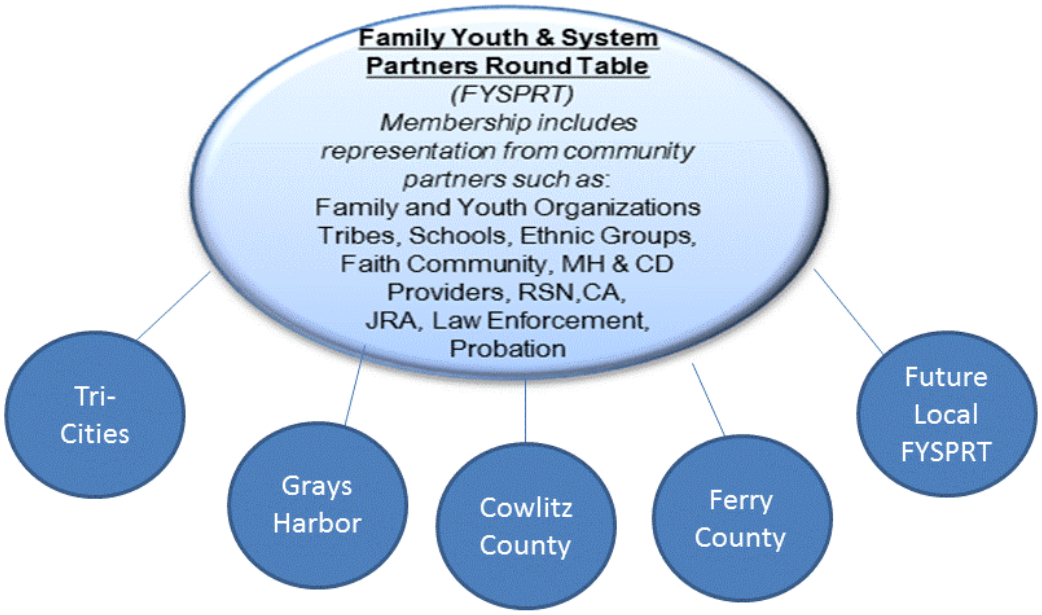
Membership
The Statewide FYSPRT will have as members:

- Executive Team, ex-officio (DSHS, HRC, DOH, OSPI, IPAC, Family, and Youth)
- SOC Family Liaison and SOC Youth Lead from Youth 'N Action, and Representatives from the System Partners (CD, DDD, CA, JRA, OSPI, DOH, HCA, IPAC)
- Indian Policy and Advisory Committee
- Family (4) and youth (4) from regional FYSPRTs (family and youth organizations)
- System Partner Representatives (4) from Regional FYSPRTs (RSN organizations, State field agency offices)
- SOC Facilitation Team (6) (Family, Youth, SOC, UW Leads)

Role of a Statewide FYSPRT Member
The Statewide FYSPRT members leverage the experiences, expertise, and insight of key individuals, organizations, and departments committed to building service delivery systems for children, youth and foster, adopted and bio-families that are based in System of Care values. The members do not directly manage project activities, but rather provide support and guidance for those who do. Members will help move the system towards SOC values and principles in workforce development, policies, practice, financing, and structural change.

Meeting Schedule and Process
The Statewide FYSPRT will meet monthly initially and determine a regular meeting schedule that is rotated around the state to provide equitable opportunity for in-person participation by all members. Ad-hoc meetings will be held as needed. They will track the progress of the project's implementation, resolve implementation issues that may arise and provide on-going support to stakeholders. The meeting agenda is developed by the SOC Project Manager in collaboration with FYSPRT members. The project manager gives a project status report at each meeting. Each member provides an update on all SOC activities from their respective organizations, workgroups, and agencies.

Region & Local Family, Youth, and System Partners Round Tables



Regional FYSPRTs: *This section was written as a collaborative effort by youth and family leaders*.
Systems of Care Family and Youth Leads are continuing to provide technical assistance and other supports as Family and Youth Leads continue to develop Local Family, Youth & System Partner Roundtables (FYSPRTs) across the state. Through this process not only are the FYSPRTs growing, but family and youth resource groups and organizations are developing as well. Established family and youth organizations are reaching across county lines helping one another to lay the foundation for much needed resource groups and organizations in communities where none existed. Outreach for the development of the Regional FYSPRTs has been extremely successful as we have families, youth and system partners participating not only from rural communities, but also from the very frontier areas of our state as well.

To date we have a Statewide FYSPRT, four functioning Regional FYSPRTs and 6 community level FYSPRTs in the developmental stages. In total there are approximately 153 family, youth, and system and community partners actively involved in the development of the FYSPRTs. Some examples of representation from system partners are pediatricians, chemical dependency treatment center staff, education representation from state to individual school district level, juvenile justice and faith based entities, as well as our identified state partners.

A diagram was developed to reflect the vision of where we want to be in 5 years. We are very close to reaching our one year goal for all regions. Regional meetings with all currently identified FYSPRT partners have been held by mid- August 2012. The regional membership is working in partnership with our TR Lawsuit TRIP (TR Implementation Planning) team to develop an effective communications plan to provide authentic family and youth, regional system partner, and tribal voice as we work to move forward to address the Interim Agreement.

Regional FYSPRT leaders are working to develop charters for their respective local roundtables to be consistent with the Statewide and Regional FYSPRTs' charters. The Regional FYSPRTs are supported with small contracts funded by United Block Grant funds, families and youth are partnering in the creation of Youth/Family Peer Support Training Curriculum that will meet Medicaid reimbursement criteria for Peer to Peer Support. Families and Youth are seen as equitable partners in the financial decision making process as well as recommendations for reallocation of funding to better support and meet the needs of children, youth and families. A proposal to increase the amount of United Block Grant funding by a considerable amount is being scribed by the Division of Behavioral Health and Recovery (DBHR) Family Liaison in partnership with the Regional FYSPRT leads.

The goal of creatively providing more venues to continue building partnership relationships is being methodically met by attending Regional FYSPRT meetings and other community/stakeholder events, and traveling outside the state headquarters area into communities. Also, researching and developing a plan to use video conferencing or expanding the use of Telehealth, and looking at how to integrate the use of technology like Skype, Team Speak or Base Camp are being explored in order to support the participation of families, youth and other system partners from the very rural and frontier areas of our state.

All partners are working together to address the challenge of the shift in cultures to infuse/practice System of Care values and principles in all areas of systems work such as finance, evaluation/data, cross system initiatives, and policy making. Plans are being formulated to introduce the idea of establishing Family/Youth Liaison positions for placement throughout our social services system. One of the steps we are taking is assessing where all partners sit on the spectrum of what Family Driven and Youth Guided Care and Practice should look like, utilizing the example of the Family Driven Practice and Care System Self-Assessment Tool (Osher & Huff) to develop a tool that meets the need of both youth and families. Regional FYSPRTs are being utilized to develop ways to assist youth in transition as well as increasing the voice and participation of youth and families as equal partners in system re-design and in the decision making process.

Families and youth are seen as equal partners throughout the planning process with them equally represented on all workgroups and committees. Families and youth are partners in the development of peer curriculum, administration of assessment tools and evaluation development, and leading the development and organization of the Regional and Community FYSPRTs. Family/Youth planning meetings are used to expand family/youth networking and advocacy and providing training specifically around Family Driven/Youth Guided care and practice. Barriers for quality family and youth involvement have been the location and times of meetings and the limited resource supports to be able to attend. Some of the barrier has been addressed through the regional development of FYSPRTs and also providing some travel support to attend meetings. Suggestions have been made to look at the utilization of telecommunications as an option as well as meeting in communities across the state not just in state headquarters.

With the establishment of the Regional FYSPRTs, each region identifies their specific needs and develops a plan to bring those needs forward to the Statewide FYSPRT, with recommendations about how to meet those needs. Current Family/Youth commitments and activities in process include:

- Trauma Informed Care included in the Peer Curriculum, ensuring Trauma Informed Care is addressed in all areas of workforce development.
- Youth and Families partner in the development of an evaluation tool that is youth and family friendly.
- Youth and families are equal partners on the Data, Evaluation & Quality Assurance Workgroup.
- Youth and families are equal partners in the fiscal and sustainability planning process.

It is our belief that one of the greatest challenges is learning how to do business differently along with the major culture shift it takes to include and recognize families and youth as equal partners in the whole process, as leaders, writers, creators, providers, and decision makers. The recognition that families raising children with complex needs or youth with complex needs bring more than their lived experience with behavioral health to the workgroups, programs and decision making processes they join. Another insight gained is how challenging we have learned it is for all parties involved to make the cultural shift from System Driven to Family Driven and Youth Guided Care and Practice and maintaining a 'balance of power'.

It is our belief we are a work in progress and as we continue to move forward with the expansion planning work we see evidence of the positive growth and change we are making together.

> **Regional FYSPRTs plan and work to engage with families and youth in the development of the evaluation and data collection process** that was initiated in the first months of Washington State's SOC Expansion Planning Grant activities through a contract with University of Washington (UW) and Youth 'n Action. The SOC Youth Lead for the Expansion Planning grant worked with UW staff, SOC Family Lead and members of the Regional FYSPRTs to develop questions to be asked of families, youth and system partners through community forums hosted via Regional FYSPRT meetings. Through this process we will learn areas of interest which will influence the types of questions we need to ask to get a clear picture of pockets of excellence and how to better meet the needs of children, youth and their families.
>
> Families and youth members of the Evidence Based Practice Institute (EBPI) Family Youth Advisory Committee, whose membership is drawn from the Regional FYSPRTs, are equitable partners in the process of identifying areas to be evaluated. Families and youth will also be involved in the administration of the tool/survey as interviewers, analysts and authors of reporting the results in partnership with the evaluation team. Utilizing the results of the evaluation and data collected at the conclusion of year two of the grant, families and youth will work with system partners through the Statewide and Regional FYSPRTS to make decisions about adjustments, changes or additional services, supports, financing venues, or policies needed to best meet the needs of children, youth and their families.

At the end of year three we would conduct another evaluation/survey to measure the effectiveness and satisfaction of the adjustments, changes and additional services, supports, financing venues or policies made at the end of year two. The results of the year three evaluation would then influence the work to be done during year four utilizing the Regional and Statewide FYSPRTs in the decision making process.

Family Driven and Youth Guided

Families are seen as equal partners throughout the planning process with a concerted effort to have family and youth equally represented on all workgroups and committees. As partners Family and Youth Leads are central in the development of peer curriculum, administration of assessment tools and evaluation development, and in the development and organization of the Regional and Local FYSPRTs. Family focus continues to be in planning meetings to expand Family networking and advocacy, and providing training specifically around Family Driven Care and Practice.

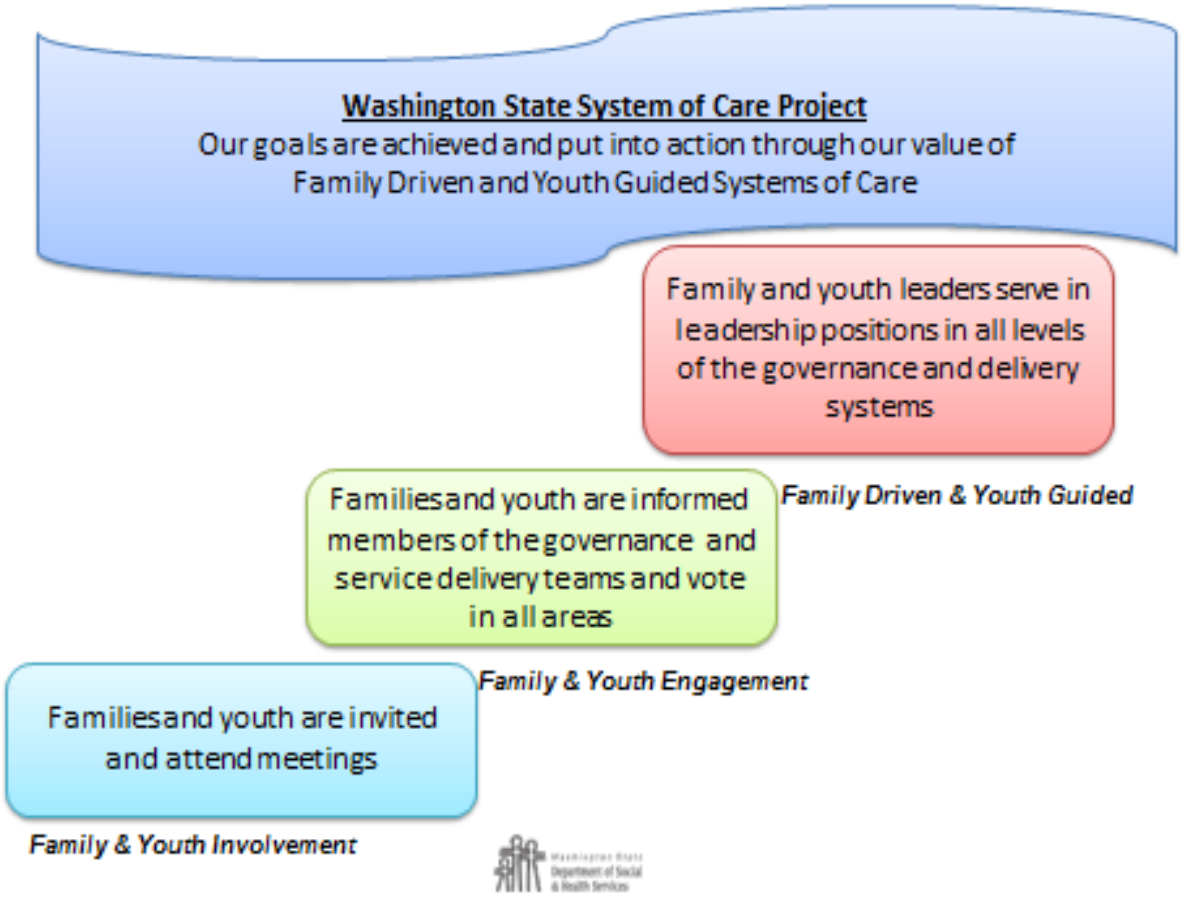
Establishing effective voice and meaningful leadership of family and youth continues to be a primary goal of Washington State's system of care efforts because it provides the critical aspect of lived experience in our SOC efforts. The inclusion of youth and family voice in the governance structure ensures that the system sustains and its services reflect the guiding values of SOC. The family driven youth guided engagement activities developed by the Statewide FYSPRT are:

- Implement the infrastructure plan for Regional and Local FYSPRTs initiated by Family and Youth Leaders throughout the state as described in previous section.
- Establish venues for Family and Youth to gain leadership skills and become equitable partners in system of care decision making processes.

- Select and mentor leaders to serve on the Statewide FYSPRT.
- Support family and youth coordinators to provide technical assistance and guidance to SOC partners.

Utilizing the results of the evaluation and data collected families and youth will work with system partners through the state and regional FYSPRTs to make decisions about adjustments, changes or additional services, supports, financing venues, or policies needed to best meet the needs of children, youth and their families. The results of the evaluation conducted will influence the work that results utilizing the Regional and Statewide FYSPRTs in the decision-making process.

Without exception System of Care partners are bringing family-driven and youth-guided core values to the work they are doing individually within their respective agencies and collaboratively in cross-system efforts. Critical to ensure family-driven and youth-guided approaches are created will be to bring the authenticity of family and youth voice to all planning, programs, and decision making taking place in child serving agencies on system of care initiatives.



Screening/Assessment & Intensive Services

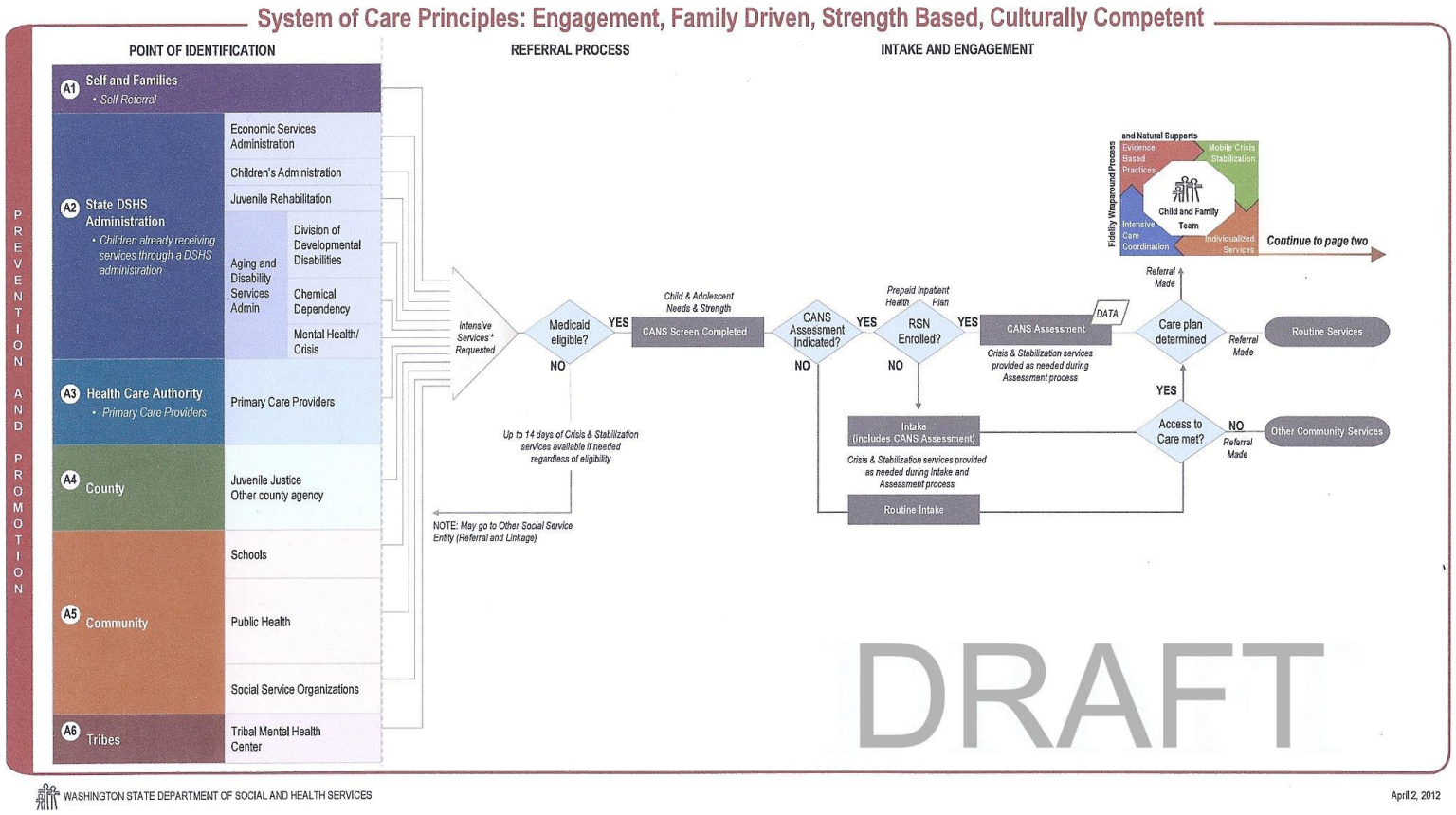
Access Model to Intensive Community Mental Health Services:

As part of addressing the T.R. Interim Agreement Requirements and System Improvements, Washington developed and access model to select how children and youth with serious emotional disturbances will be able to be identified, referred, screened, assessed, treated, offered a CFT, monitored for outcomes, and transition out of intensive mental health services.

The protocol developed begins at the point of identification and moves through access to intensive services and transition out which was vetted statewide by Regional FYSPRTs, system partners, RSNs, and other stakeholders. Pre-paid Inpatient Health Plans (PIHPs), providers, and allied systems will identify children and youth who have the functional indicators contained in the TR proxy analysis and will recognize that screening for intensive services is essential when there is a: (1)request for out of home treatment or placement due to mental health needs; (2) step-down request from institutional or group care; or (3) PIHP crisis intervention and the individual presents with past or current functional indicators in the TR Proxy.

The following access diagrams and ACCESS MODEL NARRATIVE identified as a DRAFT public version illustrate the process of considerations, actions, and decision points for intensive community mental health services.

Access Model to Intensive Community Mental Health Services*



Access Model to Intensive Community Mental Health Services*
System of Care Principles: Engagement, Family Driven, Strength Based, Culturally Competent
QUALITY MANAGEMENT
REPORTS
PERFORMANCE IMPROVEMENT PROJECTS
Fidelity Tools
Performance Indicators
Assessment of Statewide Service Capacity
CANS data
Individual
Agency
RSN
State
Public Transparency
CARE PLANNING
SERVICE DELIVERY
TRANSITION OUT OF FORMAL SUPPORTS
REFERRED FOR INTENSIVE SERVICES*
From page 1
WRITTEN CARE PLAN DEVELOPED WITH THERAPIST
NO
Formal ongoing Child and Family Team accepted?
YES
SERVICE INITIATED
CARE PLANNING
✓Facilitator engages with family
✓Immediate needs identified and addressed
✓Strengths, needs & culture clarified
✓Family Vision developed
✓Facilitator & family engage with team
ONGOING SERVICES IMPLEMENTED
Fidelity Wraparound Process and Natural Supports
Evidence Based Practices
Mobile Crisis Stabilization
Child and Family Team
Intensive Care Coordination
Individualized Services
✓Vision & Goals agreed upon
✓Written team plan developed
✓Meeting schedule & logistics determined
✓Progress assessed & plan revised
MONITORING AND ADAPTING
Ongoing
CANS Child & Adolescent Needs & Strengths
RE-EVALUATION
every 3 months
DATA
Outcomes achieved
YES
NO
TRANSITION
Linkages Made
OTHER SUPPORTS/ SERVICES
Mental health, community, natural, vocational, etc
Over 21 years?
YES
NO
TRANSITION
Linkages Made
ADULT SERVICES
DRAFT
WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
April 2, 2012
2

Cultural & Linguistic Competency

The SOC project has focused primarily on youth between the ages of 13 through 18 with SED, out-of-home placement, and/or juvenile justice / child welfare histories (2.8% of the youth in Washington and 5% of DSHS-served youth). The project strategic plan will extend to reach youth with co-occurring disorders, younger children in need and youth at-risk. Over 40% of these children are children of color, with over-representation among African American and American Indian children.

At this time no established data source is available to collect related to gender or sexual orientation for the SOC project population. The table below identifies the focus population by race that was used for the Washington State SOC Expansion Planning Grant Application.

Washington State	Asian/Pacific Islander	American Indian	African American	Hispanic	White	Unknown Race
SOC Population	**4.8%**	**14.0%**	**14.8%**	**15.0%**	**57.5%**	**1.3%**

The 2010 Census Demographic Profile Summary File data for Washington State (Table below) was released in May 2011. This information is provided as an overview of the state population that is inclusive of the SOC population.

WA State	Two or more races	Asian	Native Hawaiian/ Pacific Is.	Native American	Black	Hispanic	White	Other
2010 Census	**3.7**	**7.1%**	**0.6%**	**1.3%**	**3.4%**	**11.2%**	**72.5%**	**0.2%**

The Department recognizes that everyone has a culture and we have a commitment to promote respect and understanding of diverse cultures, social groups, and individual attributes. The mission, vision, and values of DSHS embrace inclusivity that supports people and communities in reaching their potential. To further that mission, Cultural Competency guidelines provide a framework for cultural competence and culturally responsive service delivery. The Department's stated diversity commitments, Equal Opportunity, Non Discrimination, and Cultural Competence Administrative Policy convey a welcoming environment when recruiting staff throughout the state where communities are being served. An example of the diversity inclusiveness is the DSHS Gay, Lesbian, Bisexual, and Transgender Persons - Equity Work Group. The CHARTER – The Transformation through Action which is included in the Appendices (Appendix I).

Washington State has been a leader nationally in instituting policy for services responsive to the diversity of our state's people and communities, most notably through payment through our Medicaid mental health system for Mental Health Specialists. This policy (WAC 388-865-0150) requires consultation for racial and ethnic minorities, age groups (child and geriatric specialists), and persons with intellectual or physical disabilities. Mental Health Specialists in each of these areas are available to inform assessment and treatment planning and consult with ongoing care providers in their areas of specialty.

The Health Disparities Work Group was formed in 2010 to develop policy priorities and system-level recommendations related to health disparities across race, ethnicity, religion, gender, age, geography, socioeconomic status, language, sexual identity, and intellectual and physical disabilities. The DSHS Cultural-Competence Policy and Guidelines became effective in September 2011 and apply to all DSHS administrations and employees. The guidelines provide a framework for cultural competency and culturally responsive service delivery. In addition to defining what constitutes cultural competence, these guidelines have performance requirements for each DSHS administration. These will be integrated into the SOC project through the cultural competence service delivery model and specific action plans.

Linguistic diversity and competence is addressed through established DSHS interpreter services that are provided to meet the communication needs of Limited English Proficient (LEP) Medical Assistance Clients. Interpreter Services are available and covered for healthcare services to current Medicaid clients who have trouble speaking or understanding English, are deaf, blind, or hard of hearing.

Washington State SOC Partners

Family, Youth, and System Partners Reflections

Division of Developmental Disabilities (DDD)

We are successful if people with developmental disabilities

- **Are healthy and safe**
- **Have choices in their lives and services**
- **Experience respect**
- **Are involved in their communities**

Christie Seligman, Children's Intensive In-home Behavioral Support Program Manager
Monica Reeves, Crisis Services Program Manager

During the last year, DDD has participated in and contributed to the Statewide Expansion Planning Grant activities. We have continued to infuse the principles of wraparound and systems of care throughout our system in support of children, youth, and families.
The Children's Intensive In-home Behavior Support (CIIBS) Program, which is a federal 1915(c) Home and Community Based Services Waiver, utilizes wraparound planning in addition to positive behavior support to support children and youth at the highest risk of out of home placement in our state. We held workgroups for CIIBS families and providers at the beginning of this year to solicit feedback regarding program strengths and areas for improvement as we continue to move forward. A new CIIBS policy has been drafted highlighting the wraparound principles, phases of activity, and planning documentation in an effort to ensure continuous quality improvement in our facilitation of the planning process.

DDD has begun to utilize a wraparound training curriculum, designed for use in Washington State by Dan Embree of Portland State University, with DDD staff that supports children, youth, and families. We are currently expanding our training delivery to include families, contracted providers, and other community members to reflect the membership of child and family teams. DDD sponsored a training series this spring, on both sides of the state, which highlighted several of the areas of focus in Washington's SOC grant. Elizabeth Vermilyea presented trauma-informed care; Mark V. Durand presented Optimistic Parenting; and Dan Embree presented wraparound principles.

Development is underway for a new community crisis services program in Lakewood serving children and youth with intellectual disabilities. The program is designed to promote the systems

of care approach and be guided by wraparound principles throughout the delivery of program services and the planning process with families. Its goal is to successfully address crisis through community resources and support families to be successful together again in their home community following crisis.

DDD looks forward to continued partnership with families, youth, and other systems toward our shared vision for healthy, happy, and involved youth in the communities throughout our state.

Chemical Dependency (CD)/Division of Behavioral Health and Recovery (DBHR)
Tina Burrell, Behavioral Health Youth Treatment Lead

During the last year, the Substance Use Disorder (SUD) treatment system for youth has received overview information about the System of Care planning grant, the principles of the project and the development of the Family, Youth, System Partner Roundtables (FYSPRTs) throughout the state. I have had the opportunity to recommend potential members to represent SUD services on one of the FYSPRTs.

Through collaborative systems partners work it is recognized that DBHR would benefit by further review of the needs, standards of care and program development for youth and their families/caregivers, with co-occurring disorders. There is an interest in having technical assistance provided by Doreen Cavanaugh to assist in reviewing and creating potential planning steps for implementation to better address the needs of COD youth and their families/caregivers. At the state level, SUD treatment and mental health (MH) services for youth is not an integrated system but both service systems are assisting the shift towards a System of Care (SOC) for youth services. For SUD services, this is under the model of Recovery Oriented Systems of Care (ROSC). There will be more opportunity in the future to further cross training between SUD and MH systems and participants, youth, families, providers, to highlight the commonalities between ROSC and SOC. The state also looks forward to gaining more insight from the work being done in Maryland on the ROSC /SOC comparisons.

During this past year, DBHR developed a model for a county wide Youth Recovery Oriented System of Care pilot program. This pilot program kicked off its first activity in July with youth and family focus groups to inform the project on their specific interests and needs in the county selected for the pilot. This pilot project will provide care coordination for youth and families and funds to support recovery support services not currently funded. DBHR looks forward to learning from the youth, families/caregivers and the community as project moves forward.

Children's Administration (CA)

Barb Putnam, Well Being and Adolescence Services Supervisor
Michael Luque, Children's Administration Program Manager

Children's Administration (CA), Washington State's public child welfare system, has been an active and integral participant in the System of Care effort. Along with the mental health service needs for the children, youth and their families we bring additional resources both at the individual child and family level and in the local level with Regional Support Networks to support specific programming that is preventative of deeper system penetration.
CA also participates by providing resources such as service coordination and home based services for identified jointly served clients. While our mandates are different for mental health related cross system children and youth, CA field staff participates on child and family teams and bring resources to the table at the local level. On a macro level, CA has co-funded multiple projects with local Regional Support Networks a range of services such as: crisis services, wraparound services and co-location of community mental health staff in regional child welfare offices.

CA also has initiatives that are consistent with System of Care values and principles:

Youth Voice: Passion to Action is a dynamic youth advisory board who consist of current foster youth and alumni of care. This work began approximately six years and currently there are 20 individuals are youth leaders and draw together from around the state and meet every six weeks throughout the year. They inform CA Administration regarding program and policy decisions that affect their lives, review materials, participate on tasks forces and advisory groups, train and mentor others.

Wraparound Training: CA has recently developed a wraparound e-learning training for all child welfare staff. This includes the values and principles and how they relate to the Solution Based Casework practice model that is already embedded in social work practice, what to anticipate on a wraparound team for those complex mental health related cases as it is being developed through mental health and what is expected of a good team member. This will be available in November of 2012.

Integrated Case Management: CA has joined with the Juvenile Rehabilitation Administration (JRA) to create four Integrated Case Management (ICM) pilots with the intention of changing practice and integrating services for youth served by both systems. One of the pilot sites has used local funding to hire a parent support person to help families navigate both the juvenile justice and child welfare systems.

Parent Voice: CA is redesigning child welfare services through performance based contracting. This initiative has completed an extensive amount of research by asking parents involved in child welfare what are the services ***they need.*** It is through this comprehensive effort has helped to inform the redesign of services and support that parents feel most likely will help them to stabilize and safely reunite with their children.

Juvenile Rehabilitation Administration (JRA)
Dan Schaub, Community and Parole Programs Administrator
Jacob (Jake) Towle, Juvenile Rehabilitation Administration Program Administrator

JRA has implemented the following strategies and programs as it relates to Systems of Care:

1. Youth Voice: JRA has incorporated Youth Voice at various levels of the Administration to include:

- Governor's Partnership Council – Youth Subcommittee – meets 6 times yearly
- Youth Leadership Training – monthly
- Youth Personal Development and Growth – monthly
- Disproportionate Minority Contact and Confinement Focus and Work Groups (June – December 2011)

These youth are both residential and parole youth. They have access to meeting and can give input to School District Administrators, JRA Administrators, Community, Legislative and Law Enforcement Representatives, Judges, Researchers and Business Leaders

2. Integrated Case Management:
Integrated Case Management (ICM) is a multi-system infrastructure that embeds wraparound principles and guides the process of coordinating services for vulnerable youth with complex needs and their families who are served in Child Welfare and Juvenile Justice.

Children's Administration (CA) in collaboration with the Juvenile Rehabilitation Administration (JRA) and local communities have developed four implementation sites in the Skagit, Pierce, Okanogan and Thurston Counties. Through ICM, DSHS is partnering with local jurisdictions to help guide and support locally driven Multi-Sytem Collaboration and Coordination (MSCC) work.

Resources have been developed to share amongst the implemenation sites as well as to help guide and support ICM work at the DSHS level. A DSHS ICM Share Point site was developed and is maintained as a central location for all information pertaining to ICM work inside DSHS and the four implementation sites. This site includes resources from national experts on MSCC work and details the infrastructure set up in DSHS to implement and sustain ICM across the department.

DSHS is currently working on developing a tool kit to articulate how they have developed and implemented ICM work across the department and within local communities through the implementation sites. This tool kit is meant to serve as a guide for other communities in Washington State as they implement ICM practice as well as memorialize the work.

Data is being gathered by DSHS's Research and Data Analysis (RDA) division as local sites begin to staff cases. This data will help tell the story of how youth and families are positively impacted by participating in ICM.

JRA's 4 main objectives with a System of Care are:

1. Youth have access to mental health services prior to coming to JRA which may ultimately prevent them from coming into JRA.

2. Youth committed to JRA with significant mental health issues may have the option of a Sentencing Alternative that will address their mental health issues, as opposed to incarceration.

3. Facilitate the continuation of a youth's mental health/Wraparound Team involvement while a youth is incarcerated at JRA residential facilities.

4. Facilitate a smooth transition back to community mental health services for those youth leaving JRA residential facilities.

Department of Health (DOH)
Maria Nardella, Children with Special Health Care Needs Program Manager
Carol Miller, Autism/Learn the Signs Act Early Project Coordinator

The Washington State Department of Health's (DOH) Prevention and Community Health Division, Office of Healthy Communities recently reorganized the division to reflect alignment with national and state efforts in an integrated manner for change. Part of the work includes priorities across life course with an overarching goal to increase the number of Washington residents who are healthy at every stage of life. Social and emotional wellness sits as one of those key priorities of work. Another key component is quality screening, identification, intervention and care coordination.

DOH currently is in process of changing contract language to start January 2013 with local health jurisdictions (LHJ) across the state. The LHJ's are being required to align their work with national performance measures and these include work on Adverse Childhood Experiences (ACES), Children with Special Health Care Needs, and Developmental Screening. Additionally, the agency is involved in several other program efforts: a school health/education workgroup; integrating families and experts into the SOC FYSPRT's in communities through the Community Asset Mapping Project; working on interagency workgroups; as members of a State Prevention Enhancement consortium; through inclusion of mental health information sharing in Medical Home sites and primary care; and networking with our DBHR partners on a communication plan for use across the state to push information out to families and partners.

As an agency partner working on Systems of Care, developing partnerships across the agencies is more than exciting. When you break down the silos of agency work, people discover that each of us is passionate about making change to systems through multiple means that benefit the families and children. We all serve the same group of people in the state and we discovered that we feed on each other's enthusiasm as we see small pieces of transformation happen.

Office of Superintendent of Public Instruction

Ron Hertel, Readiness to Learn, Compassionate Schools, Mental Health, Foster Care Program Supervisor
Sarah Butzine, Coordinated School Health Program Supervisor

1. Changes made to your system(s) that values children, youth and families

Slowly, schools are beginning to adapt new policies, practices, programs, and approaches to better partner with children, youth, families, and community partners. There are many examples of how we have supported this shift at OSPI, but we will share three specific examples here. The first focuses on parent engagement through programs such as Readiness to Learn and Compassionate Schools. The second focuses on student engagement through programs such as Coordinated School Health. The final example highlights our efforts to build sustainability and capacity for youth, family, and community engagement through a newly created AmeriCorps VISTA position at OSPI.

Parent Engagement
Although some administrators mostly see families as people coming to them to complain, more and more, school administrators are seeing the value of incorporating families in day to day school operation, being advocates for their own children, being mentors for other parents, and having meaningful participation and engagement in the school operation. As a part of the Readiness to Learn program, it is a new requirement in order to receive funding, that they have a parent leadership training component to their programming to train parents as mentors and advocates. It is also incorporated into the Compassionate Schools curriculum.

Student Engagement
Schools are also creating new ways to invite student voice and action to inform their school operations. For example, students are serving on advisory committees, participating in student engagement teams, participating in peer mentoring programs, and building civic connections. More schools are formalizing student groups who have a vital role in school operation. For example, at the Healthy School Summit, one of the most popular workshops was a youth-driven Voices of Youth workshop where students from every district in Thurston County shared their experience leading focus-groups in their high schools, designing and facilitating a county-wide Town Hall, and making positive health related changes in their schools. This training is an example of student-led professional development made possible by funding and technical assistance from the Coordinated School Health Program.

Sustainability
Due to Systems of Care efforts, OSPI has added a full-time AmeriCorps VISTA position focused on strengthening youth and community engagement in the design of our educational and support programs. The AmeriCorps VISTA member started with OSPI on August 31, 2012 and will serve until August 30, 2013. Their primary role is to build capacity for OSPI to infuse more youth and family engagement throughout our agency. They will help design processes and systems to expand our current "pockets" of great student and family engagement in select programs and districts to an agency wide system. They will accomplish this by assessing current strengths and areas of opportunities and then developing a toolkit of Washington school related student engagement resources. This toolkit will include tips, examples, and funding opportunities for effective, meaningful student engagement. The AmeriCorps VISTA member will also engage in grant writing, and will partner with OSPI colleagues to create a sustainability plan for this work, and ideally this role to continue.

2. Incorporated/adopted System of Care approaches to existing protocols

Schools can't do it alone and even if they could, they probably shouldn't. As schools open their doors to communities and invite them to be a part of educating children in the community, communities are becoming interested in helping shape the future citizens who will hold vital roles in their community. As a part of the Graduation, a Team Effort (GATE), we have a workgroup specifically devoted to developing a system of care and collaboration between communities and schools to support students and meet the needs of the whole child.

3. Actions/events conducted related to our SOC Goals

We have incorporated Systems of Care approaches into our existing efforts to address mental health related barriers to learning; such as Compassionate/Trauma Informed Schools, Readiness to Learn, and Coordinated School Health.
We have provided more than 45 trainings/workshops/presentations to audiences ranging from 20 – 400. We have worked with Educational Service Districts, local school and district staff, and students and families to develop these programs; obtaining their input for the design, training, marketing and dissemination so that eventually all schools in the state of Washington will utilize the System of Care as their new paradigm.

4. Dreams, hopes, and ideas for future SOC activities

Our dreams, hopes, and ideas for future SOC activities include incorporation of the System of Care as the standard of operation and statewide paradigm shift toward this collaborative work process and to obtain funding for programs to support efforts and benefits that SOC offers.

Washington State System of Care
Family and Youth Organization History
Jeanette Barnes, SOC Family Lead (DSHS/DBHR)
Tamara Johnson, SOC Youth Lead**,** Youth 'N Action Program Youth Director (UW)

Our Family and Youth movement in the efforts to develop family and youth organizations has been challenging at best. With challenge comes growth and to date we are developing a structure through which family and youth are being recognized as equal partners in the decision making process. The following represents how we got where we are to date:

- The journey began in early 1988 with the development of the Community Connectors Project to fill a recognized need for connection between parents/caregivers for support. Families (mostly moms) involved in this project were those whom folks in the community turned to for support and information.
- In 1992 Washington State submitted its EPSDT plan for Medicaid with a major component mandating the development of a Children's Oversight Committee recognizing parents/caregivers as 'major' players. This was the first year Wraparound training was provided for parents/caregivers.
- In 1993 a waiver to Medicaid rules was submitted requesting the provision of managed care services for mental health consumers. A significant piece of the waiver request was the inclusion of consumers, their families, people providing non-direct mental health services and others, at the consumer's request in Individualized and Tailored Care Planning (Wraparound).
- In 1994 the WAC (Washington Administrative Code) was changed to reflect the language in the Medicaid waiver, also requiring the plan be flexible and responsive to the consumer's needs. The WAC also required each RSN (Regional Support Network) to have an advisory board whose membership was made up of at least 51% consumers and families.
- In 1996 A Common Voice for Pierce County Parents became the first non-profit parent organization whose sole focus was supporting families of children with complex needs. A Village Project started forming with the support of Community Connectors FBG funding in King County.
- In 1997 the first Parent Advocate was hired at a children's long-term inpatient residential facility. Community Connectors participant numbers grew to 53 participants across the state. Parent resource/support groups were forming with/without the support of Federal Block Grant (FBG) dollars.
- In 1998 the Mental Health Division (MHD) contracts with a parent to serve as Child Service Advocate in the Office of Consumer Affairs.
- In 1999 the Statewide Parent Council formed through support of Mental Health Division representing family organizations from across the state.
- In 2000, October – 2001, September Federal Block Grant funds set aside to specifically assist in the development of family organizations.
- In 2000 an application for SAMHSA's Statewide Networking Grant submitted and awarded; Parent Council renamed SAFEWA (Statewide Action for Family Empowerment of Washington) beginning to form a statewide family organization.

- In 2001, March, Passages was formed and became part of the Parent Council.
- In 2001a short lived plan for a parent/caregiver to be part of the MHD Monitoring Team was implemented. Although having the position on the team created positive change in the field it was a difficult shift for some to make or accept.
- In 2003 SAFEWA obtained 501C3.
- In 2003 the MHD moved the parent Advocate position from contracted to a full time state staff position.
- In 2004 three administrations within Department of Social and Health Services, Mental Health Division, Children's Administration and the Juvenile Rehabilitation Administration started partnering and contracting with SAFEWA.
- In 2005 a Parent Advocate position at Child Study and Treatment Center became part of CSTC staff reporting to the CEO. King County's youth organization, Health N' Action transitions under SAFEWA's preview and re-names to Youth N' Action to become the first statewide youth organization whose focus is around youth with complex needs. Washington Dads begin to organize with support from MHD.
- In 2006 SAFEWA is one of the major contractors involved in Washington State's Mental Health Transformation Project (MHTP).
- In 2008 Family Alliance for Mental Health forms. MHTP supports Family Liaison position with transfer of MHTP Consumer Family Tribal Liaison into the vacated position.
- In 2009 Family Liaison position fully funded by and is incorporated into DBHR (Division of Behavioral Health and Recovery).
- In 2010 SAFEWA dissolves; "What Do Families & Youth Want?" survey is distributed & as a result MHTP allocates funds to support outcomes of survey indicating desire of families and youth to develop networks of support locally and regionally across the state.
- In 2011 regional organizing of families and youth begins through contracts with 4 family/youth organizations in response to "What do Families and Youth Want?" survey outcomes.
- In 2012 Regional Family, Youth and System Partner Roundtables (FYSPRT) begin to develop, building off the regional organizing work of 4 family and youth organizations in 2010-2011. Through outreach and development of regional FYSPRTS four additional local FYSPRTs are growing as well as 6 additional branches of already existing family and youth organizations and/or resource groups.
- Projected for 2013… Expansion of FYSPRTs across the state as well as increasing the number of family/youth organizations, resource and support groups in an effort to grow leaders and bring stronger voice. FYSPRTs will be hosting additional Lessons Learned events as well as planning and supporting local community activities to raise awareness about children's mental health as well as Children's Mental Health Awareness Day. FYSPRTs will continue to be the venue through which systems work will be vetted ensuring Families and Youth are full partners in the decision making process.

Expansion of existing and newly forming Family and Youth groups or organizations follow:

FAMILY ORGANIZATIONS:

- A Common Voice for Pierce County Parents - Tacoma, WA
- Passages for Parent Support - Spokane, WA - NE FYSPRT Lead, branch developing in frontier area
- Washington PAVE (Partnerships for Action, Voices for Empowerment) - Statewide, based in Tacoma - SW FYSPRT
- NAMI - Statewide - NAMI Yakima SW Regional FYSPRT Lead, branch developing in Tri-Cities, WA
- Family Alliance for Mental Health, Thurston County based, with organizations/groups in Lacey, Olympia, Yelm, as well as, Mason and Grays Harbor County, also part of SW FYSPRT
- Sound Mental Health Family Resource and Networks – King County, WA – NW FYSPRT Lead
- 3 Rivers Wraparound Family Resource and Networks - Tri-Cities, WA Branch of SE FYSPRT
- Cowlitz County Family Group – Longview, WA
- SAMA (Science and Management of Addictions) – Seattle, WA
- Washington Dads (WaDads) - Eastern and Western Washington Region Organizations

YOUTH ORGANIZATIONS:

- Unleash the Brilliance - King County, WA
- Passion to Action youth – Statewide, Supported by Children's Administration
- Mockingbird Society - Seattle, WA
- Lummi Nation Youth M.O.V.E. group, Lummi Nation
- YES Program - Youth N Action Mason - Shelton
- Wraparound program - Long View
- Yakima Valley SOC - Yakima
- Passages - Youth N Action - Spokane
- Valley Cities - Youth 'N Action - Auburn
- Fab-5 - Youth Drop in Center - Tacoma
- Grays Harbor Youth Center - Aberdeen
- Community Health Services - Shoreline
- Sound Mental Health - Bellevue
- 3 rivers wraparound - Kennewick
- Youth N Action Thurston - Olympia
- A Common Voice - Tacoma
- Catholic Community Services - Burlington
- NAVOS - Seattle

Washington Dads
Robert Haffner, Eastern Washington Project Manager & Regional Leader
Direct/cell 509-823-1420 877-847-3050 Ext. 6004 Email: rhaffner@wadads.org

End of Summer Means Weekend

For men wanting to improve behavioral health for their children, youth and families

Save The Date!

September 28 - 30
Lazy F Ranch
16170 Manastash Rd., Ellensburg Wa. 98926
(509)962-2780 www.lazyfcamp.org

- No registration fee
- Lodging and all meals provided at no cost
- 6 PM Friday to 12 noon Sunday
- Stress free environment with down time
- **Find out how other dads and male caregivers are coping with challenging child rearing situations**
- **Hear about what men are doing to help improve success for their children in school**

- **Learn about problem solving with adolescents and teens**
- **Hear about state programs & resources**

- **Need to bring sleeping bag, optional extra blanket, towel and fishing pole**

Register online at www.wadads.org.
or Information by calling 877-847-3050 ext 2

WADADS
P. O. Box 14336
Mill Creek WA
98082-2336
info@wadads.org

PRESENTED BY
WaDads

Evaluation and Performance Assessment

As the primary evaluation and data/information support partner of the Washington State Children's System of Care Planning Grant, the University of Washington Evidence Based Practice Institute (EBPI) was charged with:

1. Conducting a readiness assessment of system of care expansion statewide in partnership with family and youth,
2. Supporting the data and information needs of the Children's SOC statewide expansion effort, and
3. Evaluating the success of the grant in expanding systems of care statewide, and in achieving the stated core goals:
    - Establish Systems of Care as Health Homes for children with SED Involved with multiple state agencies (policy)
    - Reallocate "deep-end" resources (fiscal)
    - Take Wraparound to scale statewide (practice)

To remain true to the intention of being family- and youth-driven, primary partners in this evaluation and needs assessment process including statewide youth organizations (Youth N Action, which is located within the UW EBPI), family leaders, and the state's four regional Family, Youth, and System Partner Roundtables (FYSPRTs) that were organized as part of the SOC Expansion Planning grant.

1. Readiness Assessment

Washington State has invested in a range of needs assessment and evaluation projects regarding children's mental health in the past 5 years. The System of Care Expansion Planning grant has also resourced a number of additional needs sensing, readiness assessment, and "lessons learned" exercises during this expansion planning grant year. Overall, results from 12 evaluations of system readiness, summarized above were used to inform the Washington State strategic planning process and strategic plan. See Appendix I for full results. A summary is provided below:

System of Care Development Domain	Summary of Readiness Assessment Findings (specific assessments/reports indicated in parentheses)
System of Care Plan, Approach and Value Base	• Many local providers embrace SOC values/understand wraparound principles (2,3) and are locally adaptive (4,8,9,10) • Consensus on meaning of wraparound practice model and principles is growing, but there is a need for better statewide operational definitions (4,8,9) • The system continues to be governed by single-agency based service

	delivery, with infrastructures not established for cross-system collaboration (2,3, 6,8,9) • System of care expansion grant has established FYSPRTs as an encouraging governance approach (7,8,9) • System stakeholders in general do not use vocabulary of family driven or apply the principles (7,9) • Administrative data indicates that the proportion of children's MH dollars spent is trending away from community based services and toward restrictive services (6,9)
Service Delivery	• Many local providers embrace SOC values but this needs to be taken to scale (2,7,8,9) • Front end restrictions to care are common barriers. Access to care standards, utilization management, and other regulatory issues must be addressed for a seamless system of services to be available (1,8,9). • Incentives are needed to provide services after hours and in convenient settings (1,8,9) • Some local systems have well developed system of screening and eligibility determination, but it is not a statewide standard (4,8) • No eject/no reject policies are not the standard of care (4). • Intensive case management pilots provide a guide to system integration (8). • Transition aged youths must be supported into the adult system (8,9).
Service Array	• Family advocacy and support should be made more widely available (1,2,3,5,8,9). • Youth advocacy and peer support should be made available (1,5,8,9). • More availability of EBPs and high-quality/promising practices in targeted areas (youth at risk of out-of-home placement, youth exposed to past trauma, youth with co-occurring mental health and substance abuse disorders, behavioral problems) are needed (1,2,3). • Formal, high-fidelity wraparound process should be made available for a

	targeted group of youth with the most intensive needs (1,3,8,9). • Specific Services for transition aged youths must be made available (8,9) • Greater availability of services that can intervene early with behavioral problems of youths before it reaches crisis stage (1,2,3,8,9).
System Infrastructure	• Fiscal support such as blended or braided funding for multi-system youths is needed – there is no plan for such a fiscal strategy in the state (2,3,8,9) • Increase leadership roles of youth and families in system design and accountability (1,8,9). • System has a strength in terms of potential accountability structures (e.g., UW evaluation and research expertise, wraparound pilot evaluations, National Wraparound Initiative (2,9). • System has a relative strength in terms of capacity to support human resource development in wraparound and SOC; however it needs to be taken to scale statewide (2,4,8,9,10). • Information Technology that supports implementation of wraparound teams and evaluation of quality and outcomes is needed (4,8,9). • Regulatory changes to WAC regarding licensing and auditing, billing, and intake and diagnosis are needed to ensure wraparound and family/youth support can be consistently available (5,8,9).

2. Meeting Information Needs and Developing Data Infrastructure

Working with youth and family advocates, the UW EBPI has met information needs of the Expansion planning grant process through several mechanisms:

- Conducting focus groups of families, youth, and system partners statewide
- Compiling and interpreting information from needs assessments and evaluations that are relevant to the planning process (see above)
- Conducting evaluations of relevant service initiatives and applying results and findings to planning process (e.g., evaluation of statewide wraparound pilots; see below)
- Co-chairing an effort to develop a statewide performance monitoring process for children's mental health (see below)

Evaluation of Wraparound Pilots

Results from evaluation in the 3 counties showed that wraparound fidelity has declined some with less available workforce practice supports. The July 2012 Wraparound Workforce Development survey reported that ten of 12 RSNs provide Wraparound training with eight of twelve surveyed agencies reporting that they provide wraparound and that the "10 principles are infused" within children's services. Themes reflecting these principles were frequently heard at the Lessons Learned events conducted in April and May 2012. Based on low scores related to fidelity to each of the wraparound principles the strategic plan includes: 1) a plan for outcome (not just provision of care) measurement – the data workgroup will address this in an ongoing manner, specifically CANS will be implemented in 2013, and 2) continued efforts toward sustainable funding and policy supports in addition to the cross-system partnerships. Regional FYSPRTs provide a forum for cross-system partnerships and will continue to be supported and enhanced.

Washington State System of Care Data Quality Team (Children's Behavioral Health)

In addition, a primary achievement of the Expansion Planning Grant process was development of the Washington State System of Care Data Quality Team (Children's Behavioral Health). This team will provide a forum for developing and refining data collection and management strategies related to screening, assessment, quality and performance monitoring, outcomes evaluation, and other types of accountability activities relevant to Washington State's Children's System of Care. The Workgroup will also assure integration of data activities across systems involving children, youth and families. Specific functions are to:

- Identify system-wide performance indicators for children's mental health and the state's system of care, with input from SOC Executive Team, Statewide FYSPRT and others as required. Determine performance indicators' operational definitions, source and frequency of data collection as well as data reporting format.
- Oversee the process of conducting statewide screening and assessment using standardized instruments such as the Child and Adolescent Needs and Strengths (CANS).
- Develop strategies for monitoring quality of services provided by child and family teams, and "intensive services" rubric and other service categories relevant to Washington's System of Care.
- Provide accurate and timely data analysis of data relevant to the above projects.
- Provide timely data reports to the SOC Executive Team, Statewide and Regional FYSPRTs as well as RSNs to facilitate continuous quality improvement.
- Solicit feedback and input from end users to assure data collection, analysis, reporting, and accountability activities are meeting SOC values and goals.
- Meet or exceed SAMHSA reporting requirements for TRAC and GPRA.
- Look for opportunities to improve data collection and reporting processes and make desired changes.

Statewide Children's Mental Health Performance Monitoring

The Tables below present the current Performance Monitoring plan for Children's MH in Washington State, including results, indicators, and data sources.

GOAL AREA 1: HEALTH

Children and youth are emotionally and physically healthy and receive the support they need to manage their mental health

System of Care objectives for children and youth with identified mental health issues		Indicators	Possible Comparison
1.1	Children and youth experience improved functioning and reduction in symptoms	Number and proportion of children and youth with mental illness who have functional impacts such as crisis encounters, suicidal behavior, drug overdoses, inpatient stays and substance abuse from administrative data sources	Children and youth with SED and intensive service needs in follow-up period compared to similar group in baseline period
1.2	Children and youth screened and treated if necessary for substance abuse	Number of youth with AOD need as indicated by CANS and other administrative data sources who are screened, identified, and/or treated for substance abuse	Children and youth with any mental health needs in follow-up period compared to similar group in baseline period
1.3	Children and youth do not use emergency rooms for treatment inappropriately	Rate of emergency department use	Children and youth with any mental health needs in follow-up period who receive evidence-based services compared to those who receive other services as usual.
1.4	Children and youth demonstrate reduced recidivism and involvement in	Number and proportion of youth with mental illness who have any criminal justice	Children and youth with mental illness who receive evidence-based

	juvenile justice	involvement, including arrests, court filings, and convictions	services, compared to similar youth who do not
1.5	Children and youth receiving psychotropic medications are also receiving mental health treatment	Number and proportion of children and youth with mental health needs receiving psychotropic medications who receive additional mental health treatment	Comparison of similar youth over time; pre and post baseline periods

GOAL AREA 2: HOME
Children and youth live in safe, stable, home or home-like settings that support their resilience and well-being

System of Care objectives for children and youth with identified mental health issues		**Indicators**	**Possible Comparison**
2.1	Children and youth live and receive treatment in the context of their family, home, and other natural settings	Proportion of services delivered in community or outpatient settings; services treatment received in home or community, outpatient, and inpatient services, will be analyzed together and separately	Comparison of similar youth over time; pre and post baseline periods
2.2	Children and youth have less long-term inpatient stays and shorter inpatient hospitalization stays	Number and proportion of children and youth with long-term inpatient stays and length of inpatient hospitalizations	Comparison of similar youth over time; pre and post baseline periods
2.3	Children and youth are safe	TBD	TBD
2.4	Children and youth in child welfare achieve permanency within federal guidelines or sooner.	TBD	TBD

GOAL AREA 3: PURPOSE

Children and youth learn, work, and contribute meaningfully to their community

System of Care objectives for children and youth with identified mental health issues		Indicators	Possible Comparison
3.1	Children and youth are successful in school	Achievement, attendance, continuous enrollment, CANS functional indicator	Children and youth with mental illness who receive evidence-based services, compared to similar youth who do not
3.2	Youth complete high school	High School Graduation and GED	Children and youth with mental illness who receive evidence-based services, compared to similar youth who do not

GOAL AREA 4: COMMUNITY

Youth are engaged in relationships and social networks that provide support, friendship, love, and hope

System of Care objectives for children and youth with identified mental health issues		Indicators	Possible Comparison
4.1	Families and natural supports are fully integrated into treatment	Integration of family members and natural supports on CFTs as assessed by Child and Family Team quality tool reported satisfaction levels	Youth with SED who receive intensive services and/or wraparound, compared to similar youth who receive no services or services as usual.
4.2	Youth and families have access to peer support when needed	Number of certified peer counselors accessed by parents, caregivers and youth	Comparison of similar youth over time; pre and post baseline periods

GOAL AREA 5: PRACTICE

Services are family-driven, youth-guided, integrated, developmentally appropriate, and culturally competent, and practice is evidence based

Outcomes		Indicators	Possible Comparison
5.1	Duplication of care and care plans is minimized	Child and Family Team (CFT) quality tool satisfaction survey questions	Kids with intensive services compared to similar group where such services have not yet been phased in
5.2	Services are integrated, flexible, and capable of meeting individualized needs, including the needs of youths with the most complex needs	Services received are consistent with findings from CANS assessment and measures constructed from admin data	Kids with intensive services in follow-up period compared to similar group in baseline period (admin data only)
5.3	Services, supports, and practices are research or evidence-based	Proportion of services that are EBP's	Kids with MI receiving EBPs in follow-up period compared to similar group in baseline period

GOAL AREA 6: SYSTEM

A comprehensive continuum of effective services, from prevention, early identification, and intervention through crisis intervention and inpatient treatment, and including care coordination and peer support, is available and accessible

Outcomes		Indicators	Possible Comparison
6.1	The system provides a comprehensive and accessible array of services for children, youth, and families	The availability of child and family teams, EBPs and mental health treatment across the state relative to estimated need	Comparison over time; pre and post baseline periods
6.2	The system is characterized by accessibility and equity in access to care for children, youth,	The proportion of mental health and substance abuse treatment services delivered across the	Comparisons of those receiving needed mental health and other services by race/ethnicity/RSN

	and families	state by gender, race, ethnicity, and geography, relative to estimated need	

3. Evaluation of the Expansion Planning Grant

As part of its method of completing an evaluation of the success of the project in achieving its core goals, Eric Bruns, Ph.D., UW Associate Professor, Co-Director of the EBPI, and Director of the National Wraparound Initiative is conducting key Informant interviews of family and youth and state leaders. Informants are being asked their perspectives on the State's success and strategies in the above areas. Data collection is ongoing, and information will be used to inform expansion grant planning in ongoing fashion as well as help ensure DSHS and DBHR leadership are focused on core SOC expansion goals and self-assessment of success. Data from the Children's MH Performance Assessment Dashboard, quality assessment systems that will be built in upcoming years, and other sources will also be used as core metrics of success of the Washington State SOC Statewide Expansion process.

Readiness Assessment

Washington State's System of Care (SOC) Expansion Planning process and Strategic Plan were informed by a range of evaluation, administrative data analysis, and needs sensing activities spearheaded by the DBHR Expansion Planning Grant team, the University of Washington Evidence Based Practice Institute (EBPI), and other entities. Taken together, this synthesis of results, findings, and lessons learned represent our assessment Washington State's "Readiness" to take the system of care framework to scale. Specifically, the results and findings of these various evaluations and assessment reports point to (1) relative strengths on which our state can build and (2) needs for improvement in our child serving systems that provide focus for our strategic plan and its activities.

Method

During the Expansion Planning Grant year, the University of Washington (UW) EBPI facilitated a family- and youth-driven process to:

1. ***Compile current and recent evaluation and assessment reports*** that point to SOC readiness, strengths, and needs;
2. ***Conduct new/original data collection*** to engage youths, family leaders, and system partners; fill gaps in knowledge and understanding of "readiness;" and inform the strategic planning process; and
3. ***Synthesize the information*** into a consistent structure that aligns with the field's best understanding of the ***domains of statewide system of care expansion***.

To remain true to the intention of being family- and youth-driven, primary partners in this needs assessment process including statewide youth organizations (Youth N Action, which is located within the UW EBPI), family leaders (Jeanette Barnes, consumer and family liaison, DBHR),

and family and youth leads from the state's four regional Family, Youth, and System Partner Roundtables (FYSPRTs) that were organized as part of the SOC Expansion Planning grant. Below we summarize the current and recent evaluation reports that were used in this readiness assessment, the new and original data collection that was undertaken, and the method we used to synthesize the information using a well-established set of SOC domains.

Current and recent evaluation reports

The following relevant research, evaluation, needs assessment, and other reports were compiled and used during Expansion Planning Grant activities and are synthesized in this summary report.

Report*	**Authors/Year**	**Purpose/Methods**
Comprehensive Children's Mental Health Needs Assessment (1)	University of Washington School of Medicine, Evidence Based Practice Institute, 2009	Legislatively mandated comprehensive assessment of adequacy of access to and quality/effectiveness of state children's MH services. Findings and recommendations were based on statewide Community Forums (N=170, N=180); Interviews and questionnaires completed by Regional Support Network (RSN) representatives (N = 8); Input from DSHS Assistant Secretaries and Administrators (N = 4); A statewide Children's Mental Health Survey (N = 1,065); and Two Tribal Roundtables (N=23, N=22).
Community Supports for Wraparound assessment (2)	University of Washington School of Medicine, Evidence Based Practice Institute, 2010	Evaluation of state and community readiness to support local wraparound initiatives. Findings and recommendations were based on ratings from local stakeholders using a standardized instrument (the Community Supports for Wraparound Inventory, CSWI; Walker & Bruns, 2009).
Wraparound Washington pilot site evaluations (3)	University of Washington School of Medicine, Evidence Based Practice Institute, 2010, 2011, 2012	Evaluation of DBHR-funded wraparound pilot projects in three counties. Findings and recommendations based on longitudinal outcomes data collection of enrolled youths and families, wraparound fidelity assessment using standardized instruments (e.g., the Wraparound Fidelity Index or WFI), and stakeholder interviews.
State wraparound & SOC Summit participant survey (4)	DBHR and National Wraparound Initiative, 2010	Structured survey of the strengths and needs of Washington State's children's system of care and wraparound implementation context. Used a structured survey that asked a representative group of stakeholders (N=65) that attended a statewide Summit to rate state readiness to implement SOC and wraparound.
Assessment of SOC billing, accreditation,	University of Washington School of Medicine,	Assessment of the conduciveness of current Washington State regulatory codes to model-adherent implementation of wraparound.

and regulatory context (5)	Evidence Based Practice Institute, 2010, 2011, 2012	
Washington State Cross-Systems MH Performance Monitoring Dashboard (6)	Washington State DSHS, Research and Data Analysis Division and MH Transformation Workgroup, 2010-2012	A primary product of Washington's SAMHSA-funded MH Transformation Grant project, the "Dashboard" is a continually updated statewide, cross-system assessment of the performance of the statewide system of care for individuals with mental illness in Washington State. Relies primarily on administrative data from Washington's well-developed integrated database.

* Numbers in parentheses identify the report and provide a means for cross-referencing reports to summary findings in the Results section

New/Original Data Collection

In order to fully engage youths, family leaders, and system partners in the readiness assessment process and to fill gaps in knowledge and understanding of "readiness" for system of care expansion, the SOC Expansion Grant and evaluation teams conducted several additional SOC expansion readiness assessment activities during the course of the Grant Project. These are summarized below:

Report*	**Authors/Year**	**Purpose/Methods**
Family-driven Care and Practice System Self-Assessment Tool (7)	Portland State University and DBHR (Jeanette Barnes), 2012	The Family-driven Care and Practice System Self-Assessment Tool was used by the statewide FYSPRT to get a sense of Washington State's current capacity to make the transformation to system of care-guided practice. A standardized instrument (Huff & Osher, 2007) was used in the context of two statewide FYSPRT meetings.
East and West Side Lessons Learned Forums (8)	Portland State University, DBHR, and UW, 2012	Two convenings of stakeholders intended to glean the important aspects of SOC expansion to attend to in the core areas of focus for the project: 1. Infuse SOC Values in all Systems for Children, Youth, and Families; 2.Ensure Services are Seamless for Children & Youth who are the Population of FOCUS; 3.Build Access and Availability of Home and Community Based Services; 4.Develop/Strengthen Workforce that Operationalizes SOC Values; 5. Strength Build Strong Data Management Systems to Inform Decision Making and Ensure Outcomes
Regional Family, youth, and system partner Focus	Youth N Action / UW Evidence Based Practice Institute, 2012	Regional focus groups conducted as part of quarterly Regional FYSPRT meetings to get youth, family, and stakeholder input on strengths and needs and overall readiness to expand SOC statewide in Washington.

Groups (9)		Used structure of the Rating Tool for Community Level Implementation of the System of Care Approach (Stroul, 2012) to organize focus group questions and input.
Survey of providers and regional support networks (RSNs) (10)	DBHR and UW EBPI, 2012	Survey of major provider organizations (N=17) and RSNs (N=12) regarding their readiness to implement aspects of the Washington State core practice model (system of care principles and child and family teams) per interim agreement of the TR vs. Dreyfus lawsuit.
Interviews with Agency Leadership (11)	Youth N Action / UW Evidence Based Practice Institute, 2012	A youth and family-led process to evaluate the perspectives of key leadership at DBHR on the state's strengths and needs regarding SOC expansion and the success of the SOC expansion planning grant process (still underway).

* Numbers in parentheses identify the report and provide a means for cross-referencing reports to summary findings in the Results section

Domains of Statewide System of Care Implementation

Findings and recommendations from the above assessments and evaluations were organized by an adapted version of the domains of the *Rating Tool for Community Level Implementation of the System of Care Approach* (Stroul, 2012). This approach provided a means for organizing findings and recommendations using a well-validated framework developed by the original developer of the system of care concept.

SOC Domains:

1. System of Care Values and Approach

2. Service Delivery
    a. Individualized, Wraparound Approach to Service Planning and Delivery
    b. Family-Driven Approach
    c. Youth-Guided Approach
    d. Coordinated Approach
    e. Culturally and Linguistically Competent Approach
    f. Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches
    g. Least Restrictive Approach

3. Service Array
    a. Services and Supports
    b. Treatment Services
    c. Supportive Services
    d. Out-of-Home Treatment Services'
4. System Infrastructure

a. Structure/Focal Point for Policy Making
b. Financing
c. Interagency Partnerships/Agreements
d. Family Organization and Partnerships
e. Capacity to Use Data to Inform Decision Making and for Continuous Quality Improvement
f. Capacity for Training, TA, Workforce Development

Results

Findings are organized by the four major domains of the *Rating Tool for Community Level Implementation of the System of Care Approach* (Stroul, 2012) and are listed in detail in the previous section, Evaluation and Performance Assessment. **A full summary of recommendations by report is provided in Appendix I.**

Discussion

Washington State has invested in a range of needs assessment and evaluation projects regarding children's mental health in the past 5 years. The System of Care Expansion Planning grant has resourced a number of additional needs sensing, readiness assessment, and "lessons learned" exercises, as well as a process of applying results of all these assessments and evaluations to the strategic planning process.

Results from the 12 evaluations of system readiness, summarized above were used to inform the current strategic planning document. This is most directly observable in the matrix of strategies and goals found in the main body of the plan. Examples of how the readiness assessment informed the strategic plan elements are provided below:

- Adoption of SOC language and principles is far from universal across Washington's child serving systems. Thus, among other strategies, the plan states that SOC values and principles will be infused in agency, provider, and RSN contract language.
- Washington has not yet fully embraced high-level cross-system collaboration. Thus, development of high-level governance structures; cross-system referral, screening, and assessment approaches; cross-system care coordination agreements; and cross-system trainings have been included as priority strategies.
- Specific fiscal mechanisms to support SOC and wraparound-based approaches have been discussed for years but not yet fully implemented in Washington. Thus, the strategic plan asserts that Washington will:
    - explore re-alignment of future state block grant, Medicaid and other fund sources to support the short-term and long-term strategic plan
    - implement state plan modalities to ensure the EBPs, wraparound and intensive services are Medicaid "matchable;"
    - examine alternative waiver strategies to develop a differential mental health benefit package for children co-served by Children's Administration; and
    - develop and maintain a cross system finance workgroup of the State wide FYSPRT with high level finance individuals from identified system partners.

- The community service array is not consistent and of adequate intensity statewide. Thus, the strategic plan states that Washington will develop mechanisms to facilitate screening, identification, and access to care coordination, mobile crisis, and intensive in-home supports, as well as EBPs such as MTFC, AFCBT, TF-CBT, and CBT-Plus.
- Though advocates have been asserting the need for years, Family and youth peer support is not widely available in Washington. The strategic plan asserts that training and fiscal support for these critical elements of the workforce will be developed.
- Although expertise is prominent in Washington, training and workforce development for critical services such as wraparound care coordination is fragmented. The strategic plan asserts that a Center of Excellence will be established.
- Despite substantial state and local investment in wraparound and SOC implementation, a common information technology approach to support implementation, quality improvement, evaluation, and management has not been obtained or developed. The plan states that funding will be prioritized to support the development of an evaluation and data collection process that is based on the System of Care values, principles.

SOC Infrastructure Organizing Documents

Statewide FYSPRT Charter:

STATEWIDE FAMILY YOUTH & SYSTEM PARTNER ROUND TABLE (FYSPRT)

For Washington State's Systems of Care Project

CHARTER

Project Name: Statewide Family, Youth & System Partners Round Table (FYSPRT) Charter

Prepared By: Margarita Mendoza de Sugiyama

Date: July 29, 2012

A Purpose of the STATEWIDE FYSPRT

Primary Functions

The primary function of the STATEWIDE FYSPRT is to take responsibility for the development of a statewide infrastructure building plan that will address the outcomes of the Washington State Systems of Care Project (WSSOCP). The FYSPRT will monitor and review the project status, as well as provide oversight of the project deliverables. The FYSPRT provides statewide leadership to influence the establishment and sustainability of SOC values and principles throughout the planning grant and beyond. The FYSPRT provides insight on long-term strategies in support of Washington State's Systems of Care Project. FYSPRT members support and track the five goals of the Washington State System of Care (SOC) Grant which are to:

1. Infuse SOC values in all systems for children, youth, and families.
2. Ensure services are seamless for children and youth who are the population of focus and their families.
3. Build access and availability of home and community based services.
4. Develop and strengthen a workforce that operationalizes SOC values.
5. Build a strong data management system to inform decision making and track outcomes.

The goals of Washington State's Systems of Care project and well as the SOC values and principles are monitored to determine the degree of goal achievement related to institutional processes and mental health service delivery. Statewide FYSPRT responsibilities include performing the following functions:

- Providing assistance to the project as appropriate;
- Controlling project scope as emergent issues may force changes to be considered, ensuring that scope aligns with the agreed business requirements of the project sponsor and key stakeholder groups;
- Provide input into direction and approaches; and
- Work together to accomplish project deliverables.

Communication Responsibilities

- Maintain communication with Executive Team, work groups, and Regional FYSPRT.
- Provide timely SOC progress reports to chain of command authorities for feedback and support.

Decision Making Responsibilities

The FYSPRT is responsible for approving project elements such as:

- Prioritization of project objectives and outcomes as identified in the grant;
- Deliverables as identified in the project *Scope Statement*;
- Schedule;
- Project management and quality assurance practices.
- Workgroup over site

B Statewide FYSPRT

Membership

In addition to the executive sponsors as *ex-officio* members, the initial Statewide FYSPRT members will consist of the following stakeholder members:

Name	Role	Agency
Alice Huber	Principle Investigator	DSHS/DBHR/EQA
Andrea Parrish	SOC Project Director	DSHS/DBHR/CMH
Kathy Smith-DiJulio	SOC Research Manager	DSHS/DBHR/EQA
Margarita Mendoza de Sugiyama	SOC Project Manager	DSHS/DBHR
Jeanette Barnes	SOC Family Lead	DSHS/DBHR

Tamara Johnson	SOC Youth Lead	Youth 'N Action
Starcia Ague	Youth Representative	Youth 'N Action
Tina Burrell	CD Representative	DSHS/DBHR/CD
Christie Seligman	DDD Representative	DSHS/DDD
Monica Reeves	DDD Representative	DSHS/DDD
Barb Putnam	CA Representative	DSHS/CA
Michael Luque	CA Representative	DSHA/CA
Dan Schaub	JRA Representative	DSHS/JRA
Jacob (Jake) Towle	JRA Representative	DSHS/JRA
Ron Hertel	OSPI Representative	Office of Superintendent of Public Instruction
Sarah Butzine	OSPI Representative	Office of Superintendent of Public Instruction
Maria Nardella	DOH Representative	Department of Health
Carol Miller	DOH Representative	Department of Health
Margaret Wilson	HCA Representative	Health Care Authority
Helen Fenrich	IPAC Representative	Indian Policy Advisory Council
Becky Bates	NE FYSPRT Family Representative	North East Regional FYSPRT
Wilde Sage	NE FYSPRT Youth Representative	North East Regional FYSPRT
Danielle Groth-Cannon	NE FYSPRT System Representative	North East Regional FYSPRT
Lori Gendron	SE FYSPRT Co-Family Representative	South East Regional FYSPRT
Melissa Sanchez	SE FYSPRT Co-Family Representative	South East Regional FYSPRT
Cathy Callahan-Clem	NW FYSPRT Co-Family Representative	North West Regional FYSPRT
Kim Thomas	NW FYSPRT Co-Family Representative	North West Regional FYSPRT

Vicky McKinney	SE FYSPRT Co-Family Representative	South West Regional FYSPRT
Jimmie Lundquist	SE FYSPRT Co-Family Representative	South West Regional FYSPRT
Judy Hall	Planning, Performance and Accountability Education Liaison	DSHS/PPA
Keri Waterland	Finance Work Group Lead	DSHS/ADSA
Lin Payton	Core Practice Model Workforce Development Co-Lead	DSHS/DBHR/CMH
Eric Bruns	SOC Facilitation Member & Core Practice Model Co-Lead	University of Washington School of Medicine

Role of a Statewide FYSPRT Member

It is intended that the Statewide FYSPRT leverage the experiences, expertise, and insight of key individuals, organizations, and departments that are committed to building a Systems of Care for children's mental health. Statewide FYSPRT members are not directly responsible for managing project activities, but provide support and guidance for those who do. Thus, individually, members will:

- Help move our respective part of the system towards system of care values and principles in workforce development, policies, practice, financing, and structural change.
- Provide SOC progress reports to respective partner leadership for feedback and support.
- Bring individual and agency strengths in completing necessary tasks.
- Identify barriers/challenges and approaches to resolve issues.
- Identify strengths/initiatives/projects of existing system agencies that support systems of care.
- Educate other system of care partners.
- Develop problem solving approaches for moving forward.

- Track demonstrations of success integrating the WA SOC Grant goals in activities/events.
- Gather SOC related activity information to submit for federal reporting in the TRAC System.
- Review the status of the project.
- Review SOC outputs for compliance with grant requirements and expectations of key stakeholders.
- Participate in writing the WA SOC plan representing agency perspective.

C Statewide FYSPRT Meetings

Meeting Schedule and Process

The Statewide FYSPRT will meet monthly or as needed to track issues and progress of statewide implementation and to provide on-going support to stakeholders.

Meeting Agenda

An agenda for regularly scheduled meetings will be developed by the SOC Project Manager with input from FYSPRT members. At each meeting, a project status report will be given by the project manager to the FYSPRT. Each member will also provide an update on any new or pending SOC activities from their respective organizations, work areas, and agencies.

D Timeline Requirements

Activities	Time Frame	Due
Getting Started Establish SOC Team Vision, Mission, Goals Determine Population Focus Conduct Environmental Scan Create Planning Timeline	October –December 2011	Partially complete
1st Quarter TRAC Report	October 1– December 31	January 31, 2012

Plan Development Identify core strategies to expand SOC approach Identify strategies for operationalizing SOC values in plan Expand vertical and horizontal partnerships and collaborative networks	January – March 2012	April 30, 2012
Semi-annual SOC Progress Report	October 1, 2011 - March 31, 2012	April 30, 2012
2nd Quarter TRAC Report	January 1-March 31, 2012	April 30, 2012
Development of Action Plan Determine actions, timelines, & roles and responsibilities for short & long –term strategic plan to expand SOC Determine financing plan to support implementation of action steps	April – June 2012	July 31, 2012
3rd Quarter TRAC Report	April 1- June 30, 2012	July 31, 2012
Benchmarks to Measure Plan; Finalizing Plan Determine benchmarks and measures to demonstrate progress towards SOC implementation and indicators of success	July- September 2012	September 30, 2012
4th Quarter TRAC Report	July 1-September 30, 2012	October 31, 2012

Regional FYSPRT Charter:

REGIONAL FAMILY YOUTH & SYSTEM PARTNER ROUND TABLE (FYSPRT)

For Washington State's Systems of Care Project

CHARTER

Project Name: Regional Family, Youth & System Partners Round Table (FYSPRT) Charter

Prepared By: Jeanette Barnes

Date: March 19, 2012

A Purpose of the Regional FYSPRT

Primary Functions

The primary function of the REGIONAL FYSPRT is to be an equitable partner in the development of a statewide infrastructure building plan that will address the outcomes of the Washington State Systems of Care Project (WSSOCP). The FYSPRT will monitor and review the project status, as well as provide oversight of the project deliverables. The FYSPRT provides statewide leadership to influence the establishment and sustainability of SOC values and principles throughout the planning grant and beyond. The FYSPRT provides insight on long-term strategies in support of Washington State's Systems of Care Project. FYSPRT members support and track the five goals of the Washington State System of Care (SOC) Grant which are to:

6. Infuse SOC values in all systems for children, youth, and families.
7. Ensure services are seamless for children and youth who are the population of focus and their families.
8. Build access and availability of home and community based services.
9. Develop and strengthen a workforce that operationalizes SOC values.
10. Build a strong data management system to inform decision making and track outcomes.

The goals of Washington State's Systems of Care project and well as the SOC values and principles are monitored to determine the degree of goal achievement related to institutional processes and mental health service delivery. Statewide FYSPRT responsibilities include performing the following functions:

- Providing assistance to the project as appropriate;
- Controlling project scope as emergent issues may force changes to be considered, ensuring that scope aligns with the agreed business requirements of the project sponsor and key stakeholder groups;
- Provide input into direction and approaches; and

- Work together to accomplish project deliverables.

Communication Responsibilities

Maintain communication with Executive Team, work groups, and Regional FYSPRT.

Provide timely SOC progress reports to chain of command authorities for feedback and support.

Decision Making Responsibilities

The FYSPRT is responsible for approving project elements such as:

- Prioritization of project objectives and outcomes as identified in the grant;
- Deliverables as identified in the project *Scope Statement*;
- Schedule;
- Project management and quality assurance practices.
- Workgroup over site

B Regional FYSPRT Leads

Membership

In addition to the executive sponsors as *ex-officio* members, the initial Statewide FYSPRT members will consist of the following stakeholder members:

Name	Role	Agency
Jeanette Barnes	SOC Family Liaison	DSHS/DBHR
Tamara Johnson	SOC Youth Lead	Youth 'N Action
Evey Rund	SOC Youth Lead Assistant	Youth 'N Action
Becky Bates	NE FYSPRT Family Representative	North East Regional FYSPRT
Wilde Sage	NE FYSPRT Youth Representative	North East Regional FYSPRT
Danielle Groth-Cannon	NE FYSPRT System Representative	North East Regional FYSPRT
Lori Gendron	SE FYSPRT Family Co-Representative	South East Regional FYSPRT
Melissa Sanchez	SE FYSPRT Family Co-Representative	South East Regional FYSPRT

Jimmie Lundquist	SW FYSPRT Family Co-Representative	South West Regional FYSPRT
Vicky McKinney	SW FYSPRT Family Co-Representative	South West Regional FYSPRT
Cathy Callahan-Clem	NW FYSPRT Family Co-Representative	North West Regional FYSPRT
Kim Thomas	NW FYSPRT Family Co-Representative	North West Regional FYSPRT
Stephanie Northern	NW FYSPRT Youth Representative	North West Regional FYSPRT

Role of a Regional FYSPRT Member

It is intended that the Regional FYSPRT leverage the experiences, expertise, and insight of key individuals, organizations, and departments that are committed to building a Systems of Care for children's mental health. Regional FYSPRT members are not directly responsible for managing project activities, but provide support and guidance for those who do. Thus, individually, members will:

- Help move our respective part of the work towards system of care values and principles in community organization, workforce development, policies, practice, financing, and structural change.
- Provide SOC progress reports to SOC Youth and Family Leads for feedback and support.
- Bring community, individual and agency strengths in completing necessary tasks.
- Identify barriers/challenges and approaches to resolve issues.
- Identify strengths/initiatives/projects of existing community and system agencies that support systems of care values and principles.
- Educate our system of care partners as we develop and grow.
- Develop problem solving approaches for moving forward.
- Track demonstrations of success integrating the WA SOC Grant goals in activities/events.
- Gather SOC related activity information to submit for federal reporting in the TRAC System and send that to the SOC Family or Youth Lead.
- Review the status of the project.
- Review SOC outputs for compliance with grant requirements and expectations of key stakeholders.
- Participate in writing the WA SOC plan representing respective Regional FYSPRT perspective.

C Regional FYSPRT Meetings

Meeting Schedule and Process

Each Regional FYSPRT will host a meeting in their respective areas to track issues and the progress of the creation of the 1 and 5 year plans as well as tracking on-going support to stakeholders. Those dates are: NW FYSPRT, April 4th,
NE FYSPRT, June 20th, SW FYSPRT, August 15th. There is video conference type meetings scheduled for May 30th and July 11th for 2 hours each. Other meetings will be scheduled as needed for special topics or events.

Meeting Agenda

Agenda topics will be offered by each Regional FYSPRT and an agenda will be formulated for review for regularly scheduled meetings. At each meeting, an update will be given by each Regional FYSPRT. The updates will include new or pending SOC activities from their respective regions.

D Timeline Requirements

Activities	Time Frame	Due
Convene Planning Meeting– an outline and timeline of intended steps and activities to engage with families, youth, system partners and community organizations to accomplish deliverables outlined in SOW.	March-April 2012	April 30, 2012
Partnership Plan- an outline demonstrating evidence of partnership development including promotion of Cultural and ethnic relevance.	March-May 2012	Draft May 30, 2012

Technical Assistance Plan- outline plan for leadership development tool box.	April-July 2012	Submit as needed or monthly
Growth and Sustainability Plan- outline plan to support ongoing engagement and participation with families, youth, system partners and community organizations.	May-August, 2012	September 15, 2012
Plan Development - Identify core strategies to expand SOC approach Identify strategies for operationalzing SOC values in plan Expand vertical and horizontal partnerships and collaborative networks	January – March 2012	April 30, 2012
Semi-annual SOC Progress Report	October 1, 2011 - March 31, 2012	April 30, 2012
2nd Quarter TRAC Report	January 1-March 31, 2012	April 30, 2012
Development of Action Plan - Determine actions, timelines, & roles and responsibilities for short & long –term strategic plan to expand SOC Determine financing plan to support implementation of action steps	April – June 2012	July 31, 2012
3rd Quarter TRAC Report	April 1- June 30, 2012	July 31, 2012

Benchmarks to Measure Plan; Finalizing Plan - Determine benchmarks and measures to demonstrate progress towards SOC implementation and indicators of success	July- September 2012	September 30, 2012
4th Quarter TRAC Report	July 1-September 30, 2012	October 31, 2012

Regional FYSPRT Leads

Washington State System of Care (SOC)
Regional Family, Youth and System Partners Round Table (FYSPRT) Leads (7/11/12)

North East Regional FYSPRT
Counties:
Okanogan, Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams, Grant, Chelan, Douglas

Becky Bates
bbates@passagesfs.org
509-892-9241

Wilde Sage
wildeasage@gmail.com
509-294-7506

Danielle Groth-Cannon
dcannon@Spokanecounty.org

North West Regional FYSPRT
Counties:
Jefferson, Clallam, Kitsap, Pierce, King, Snohomish, Skagit, Whatcom, San Juan, Island

Cathy Callahan-Clem
cathyc@smh.org
206-459-6467

Kim Thomas
Kimth@smh.org

206-714-4371

South West Regional FYSPRT
Counties:
Grays Harbor, Mason, Thurston, Pacific, Wahkiakum, Lewis, Cowlitz, Clark, Skamania

Vicky McKinney
vmckinney@wapave.org
253-565-2266

Jimmie Lundquist
Jimmielongview@aol.com
360-430-1414

South East Regional FYSPRT
Counties:
Yakima, Kittitas, Klickitat, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, Whitman

Lori Gendron
lorig@namiyakima.org
509-453-8229

Melissa Sanchez
melissas@namiyakima.org
509-453-8229

System of Care Data Quality Team (Children's Behavioral Health)

CHARTER

Co-Chairs: Alice Huber, Eric Bruns, Tamara Johnson

Date: May 16, 2012; reviewed September 10, 2012

E Purpose

The mission of the Children's Behavioral Health System of Care (SOC) Data Quality (DQ) Team is to provide a forum for developing and refining data collection and management strategies related to screening, assessment, performance measurement and quality improvement relevant to children's behavioral health in Washington State. Reporting, outcomes evaluation, and other types of accountability activities are another aspect of the Team purpose. Working in an inclusive and transparent fashion the Team will assure integration of data activities across systems involving children, youth and families.

Specific functions:

- Identify system-wide performance indicators for children's behavioral health and the state's SOC, with input from SOC Executive Team, Statewide FYSPRT and others as required. Determine performance indicators' operational definitions, source and frequency of data collection as well as data reporting format.
- Seek and consider input from stakeholders and partners regarding data collection, analysis and reporting.
- Develop strategies for monitoring behavioral health services for children/youth throughout the state.
- Monitor intensive services provided through the core practice model for children's behavioral health.
- Recommend, review and interpret analysis and required children's behavioral health services reports to SOC Executive Team and FYSPRTs.
- Recommend, review and monitor the use of screening and assessment with standardized instruments. For example, a subset of children and youth in RSNs will receive the Child and Adolescent Needs and Strengths (CANS).
- Provide regular data reports to the SOC Executive Team, Statewide and Regional FYSPRTs as well as RSNs to facilitate continuous quality improvement.
- Provide a forum for sharing relevant behavioral health research occurring across the SOC and with partners, families and youth and consider evaluation needs.

F Membership, Authority and Accountability

Membership

Membership is intended to be broad and include representatives from state agencies, system partners, families, youth and DBHR staff.

Name	Role	Agency
Alice Huber	Co-chair, Principal Investigator	DSHS/DBHR
Eric Bruns	Co-chair, Associate Professor, UW School of Medicine	UW Children's Evidence Based Practice Institute; Director, National Wraparound Initiative and Wraparound Evaluation and Research Team
Tamara Johnson	Co-chair, SOC Youth Lead	Youth 'N Action
Kathy Smith-DiJulio	SOC Research Manager	DSHS/DBHR

Barb Lucenko	Senior Research Manager	DSHS/RDA
Jeanette Barnes	SOC Family Liaison	DSHS/DBHR
Lin Payton	MH Program Manager	DSHS/DBHR/CMH
Rebecca Kelly	Children's Supervisor	DSHS/DBHR/CMH
Tina Burrell	CD Representative	DSHS/DBHR/CD
Sarah Butzine	Representative of schools	Office of Superintendent of Public Instruction
	CA Representative	DSHS/CA
Monica Reeves	DDD Representative	DSHS/DDD
Teresa Vollan	DOH Representative	Department of Health
Dan Schaub; Jacob Towle	JRA Representative	DSHS/JRA
Barbara Lantz	HCA Representative	Health Care Authority
	Representative of Indian Programs	Office of Indian Programs
Traci Crowder	Provider Representative	Chief, Performance Management Behavioral Health Resources Olympia, WA
Raette Davis	RSN Representative	Optum Pierce RSN, Tacoma, WA
Hathaway Burden	Community Partner	Project Coordinator, Center for Children and Youth Justice Seattle, WA

Authority

The SOC DQ Team (Children's Behavioral Health) operates under the direction of the SOC Executive Team, statewide FYSPRT and DBHR Management.

Accountability

The SOC DQ Team is committed to open, transparent and public processes. Work products will be posted on a website (to be developed) with access available to youth, families, other caregivers and system partners.

G Meetings

Schedule

Monthly meetings throughout 2012, then TBD.

Agenda

An agenda will be developed by the SOC Research Manager in consultation with Committee Co-chairs with input from Team members.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Aging and Disability Services Administration

Division of Behavioral Health and Recovery

PO Box 45330, Olympia, WA 98504-5330

CHARTER FOR DBHR INTEGRATED WAC CHEMICAL DEPENDENCY TREATMENT AGENCIES AND COMMUNITY MENTAL HEALTH AGENCIES

Date: September 13, 2010

Customer/End User Group: Chemical Dependency Treatment, Problem Gambling, and Community Mental Health Agencies licensed and/or certified by the Department of Social and Health Services (the Department) Division of Behavioral Health and Recovery (DBHR).

Project Managers: Dennis Malmer and Pete Marburger

Executive Sponsors:

David Dickinson, Director, ADSA DBHR
Victoria Roberts, Chief, ADSA DBHR

Problem Addressed: DBHR licensed and certified chemical dependency treatment agencies and community mental health agencies that treat patients with substance abuse, problem gambling, and mental health conditions are required to meet multiple sets of laws -- Revised Code of Washington (RCW) and rules--Washington Administrative Code (WAC) – along with a number of federal rules, in order to provide treatment services. Agencies must comply with regulations authorized by:

Chapter 70.96A RCW*	Chapter 10.05 RCW*	Chapter 70.02 RCW*
Chapter 71.05 RCW*	Chapter 10.77 RCW	42 CFR – Public Health (Medicaid)
Chapter 71.24 RCW*	Chapter 46.61 RCW	42 CFR Part 2
Chapter 71.34 RCW*	Chapter 74.50 RCW	42 CFR Part 8
Chapter 43.20A.890 RCW*	Chapter 49.60 RCW	45 CFR Parts 160 & 164

Chapter 388-805 WAC
Chapter 388-816 WAC
Chapter 388-865 WAC (includes Credentialed Community Mental Health Agencies)
*Primary Rules

Scope and Background:
To allow DBHR licensed and certified chemical dependency and problem gambling treatment agencies and community mental health agencies that treat patients with substance abuse, gambling, and mental health conditions to meet one set of rules (WAC) rather than multiple sets of rules.

DBHR became an integrated division – substance abuse, gambling, and mental health – in July 2009. During the first year of integration, the DBHR Licensing and Certification Section explored and discussed a number of opportunities to collaborate and integrate licensing and certification procedures. The review process identified a number of similar procedures, which if consolidated, could lead to enhanced and more effective licensing and certification activities, increased focus on patient health, patient safety, and risk management requirements, while reducing the regulatory burden on agencies that provide behavioral health treatment services.

High Level Deliverable: DBHR will write, review, and implement an integrated WAC that will allow licensed and certified chemical dependency, problem gambling treatment agencies, and community mental health agencies that treat patients with substance abuse, gambling, mental health conditions, or a combination of the three to meet one set of rules (WAC) to provide behavioral health treatment services.

Steps

- Draft Integrated WAC charter
- Literature search
- Confirm project team members
- Determine project time line
- Determine resources available for the project
- Determine key assumptions
- Conduct cross-walk of current WACs
- Focus integrated WAC to address public and private behavioral health treatment entities
- Draft integrated WAC
- Provide for stakeholder review and comments
- Develop rule-making schedule and rule-making documents to codify new WAC
- Usability testing
- Plain talk

Key Staff:

Pete Marburger	Dennis Malmer	Kathy Sayre	
Tony O'Leary	Deb Cummins	Julián Gonzales	Linda Graves

Proposed Initial Community Partner Advisory Group:
Cheryl Mogensen, Kitsap Mental Health
Stacey Alles, Compass Health
Rick Weaver, Central Washington Comprehensive Mental Health
Nancy Parker, Columbia River Mental Health
Linda Grant, Evergreen Manor, Inc.
Pat Knox, Recovery Centers of King County
Jennifer LaPointe, Puyallup Tribal Treatment Center
Mikel Olsson, Behavioral Health Resources
Ann Christian, Washington Community Mental Health Council
Gayle A. Jones, Tulalip Tribal Behavioral Health Services
Mary Jadwisiak, Mental Health Advocacy Training and Consulting
Jim Vollendroff, King County Mental Health Chemical Abuse and Dependency Services

Key Assumptions: The DBHR Licensing Certification Section will draft a new set of rules for licensing and certifying chemical dependency and problem gambling treatment agencies and community mental health agencies under one WAC. The DBHR Licensing Certification Section will maintain four WACs for agencies to choose from which are:

- WAC 388-805 – Certification Requirements for Chemical Dependency Service Providers
- WAC 388-816 – Certification Requirements for Problem and Pathological Gambling
- WAC 388-XXX – Certification Requirements for Behavioral Health Services
- WAC 388-865 – Community Mental Health and Involuntary Treatment Programs

The new set of rules for agencies providing integrated behavioral health services must:

- Support the goal of recovery and resiliency for all clients who seek our care.
- Contain rules allowing for a single set of agency administrative, personnel, and clinical policy and procedures manuals that address specific treatment populations and levels of care.
- Contain rules allowing for clinical staff competency, patient rights, a single assessment, treatment plan, treatment plan review, clinical documentation, discharge plan, and continuing care plan, patient records, complaints/grievance procedures, and quality management.
- Support a simple set of data requirements for publicly-funded patients (combined TARGET/CIS data base).
- Allow Flexibility to publicly-funded agencies and private for-profit agencies to seek licensure or certification through the new integrated WAC.
- Align with Medicaid Rules, the State Plan, and Federal Block Grant requirements.

Key Constraints: Tackling this effort during a period of diminishing resources is both a challenge and an opportunity for DBHR, providers, contractors, and stakeholders in order to be

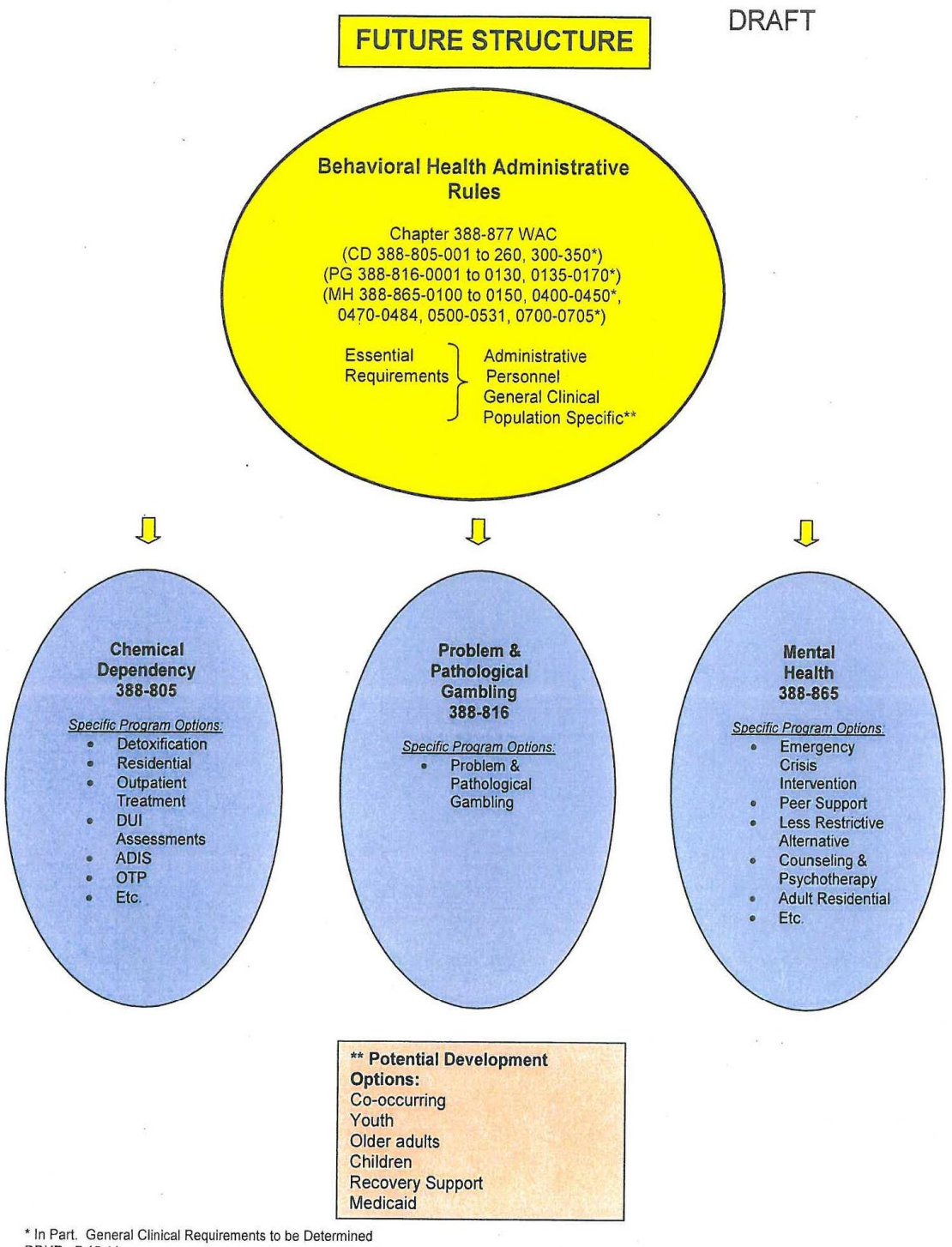
successful there will need to be a dedicated effort by everyone involved in the project. It will also be critical to do substantial work with stakeholders so that the final product can meet the needs of providers, contractors, the State, and most importantly the clients we serve.

Project Managers (signature):

_____	_____
Pete Marburger	Dennis W. Malmer

Executive Sponsors (signature):

_____	_____
Victoria Roberts	David A. Dickinson


DRAFT
FUTURE STRUCTURE
Behavioral Health Administrative Rules
Chapter 388-877 WAC
(CD 388-805-001 to 260, 300-350*)
(PG 388-816-0001 to 0130, 0135-0170*)
(MH 388-865-0100 to 0150, 0400-0450*, 0470-0484, 0500-0531, 0700-0705*)
Essential Requirements
Administrative
Personnel
General Clinical
Population Specific**
Chemical Dependency 388-805
Specific Program Options:
Detoxification
Residential
Outpatient Treatment
DUI Assessments
ADIS
OTP
Etc.
Problem & Pathological Gambling 388-816
Specific Program Options:
Problem & Pathological Gambling
Mental Health 388-865
Specific Program Options:
Emergency Crisis Intervention
Peer Support
Less Restrictive Alternative
Counseling & Psychotherapy
Adult Residential
Etc.
** Potential Development Options:
Co-occurring
Youth
Older adults
Children
Recovery Support
Medicaid
* In Part. General Clinical Requirements to be Determined
DBHR 7.15.11

CHARTER – YOUTH AND FAMILY PEER SUPPORT CURRICULUM DEVELOPMENT WORKGROUP

Purpose of the Group

To provide targeted stakeholder input by parents, family members and youth in transition involved in the system of care with lived experience in the public mental health system to the University of Washington for the purpose of creating (1) A family focused peer support training curriculum (2) A youth in transition focused peer support training curriculum (3) A knowledge test for each training (4) A power point for each training. The group is responsible for giving input into the SWOT analysis and editing the final products.

Primary Function(s)

The primary function(s) of the individual members of the group is to provide authentic feedback based on lived experience. Group members will be asked to perform the following primary functions in order for the purpose of the group to be fulfilled:

(1) Complete required homework assignments;
(2) Operate within the agreed upon "understanding of group engagement" which articulates how the group will interact with each other in order to be successful; and,
(3) Show up on time, respond to emails and phone calls in a timely manner and let the facilitator know when a member cannot participate or do homework assignments

Membership

Membership consists of parents, youth in transition and family members of diverse backgrounds and experiences from all over Washington State. Cultural and linguistic diversity will be encouraged and respected. Membership is by invitation only and acceptance of membership via telephone, email or mail signifies that the member agrees to perform the primary functions.

Meeting Schedule

The workgroup meets on an as needed basis. Survey monkey is used to ascertain the best possible meeting times for all involved. Work schedules, family life and school are all taken into consideration. Meeting at night and on weekends is probable if that is the best time for the families and youth to participate. The workgroup will meet up to four times in May, June, July and August of 2012.

Meeting Process

Meeting dates and times are dependent on the availability of each workgroup member. Availability is determined by survey, email and telephone depending on what workgroup member has identified as the best way to communicate with them. The hired consultant or UW employee will arrange travel, food and take minutes at the meeting.

The meeting process is outlined as follows:

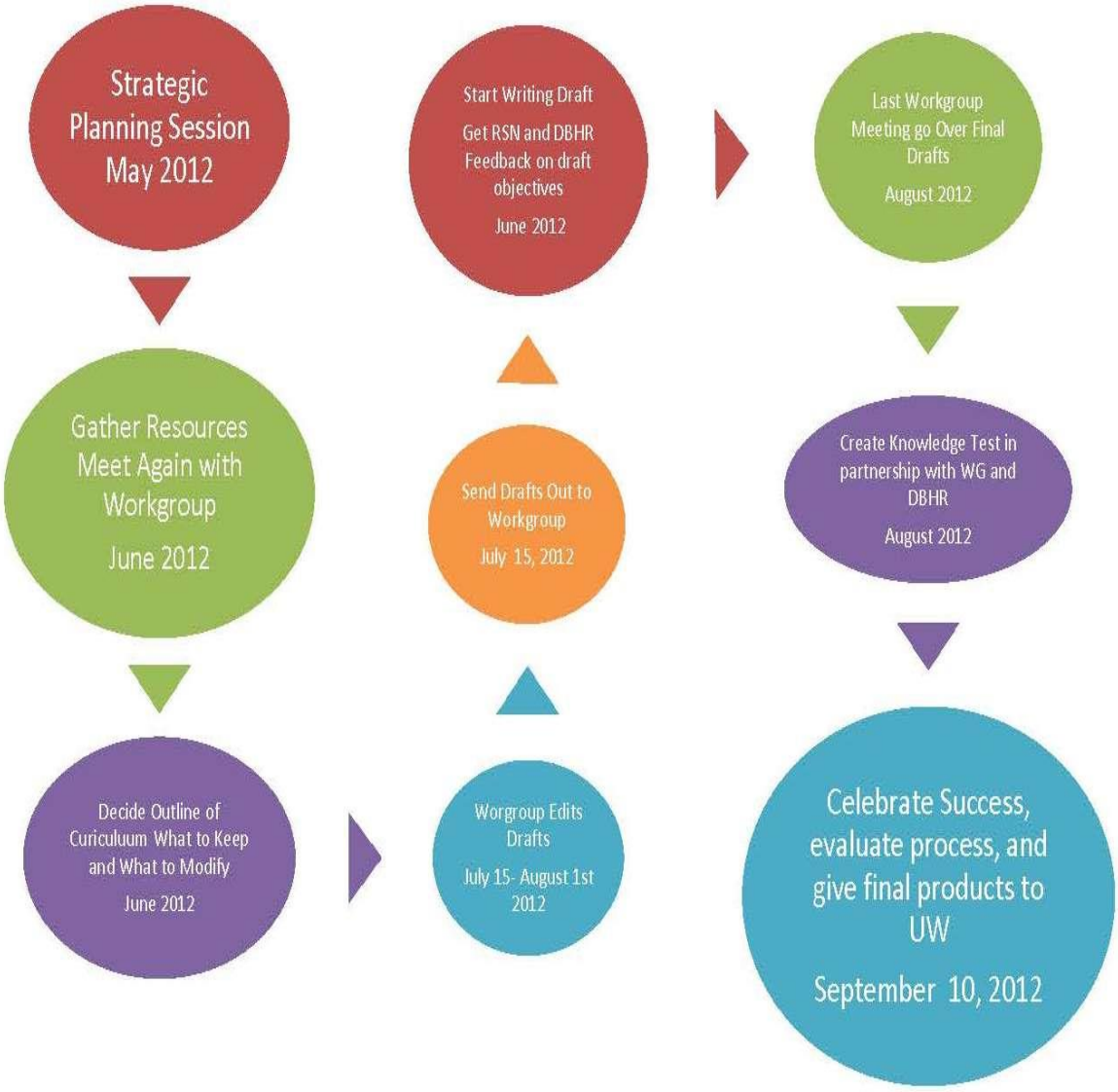
(1) Meeting time and date survey;
(2) Send homework and materials needed for next meeting;
(3) Co-development of agenda;
(4) Arrange for travel , map, directions and food;
(5) Ask for any special needs or accommodations and make arrangements to provide them;

---

(6) Introductions;
(7) Go over homework;
(8) Go over agenda (members may add to agenda at any time);
(9) Members will be asked at each meeting what it will take for them to personally feel like the meeting was successful;
(10) Workgroup members will be asked to participate in presentations and facilitation of the group at times;
(11) The meetings will be culturally and linguistically appropriate with interpreters available when needed. Family and youth culture will be respected;
(12) Participants will be provided a stipend for sharing their experience and expertise; and
(13) Notes will be taken at the meeting and distributed at least one week before the next meeting.
(14) Use parking lot and other tools for ease of facilitation

Understanding of group engagement "What will make us successful?"

Expect the best of people	Stay on track	Learn something new	Be flexible and non judgmental
Do your homework	Communication is more important than time	Leave excited as I was to get here!	Talk to outside networks about what this process is
The process needs to be as rewarding as the product	Respect each other	Come on time and prepared	Agree to disagree at times
Focus on what works .	Create a game plan	Create safe environment	Be honest and authentic in honoring the process
Finish the job	Think outside the box	Advocate for final product	Celebrate wins!


Strategic Planning Session May 2012
Gather Resources Meet Again with Workgroup June 2012
Decide Outline of Curiculuum What to Keep and What to Modify June 2012
Worgroup Edits Drafts July 15- August 1st 2012
Send Drafts Out to Workgroup July 15, 2012
Start Writing Draft Get RSN and DBHR Feedback on draft objectives June 2012
Last Workgroup Meeting go Over Final Drafts August 2012
Create Knowledge Test in partnership with WG and DBHR August 2012
Celebrate Success, evaluate process, and give final products to UW September 10, 2012

Appendices

A. What will a Re-designed Children's Mental Health System Look Like? (4/29/12)
B. CMH Redesign Training and Workforce Development on Child and Family Teamwork
C. SOC Work Groups Logic Models
D. WA SOC East & West Lessons Learned Events
E. Trauma Informed Care
F. DSHS Cultural Competence Administrative Policy 7.22
G. DSHS Cultural Competency Guidelines
H. DSHS Cultural Competency Key Principles
I. DSHS Gay, Lesbian, Bisexual, and Transgender Persons - Equity Work Group CHARTER – The Transformation through Action (insert document – Pedro job)
J. WA Governor's Executive Order 12-02
K. Readiness Assessment Major Findings/Recommendations
L. SOC Acronyms List

Appendix A

What will a Re-designed Children's Mental Health System Look Like?
April 29, 2012

The children's mental health system in Washington State will include the following elements:

a) A continuum of services from early identification, intervention, and prevention through crisis intervention and inpatient treatment, including peer support and parent mentoring services;

b) Equity in access to services for similarly situated children, including children with co-occurring disorders;

c) Developmentally appropriate, high quality, and culturally competent services available statewide;

d) Treatment of each child in the context of his or her family and other persons that are a source of support and stability in his or her life;

e) A sufficient supply of qualified and culturally competent children's mental health providers;

f) Use of developmentally appropriate evidence-based and research-based practices;

g) Integrated and flexible services to meet the needs of children who, due to mental illness or emotional or behavioral disturbance, are at risk of out-of-home placement or involved with multiple child-serving systems.

h) System of Care values infused in all systems for children, youth and families including system governance.

To accomplish this, the re-designed Children's mental health system will:

Establish Priorities for Children's Mental Health Services

- Prioritize access to mental health services for children of the state who are acutely mentally ill, severely emotionally disturbed, or seriously disturbed
- Recognize the special needs of children as an underserved population and insure that the needs of children who are disabled and/or low-income, and those of parents who are respondents in dependency cases are met within the priorities established in statute
- Prioritize children served by multiple child serving agencies for services

1

Be Culturally Competent

- Be sensitive to the unique cultural circumstances of children of color and children in families whose primary language is not English.
- Expect collaboration with tribes in the referral and treatment of Native American children.

Promote Prevention and Early Identification

- Promote the early identification of mentally ill children and ensure that they receive the mental health care and treatment which is appropriate to their developmental level.
- Value early identification, intervention, and prevention.

Include Parent and Youth Participation in Treatment and System Activities

- Recognize parents' rights to participate in treatment decisions for their children.
- Prioritize care in the family home or care which integrates the family where out-of-home placement is required.
- Assure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children. Offer services that involve minors' parents or family.
- Provide for participation in developing the state mental health program for children and other underserved populations, by including representatives of families and youth on any committee established to provide oversight to the state mental health program.
- Treat each child in the context of his or her family, and provide services and supports needed to maintain a child with his or her family and community
- Encourage the use of voluntary services and, whenever clinically appropriate, offer less restrictive alternatives to inpatient treatment.
- Integrate families into treatment through choice of treatment, participation in treatment, and provision of peer support.
- Insure treatment decisions are 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.
- Involve persons with mental illness, their family members, and advocates in designing and implementing children's' mental health services.

Focus on Evidence-based Practices

- Evidence-based, research-based and consensus-based treatment practices, including evidence-based prescribing practices, will be used in the provision of children's mental health therapy whenever possible.
- Target and coordinate a comprehensive set of evidence-based practices (including promising practices) to be implemented and promoted by the system.
- Remove barriers to the use of those practices.
- Minimize variation in practice.

- Use cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to, or in the place of, prescription medication where appropriate.

Promote Cross System Collaboration Among Child-Serving Agencies

- Improve collaboration with first responders and hospital emergency rooms, schools, primary care, developmental disabilities, law enforcement and corrections, and federally funded and licensed programs.
- Increase coordination of services within the Department of Social and Health Services, especially among those divisions within the department that provide services to children. All divisions within the Department that provide mental health services will jointly plan and deliver those services.
- Create effective linkages and transitions between services provided by the Department of Social and Health Services and the Health Care Authority.
- Insure effective cooperation between the Department of Social and Health Services 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.
- Through coordination of services, reduce duplication in service delivery and promote complementary services among all entities that provide mental health services to adults and children.
- Coordinate existing categorical children's mental health programs and funding through efforts that include elimination of duplicative care plans and case management.
- To the greatest extent possible, blend or braid categorical funding to offer more service and support options to each child.
- Integrate educational support services that address students' diverse learning styles.

Coordinate Behavioral Health Care with Primary Health Care

- Insure that effective communication and care coordination exists between primary care and mental health providers.

Effectively Manage Key Clinical Transitions

- Through effective care coordination and the incorporation of wraparound principles insure that children and their families do not "drop through the cracks".
- Insure effective handoffs at critical junctures such as transition between home and out of home care, institutions, child mental health and adult mental health systems, etc.

Make Strategic Improvements Over Time

- Expand the authority for and use of therapeutic courts including drug courts, mental health courts, and therapeutic courts for dependency proceedings is expanded
- Slow the loss of inpatient and intensive residential beds and children's long-term inpatient placements.
- Refine the balance of state hospital and community inpatient and residential beds
- Reduce the need for placements in CLIP facilities and the CSTC.
- Amend contracts to make RSNs responsible for managing the census at CLIP and CSTC facilities and to allow more flexible use of funds for community alternatives.
- Make integrated treatment of co-occurring disorders is consistently available statewide.
- Encourage the provision of a full continuum of treatment and recovery-focused services in the state including family operated services
- Build a system structure (evolving as necessary), including the entities responsible for the care of various subgroups of children and youth, to meet the identified goals.

Be Accountable

- Deliver services that are accountable, efficient and effective as demonstrated through state-of-the-art outcome and performance measures and statewide standards for monitoring client and system outcomes, performance, and reporting of client and system outcome information.
- Maximize the use of available resources for direct care of people with a mental illness
- The children's mental health system consolidates administration, reduces administrative layering and reduces administrative costs
- Hold Regional Support Networks accountable for the delivery of children's mental health services consistent with these goals and principles.
- Collect data uniformly across the state
- Make data-informed decisions
- Determine the effectiveness of the children's mental health system through the use of outcome-based performance measures.
- Utilize outcome-based performance measures such as[1]:
  a) Decreased emergency room utilization;
  b) Decreased psychiatric hospitalization;
  c) Lessening of symptoms, as measured by commonly used assessment tools;
  d) Decreased out-of-home placement, including residential, group, and foster care, and increased stability of such placements, when necessary;
  e) Decreased runaways from home or residential placements;
  f) Decreased rates of chemical dependency;
  g) Decreased involvement with the juvenile justice system; Improved school attendance and performance;
  h) Reductions in school or child care suspensions or expulsions;

[1] 2SHB 1088

i) Reductions in use of prescribed medication where cognitive behavioral therapies are indicated;
j) Improved rates of high school graduation and employment; and
k) Decreased use of mental health services upon reaching adulthood for mental disorders other than those that require ongoing treatment to maintain stability.

Appendix B

Washington State Children's Mental Health Redesign
Training and Workforce Development on Child and Family Teamwork
Draft Plan (August 25, 2012)
Core Practice Model Workforce Development Group
Lin Payton and Eric Bruns, Co-Chairs

Background

A cornerstone of the Washington State children's mental health redesign plan (and interim agreement for settlement of the *TR vs. Dreyfus* lawsuit) is implementation of a core practice model for youths with serious and complex needs. The core practice model (presented in more detail in *Appendix A*) includes 6 essential practice elements:

- Engagement with the youth and family;
- Assessment of youth/family strengths, needs, and culture;
- Effective teamwork among providers, school and agency representatives, and natural supports;
- Service planning and implementation;
- Ongoing monitoring and adapting; and
- Transition to ongoing supports.

Regional Support Networks (RSNs) have been directed to take steps to integrate the core practice model into services for children and youths and are working with DBHR to report those efforts to the *TR* litigation team.

Child and Family Teams

A central mechanism for implementing Washington's core practice model – and the first practice change to be addressed under Redesign/TR – will be Child and Family Teams. Child and Family Teams (CFT) are designed for children and youth who have complex emotional, behavioral and social issues who require care coordination across two or more systems. The CFT will facilitate family engagement, plan development, cross-system coordination, and monitoring and plan refinement to meet the youth and family's priority needs, improve functioning, and maintain the youth in home and community (see *Appendix B*).

Expectations for RSNs and Providers

- For Washington youth and families served through the Medicaid-funded behavioral health system, implementation of the core practice model and adoption of 10 Children's Mental Health Principles (see *Appendix C*) has been included as an expectation in RSN contracts as of July 2012. RSNs are working with DBHR to report those efforts to the litigation team.

- RSN contracts also dictate that all RSNs will "begin to develop" CFTs for youths with complex needs and multi-system involvement starting in October 2012.
- Starting October 2012, RSNs will be expected to code and report CFT meetings using a Service Encounter Reporting Instrument (SERI) that includes a definition of CFTs.
- Access to Care Guidelines have not and will not be altered. In addition, it is agreed that RSNs will continue to serve youth under the current state plan service array.
- However, a set of intensive services for youths with complex needs, to include in-home, mobile crisis, and intensive care coordination services, will ultimately be developed and resourced.

Supporting the Workforce to Implement Child and Family Teams

As part of the Children's Mental Health Redesign effort, and with funding from a federal statewide system of care planning grant, a state Workgroup, co-chaired by DBHR and the UW Evidence Based Practice Institute (EBPI), has been developing a plan for training and workforce support for children's mental health. Because CFTs have been identified as a critical first step in implementing the core practice model, initial planning has focused on CFTs.

Needs Sensing Survey

To inform its plan, the Workforce Development (WFD) Work Group surveyed RSNs and provider statewide on resources and needs for rolling out CFTs. Results indicated that:

- 10 of 12 RSNs currently implement wraparound or child and family teams; however, criteria, definitions and practices vary across the state and current capacity to implement other intensive services (in-home, mobile crisis, intensive care coordination) identified under *TR* is inconsistent.
- CFT implementation is accomplished via a range of mechanisms across RSNs, including stand-alone wraparound initiatives implemented by one or more providers, providers who use CFTs as necessary, as part of typical service delivery, and RSNs with little to no formal CFT implementation.
- Fewer than half of RSNs that implement CFTs have internal training and/or coaching resources for wraparound/CFTs; just over half rely on outside experts.
- There is no consistent, centralized resource in Washington to support training and implementation of Wraparound/CFTs.
- RSNs and providers identified a range of state and outside experts on whom they rely for help with training and supporting wraparound and CFT implementation.

Workforce Development Plan for CFTs in Washington State

Based on its deliberations and survey results, DBHR and the WFD Workgroup are developing an array of **training and workforce resources for CFTs**, to facilitate consistency and quality of

practice and to be disseminated statewide. During this process, DBHR would work closely with the states center of excellence for workforce development, the UW Evidence Based-Practice Institute (EBPI), University of Maryland, the National Wraparound Initiative (NWI) and Washington State wraparound experts to develop:

- A 4-5 day CFT training curriculum with exercises and rehearsals to encourage development of mastery of skills related to facilitating CFTs and implementing its core practice elements. A pre- and post-training knowledge test will be included. The curriculum will reflect priorities for Washington State while also being based on existing curricula developed by wraparound experts in Washington and nationally (e.g., University of Maryland's Innovations Institutes, Portland State University; the National Wraparound Initiative and its partners). The curriculum will provide detail on CFT expectations, the theory of positive effects, core skill sets, and how CFT practice links to other initiatives and resources statewide. This curriculum will be available for use by 2013.
- Two three-hour system partner orientation to CFTs, to help state and local stakeholders such as family and youth advocates, agency representatives, and providers understand CFT practice and how to be effective team members. This will also be available by December 2012.
- A supervision and coaching tool that parallels content of the training and the CFT practice model and supports implementation by reinforcing role expectations for CFT facilitators and allows for data collection and provision of feedback. RSNs with adequate capacity can use the coaching tool internally; however, CFT experts affiliated with a the UW EBPI-based statewide Center of Excellence (CoE) for implementation of the Children's MH Core Practice Model will also use the tool to observe practice and conduct remote coaching using web technology.
- A quality monitoring tool that is based on the evidence-informed wraparound model promoted by the NWI and that aligns with training content and skills and practice expectations of the supervision/coaching tool. The quality tool will ultimately be part of the statewide External Quality Review (EQRO) process for CFTs, to be rolled out by October 2013. The tool can also be used internally by RSNs or providers to gauge quality and integrity of CFT implementation.

How will the Workforce Resources be Made Available to Local Communities and RSNs?

As referenced above, to promote consistency and quality, a Statewide Center of Excellence will be established for implementation of the Children's MH core practice model. The CoE will coordinate provision of training, coaching support, remote coaching, and quality monitoring. It will also develop new supports as needed, such as intermediate and advanced CFT trainings and workforce support for other intensive service elements as they come on line. However, each

local RSN has its own capacities and needs regarding implementation of CFTs and other elements of the core practice model. Thus, workforce development resources will be flexibly applied and locally adaptable for use by RSNs and their provider agencies. For example:

- The CFT skills curriculum will be delivered in person across the state starting in 2013. Local RSNs may choose to send identified CFT facilitators to these in-person trainings and/or local trainers who will attend and become competent at delivering trainings themselves.
- After completion and initial piloting, CFT and stakeholder trainings will be made available on-line. These on-line trainings can be used for stakeholders, system partners, and for newly hired staff as orientation to the process before formal training and coaching begins.
- RSNs can identify local coaches who will be trained to use the coaching and supervision tools, and/or they may rely on CoE staff to conduct remote web-based coaching.

What should RSNs and Providers do to Prepare for CFT Rollout and the Upcoming Workforce Development Activities?

- Consider local capacity to deliver CFTs per the model described in Appendix B, and determine what approach will be used to facilitate the availability of CFTs, and what organizations and personnel will be responsible for facilitating CFTs.
- Identify stakeholders and system partners who should receive system partner orientations to CFTs in late 2012/early 2013.
- Identify staff persons who will need to receive the initial 3-day training on facilitating CFTs and ongoing coaching/supervision.
- Confirm/identify local experts/trainers who should be affiliated with the Statewide CoE and who can support local implementation by providing training and coaching on CFTs and other aspects of the core practice model.

APPENDIX A: CORE PRACTICE MODEL

PURPOSE

The Washington State Division of Behavioral Health and Recovery core practice model is an overarching framework for providing comprehensive behavioral health services and supports for youth with complex emotional and behavioral issues. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

PRACTICE MODEL COMPONENTS

Practice components embrace Washington State Mental Health Principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the youth and family all of components 1-6 (below) over the course of treatment and transition.

1. ***Engagement*:** Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the youth and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
2. ***Assessing*:** Information gathering and assessing needs is the practice of gathering and evaluating information about the youth and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of youth.
3. ***Service Planning and Implementation***: Service planning is the practice of tailoring supports and services unique to each youth and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the youth, family, and caregivers.
4. ***Teaming:*** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
5. ***Monitoring and Adapting*:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
6. ***Transition*:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

APPENDIX B: CHILD AND FAMILY TEAMS (CFT)

THE DEFINITION OF A CFT

The role of the Child and Family team includes:

- Assemble as a group of caring individuals to work with and support the youth and family that, in addition to the youth and family, community members and various agency and provider staff involved in service delivery, includes at a minimum a facilitator and a family support partner or family specialist for youth.
- Continue the process of engagement with the family and or caregivers about their strengths and needs, ensure that services are well coordinated, and provide a process for transparent communication.
- Identify the strengths and needs of the youth and develop an individualized, strengths-based, youth and family-focused plan to address them.
- Implement the plan and refer the youth and family to resources in the community.
- Monitor and modify the individualized plan to address the youth's changing strengths and needs and/or improve the effectiveness of the plan and services/supports provided.
- Develop and implement a transition plan as soon as the team determines it is appropriate.

EXPECTATIONS OF A CHILD AND FAMILY TEAMS

Child and Family Teams (CFT) are designed for children and youth who have complex emotional, behavioral and social issues who typically require care coordination across two or more systems. In such cases, the CFT facilitates cross system coordination to support outcomes in the restoration of a higher level of functioning for the youth and family. The CFT drives the treatment planning process to ensure that services and supports are provided in accordance with the WA State Children's Mental Health System principles and the Core Practice Model. The practice/structure expectations of CFTs include:

- The CFT process is voluntary for the family.
- The facilitator engages with the family using a structured process that helps him/her understand the family's strengths/needs and culture before any team meeting with other professionals or team members is held.
- The facilitator develops a "vision statement" for a better future with the family that provides a basis for planning and transition.
- The facilitator will have a working knowledge of the service system as well as the community and its available supports.
- The facilitator maintains a committed team and is qualified with the necessary skills and persuasiveness to bring people and resources to the table[1] in support of the youth and family.

[1] Note: The size, scope and intensity of the involvement of CFT members is driven by the needs and desires of the youth and family. There are a number of ways people and resources can be "brought to the table". The expectation is that team members will actively engage in sharing responsibility and decision making. "Convening/Meeting" can occur with some participants via phone as well as in person as appropriate for the issues, the geography and the family's *preferences*.

- A team is convened that includes representatives of all providers and systems with major roles in the family's life.
- Natural supports are identified by the family and included on the team
- A written plan of care is developed that documents:
  - The family's needs/goals and strategies that are tied to those needs/goals.
  - A crisis plan is developed that clearly describes what leads to crises for the family and ways to prevent or respond to them.
  - A Family Wellness Plan is developed outlining the family strengths, calming activities, plans and important contact information.
- The plan identifies the needs of all family members (not just the identified youth) and includes related strategies.
- Efforts will be made to connect to experienced family and/or youth support when the team identifies the need.
- The team will be expected to meet with sufficient regularity to make progress on goals and maintain clear and coordinated communication.
- The team assesses progress toward the family's needs or goals at each meeting.
- The facilitator is expected to check in with families, professionals and team members on progress made on assigned tasks between meetings.

CARE PLAN DEVELOPMENT AND IMPLEMENTATION

The foundation for plan development begins with an assessment process. *This assessment occurs in concert with the standard intake and/or assessment process at the CMHA. At this point, the full array of Washington Medicaid State Plan Modalities* (which may include intensive services) *are authorized as needed.*

The CFT members engage in brainstorming options and identify creative and nontraditional approaches, including formal and natural supports, for meeting the needs of the youth and family. Careful consideration and weight are given to the youth and family's preferences, strengths, culture and the parent's expert knowledge of their own child. Objectives that can be readily accomplished and celebrated within a short timeframe are identified to encourage early success and continued involvement and achievement.

THE CROSS SYSTEM CARE PLAN

The cross-system care plan will:

- Describe the youth and family's vision for the future (stated in their own language)
- Reflect the family's prioritization of needs and goals
- Identify the short-term objectives, interventions, supports and services that will address their identified and prioritized needs
- Incorporate pertinent, identified strengths and cultural considerations within its strategies to achieve successful outcomes;
- Be individualized and responsive to the youth and family's needs;

- Establish responsibility to CFT members for each strategy/intervention/task and establish timelines for implementation;
- Utilize both formal and informal/natural supports and services as indicated;
- Identify natural supports and connections to community supports which may need to be developed or re-energized;
- Identify outcomes, actions and strategies/interventions/tasks related to the family's vision for the future;
- Include measures by which the youth/family and CFT can monitor progress; and
- Be signed by the parent/guardian, and the child/youth (if developmentally and legally appropriate).

When the family has multi-agency involvement, every effort is made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. If a family member (e.g. parent and/or sibling) is also receiving behavioral health services, inclusion of the behavioral health goals and objectives for that family member may be incorporated into a Family Care Plan, when agreeable with the family.

Both the assessment and service planning are ongoing processes, which result in plans that are continually updated as needed to obtain desired results and meet the changing needs of the youth and family.

ONGOING CRISIS PLANNING

Effective crisis planning is a critical component of an effective care plan. The crisis plan:

- Anticipates crises based on knowledge of past behavior as an indicator of future behavior;
- Researches past crises to identify for each situation the preceding behaviors, impulsive behavioral responses (thought and action) and the consequent behaviors which follow as a natural result;
- Changes over time in response to what is known to be effective or ineffective interventions;
- Contains clear behavioral benchmarks that change over time to reflect progress, changing capacities and changes in the youth/family's expectations;
- Triages the intensity of response actions to align with the severity level of the crisis situation;
- Anticipates a 24 hour crisis response;
- Builds roles for family members and other natural support people as responders in crisis situations;
- Clearly defines roles of other CFT members and how they support the mission of the crisis plan;
- Utilizes input from the youth/family on what can go wrong with the plan and responds accordingly; and
- Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized.

ROLES ON THE CFT

(rules, responsibilities, competencies, skills, and assessment will be developed further)

THE FACILITATOR

Team facilitation can be done by a qualified and committed CFT facilitator. The facilitator maintains a committed team and is qualified with the necessary skills and persuasiveness to bring people and resources to the table in support of the youth and family.
The facilitator contributes knowledge and skills related to making sure that the meeting process is respectful and honors everyone's roles, responsibilities and perspective. While the responsibility of preparing family members and other participants may fall to others in some areas, it is the facilitator who will make sure that each participant is heard and given the same consideration as others during the meeting.

The facilitator will:

- Guide the process of the meeting.
- Encourage each CFT member to identify their priority concerns, work proactively to minimize areas of potential conflict, and acknowledge the mandates of others involved in child-serving systems;
- Utilize consensus-building techniques and is expected to avoid any "positions" or predetermined solutions in meeting the needs of the family;
- Establish and sustains an effective team culture by inviting CFT members to propose, discuss and accept ground rules for working together.
- Engage all CFT members and identifies their needs for meeting agency mandates and the strengths that each person brings to the team. The facilitator is expected to identify their perspectives on the youth/family's strengths and needs, provide CFT members with an overview of CFT practice, and clarify their role and responsibilities as a team member in this process.
- Increase the "natural support" in CFT membership and the youth/family's integration into their community. This is accomplished by periodically inquiring whether there is anyone else the family would like to invite to CFT meetings, (i.e. friends, extended family, neighbors, members of the family's faith community, co-workers).
- Identify family support, peer support or other "system" and community resources that can assist the youth/family with exercising their voice in the CFT process, if needed.
- Prepare for meetings:
    - Develop a meeting agenda with the youth, family, and other CFT members.
    - Schedule meetings at a place/time that is comfortable and convenient for all CFT members while giving special consideration to the preferences of the family.
    - Prepare visual aids or tools to facilitate the meeting process.
    - Inform all CFT members of the date, time and location of each meeting.
- Contact CFT members who are unable to attend a meeting, in advance, to elicit their input.
- Ensure all CFT members receive an updated copy of the care plan, documentation of progress, CFT meeting activities, discussions and task assignments within 7 days after the CFT meeting.

- Be sensitive to the needs of team members when working in rural areas where getting members together physically may be challenging. The facilitator must be creative in establishing a team that may meet via phone or through teleconferencing.
- When working with older youth, the facilitator and team must respect the young person's wishes around team formation.
- Inform the youth and family of their rights (including Due Process) and obtaining all necessary consents and releases of information.

THE COMMUNITY MENTAL HEALTH PROVIDER

The community mental health provider will:

- Contribute knowledge about agency and community resources and relay both the strengths that they see in the family system and the critical concerns that must be addressed in the family's care plan.
- Ensure that services and supports are provided in accordance with the WA State Children's Mental Health System principles and the Core Practice Model
- *May* use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person but will not use these tools as criteria to deny or limit services.
- Coordinates the Medicaid reimbursable mental health services.
- Most behavioral health services do not require additional PIHP authorization. When it is determined that a person is in need of a behavioral health service requiring prior RSN authorization in order to correct or ameliorate a mental illness or condition (e.g. psychiatric inpatient, or CLIP), the community mental health provider initiates action for those services in accordance with RSN policy. A decision to authorize or deny a prior authorization request *must be made by the RSN*.

OTHER SERVICE PROVIDERS

Other service providers inside the agency and in the community also contribute knowledge about resources and relay both the strengths they see in the family system and concerns they may have for family members. They are encouraged to provide information and options for the family to consider rather than make recommendations and insure all official service plans of each system emerge from the one cross system care plan.

APPENDIX C: WA State Children's Mental Health System Principles

RSNs agree to move as quickly as is practicable to develop a Medicaid funded behavioral health system that delivers services according to the Principles set forth below.

- **Family and Youth Voice and Choice**: Family and youth voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

Appendix C

Workforce Development Sub-group: #4 Family/ Youth/ Professional Partnerships and Supervision (page 1)
Goal: Operationalize Youth, Family and Professional Partnership values within SOC workforce and supervision, and provide and develop coaching and training.
Date: May 11, 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need- cross-system curriculum and tools tailored to each community Need- formalized (training institute) sustainable training system Need- information technology for communities across the state • Identify packets of excellence • Identify trainers • Assess need • Identify gaps • Identify champions (including in the legislature and foundations) • Identify champions Need-cross system plan to identify roles, practices, and skills for Family, Youth & Professional Partners Need- Specific training for upper management, supervisors, school administrative personnel, and higher education personnel	Map strengths and gaps per (needs assessment) • FYSPRTs system • geography • Parents, youth and partners level Identify Structures & systems (for all levels) • Champions • Trainers • Resources • Tools • Curriculums • Venues – tools, models, technology, academies, conferences Identify Wraparound and points of excellence statewide Create incentives to promote and support parent, youth, and professional partnerships	Core parent, youth and professional partnerships operate in communities throughout the state Community strengths and gaps are mapped Family, youth and system partner Champions are identified at all levels and agencies Youth focused conferences are regular events to support leadership development Wraparound is fully implemented	Regional FYSPRTs provide an effective forum for family, youth and system partners to address mutually important issues using SOC principles and values Regional resource sharing is evident in program delivery and training Training academies are identified and utilized for family, youth, and system partner leadership development Regional Lessons Learned Events are scheduled to bring System of Care and Wraparound advanced practitioners together to share experiences to enhance knowledge and skills that support family, youth and system partners statewide	Cross system protocols are implemented that are Family Driven and Youth Guided Reviews of RCWs and WACs are conducted in partnership with professionals, family and youth System planning is done in partnership with family and youth Aces and Compassionate Schools is the training standard for all school districts Wraparound training is fully implemented in professional training programs Tools are available that are portable and embed core training in mental health (MH)

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services ***4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES*** 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Workforce Development Sub-group: #4 Family/ Youth/ Professional Partnerships and Supervision (page 2)
Goal: Operationalize Youth, Family and Professional Partnership values within SOC workforce and supervision, and provide and develop coaching and training.
Date: May 11, 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need- Expand integrated parent, youth and professional co-trainers through train-the-trainer approach Need- Address geographical and cultural barriers Need- creating a welcoming environment in schools, facilities, and venues for values and partnerships Need- establish and reinforce the commitment that families, youth and professionals are equal partners in training and workforce statewide and at the local level Need- differentiate among trainers, supervisors, line staff, teachers/educators, and leadership specific core sustainable skills which are defined and targeted consistently statewide	Curriculum: Promote social /emotional curriculum for schools Develop curriculum for "understanding" ACES, etc Integrate and enhance training curriculums for: • Family, Youth and Professional Partnerships • Train- the- trainer • Supervisors • Administration/upper management • Cross system training (academies, CAST, Uniting for youth) • Youth & Family Systems Navigation Review WACs, RCWs, laws – find common scope and language that support effort(s)			

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services
4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Workforce Development Sub-group: #4 Family/ Youth/ Professional Partnerships and Supervision (page 3)
Goal: Operationalize Youth, Family and Professional Partnership values within SOC workforce and supervision, and provide and develop coaching and training.
Date: May 11, 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need- better understanding of a child's mental health, behaviors, and disabilities Need- toolkit for family and youth to navigate system processes Need- expand agreed upon roles, competencies and outcomes at a focused work session	Focus on hiring that promotes and operationalizes Family, Youth and Professional Partnerships i.e., modeling partnership during process and hiring youth and family members			

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services ***4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES*** 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Workforce Development Sub-group: #4 Family/ Youth/ Professional Partnerships and Supervision

Goal: Operationalize Youth, Family and Professional Partnership values within SOC workforce and supervision, and provide and develop coaching and training.

Date: May 11, 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need- cross-system curriculum and tools tailored to each community Need- formalized (training institute) sustainable training system Need- information technology for communities across the state • Identify packets of excellence • Identify trainers • Assess need • Identify gaps • Identify champions (including in the legislature and foundations) • Identify champions Need-cross system plan to identify roles, practices, and skills for Family, Youth & Professional Partners Need- creating a welcoming environment in schools, facilities, and venues for values and partnerships				

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services ***4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES*** 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Logic Model Youth and Family Peer Support Curriculum Development Workgroup

Goal: Provide authentic targeted stakeholder input by parents, family members and youth in transition involved in the systems of care with lived experience in the public mental health system to the University of Washington for the purpose of creating (1) A family focused peer support training curriculum (2) A youth in transition focused peer support training curriculum (3) A knowledge test for each t curriculum (4) A power point for each training.

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
• The current curriculum does not address youth in transition • The current curriculum does not address family participation including NAMI families and families involved in the System of Care. • There is funding for peer support trainings but a lack of job opportunities. • There is an opportunity to educate provider organizations on how to best use peer support specialists/counselors. • The current training is too generic. • The curriculum could be more youth friendly. • The curriculum could be more family friendly. • There is value added recovery in the personal story and the Peer support curriculum highlights this and this group can refine this positive attribute to effect many families and youth in transition in a positive way	• Convene stakeholder workgroup of families and youth in transition participants. • Do a SWOT analysis on current Peer Support Curriculum. • Create workgroup charter. • Create workgroup logic model. • Assign homework relevant to creating a new Family and Youth In Transition Peer Support Curriculum. • Create a Gant chart tracking project progress through timeline • Update Curriculum according to SWOT analysis. • Create a family directed peer support curriculum. • Create a youth in transition directed peer support curriculum. • Create knowledge tests. • Create power (2) points related to created curricula.	• Local communities will have input into new curricula; • Community stakeholders will receive stipends for providing their experience and expertise to this process; • Communities will be kept up to date on progress and "roll out" of new curricula through list serves and the YNA website; • The new curricula will be advertised on the local community level and provider organizations will be kept in the loop through partnerships with RSN's local providers and the Provider Council; • Local community participants will be given an evaluation to fill out evaluating the process and the product in order to inform continuous quality improvement and management; • There will be a new Family Driven Peer Support Curriculum with community input; • There will be a new Youth/Young Adult Driven, Youth in Transition Peer Support curriculum; • There will be a knowledge test created with local community stakeholder input, and, • There will be a power point created with local community stakeholder input.	• The new curricula will be advertised on the local community level and provider organizations will be kept in the loop through partnerships with RSN's local providers and the Provider Council; • Regional participants will be given an evaluation to fill out evaluating the process and the product in order to inform continuous quality improvement and measure if outcomes were met; • A participant from each Regional Support Network will be invited to participate on the work group, edit the draft materials and give stakeholder input; and, • Regional Support Networks and their Provider Networks will recognize the new Family and Youth in Transition Peer Support Curriculum as a valid and relevant credential which merits an employment opportunity when relevant and applicable to the provider organization.	• The new curricula will be advertised on the local community level and provider organizations will be kept in the loop through partnerships with RSN's local providers and the Provider Council; • System representatives will be given an evaluation to fill out evaluating the process and the product in order to inform continuous quality improvement and measure if outcomes were met; • A participant from each relevant system (chemical dependency, mental health, education, law enforcement, faith based, veteran's etc.) will be invited to participate on the work group, edit the draft materials and give stakeholder input; and, • System participants will be provided with public relation packets regarding the progress of the Youth and Family curriculum development, where the trainings will be offered, how to apply for the trainings and how the credential can and cannot be used.

Workforce Development Sub-group--licensing and certification

Goal: to plan for and develop a set of working certification rules and expectations for wraparound providers and provider agencies to ensure quality of services in Washington state.

Date: May 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need for qualified providers Need for consistent services statewide Need for standardization of definition of services Need for a clear plan that moves forward multi-agency collaboration and participation in the process.	compare WRAP Milwaukee and Arizona policies and procedures -synthesis of the two for workgroup seek guidance from Eric Bruns and others about EBP that would allow for cross systems practice. – definitions and consistency -follow up with Arizona consultant about definitions for consistency and clarity of unification of statewide services. Evaluate the potential for expanding Peer counseling curriculum to include WRAP module as currently individuals are carrying this credential. -consultation with the Obermeyers' on this strategy -consultation with DBHR Peer training oversight group. Multi agency comparison of trained individuals to identify barriers to the multi-agency approach -Conv with DCFS DDD JRA about incorporation of system partner training in order to facilitate multi-agency cooperation	evidence an increase in provider agencies – credentialed Evidence an increase in credentialed providers.	information is clear across agencies as to what barriers keep wraparound services from progressing to allow for policy and procedure that support services • Barriers • Next steps • Necessary interventions and supports	credentialing and review process in place for provider agencies credentialing and review process in place for : • Family Partners • WRAP Facilitators

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services ***4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES*** 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Workforce Development Sub-group: Intensive Services/Core Practice Model/TR Workgroup
Goal: Create a statewide workforce development plan and process to address the issues outlined in the *T.R. v. DREYFUS* INTERIM AGREEMENT
1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services
4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES

Date:

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
T.R. v. DREYFUS litigation and interim agreement Core Practice Model (wraparound) adoption across systems WA Children's Mental Health Principles adoption across systems	**Identify existing resources** (funding, venues, trainers, communication platforms) for: • initial training, • ongoing training and TA (train the trainers – local experts), • imbedding in practice and protocols • development of toolkits (to include orientation materials for various stakeholders) **Identify Population** to be served through intensive services **Further define Intensive mental health services** (from agreement) a. Intensive Care Coordination b. Mobile Crisis c. Direct Services **Clarify** rules, responsibilities, competencies, skills, assessment needs related to training topics. **Develop specific training plans** in conjunction with other TR work and SoC workforce development subgroups on : 1. **Core Practice Model** (wraparound) 2. **WA Children's Mental Health Principles** 3. **Child and Family Teams:** (from CMHC/RSNs/DBHR) a. definition b. expectations c. coding d. facilitation – specific expectations and training e. how team members (particularly DSHS) participate f. incorporate quality tool	Demonstration through data and reports of the adoption of the Core Practice Model which guides service delivery across the state consistent with WA Children's Mental Health Principles. Cross system protocols are in place and being consistently used across the state for screening and assessment of youth with intensive mental health issues. Child and Family Teams are available throughout the state for youth with intensive mental health needs utilizing consistent processes and a quality management structure.		

	4. Screening and Access - RSNs, Providers and allied partners (from Cross Systems Initiative Team) a. identifying who to refer b. knowledge of how to refer and what to expect c. knowledge of screening material needed to refer d. Cross system protocols e. Continuity of care/transitions f. Link with CANS Screening Assessment training g. Coordinate with communication plan **Develop toolboxes** for use by local experts/programs geared to each audience (RSN, providers, DSHS partners, schools, PCPs, etc.) **1. RNSs and their providers** a. ACS and B Dx b. CFT recommendations/authorization of services/due process/NOA c. how to participate d. quality tool elements 2. **Screening and Access** - RSNs, Providers and allied partners (with CSI workgroup) e. identifying who to refer f. knowledge of how to refer and what to expect g. knowledge of screen material needed to refer **3. Cross system protocols (CSI)** **4. Continuity of care/transitions** **Identify people/groups for review/input/feedback** (will likely be different groups for various pieces) **Coordinate with communication plan** **Leadership vetting process**		

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services *4) DEVELOP AND STENGTHEN A WORKFORCE THAT OPERATIONALIZES SOC VALUES* 5) Build strong data management systems to inform decision making and ensure outcomes	
SOC Workforce Goal: Create a state training program that reflects all levels and practice models of Systems of Care and Wraparound implementation and that has the capacity to train and support individuals who can function in key roles at all levels, inclusive of families and youth.	
SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.	

Workgroup Name: SOC Finance Workgroup
Goal:
Date: May 26, 2012

DRIVERS FOR CHANGE	ACTIVITIES/ INTERVENTIONS	MEASUREMENTS/OUTCOMES		
		Community	Regional	System
Need to expand service capacity in order to meet identified needs for prevention and intensive services. Need to align funding sources in order to: a) Strengthen interagency collaboration b) Support improved long-term outcomes c) Develop funding mechanisms for intensive services including a. Mobile crisis b. Intensive in-home services and supports c. Intensive care coordination Need to improve integration of Children's Administration (child welfare) and DBHR Title XIX services to: a) Improve cost effectiveness of purchasing b) Improve the ability for seamless access to services	Map existing funding structures: a) Types of funds b) Uses/modalities c) Eligibility d) Existing integration activities e.g., CHAP, local efforts Review and provide input health care reform implementation activities and their potential impacts on children Obtain consultation on opportunities for innovation e.g., waivers, learning from other states, etc. Develop a written financing plan for the children's mental health system in WA.	Children and families can access needed services easily and seamlessly regardless of the organization paying for and/or providing the service.	Clear pathways are available for innovative cross system service collaborations using existing or adapted models.	The written finance plan is adopted and guides the system design and development, legislative requests, etc.

Washington State SOC Goals: 1) Infuse SOC values in all systems for children, youth and families 2) Ensure services are seamless for children, youth and their families 3) Build Access and availability of home and community-based services 4) Develop and strengthens workforce that operationalizes SOC values. 5) Build strong data management systems to inform decision making and ensure outcomes

SOC Values and Principles are the Bedrock/Foundation: 1) Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided. 2) Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level. 3) Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Appendix D

Washington SOC
Eastside / Yakima Event
Lessons Learned
May 2012

1. **Infuse SOC Values in all Systems for Children, Youth, and Families**
   - Educating and understanding roles of Family, Youth & Professionals in the partnership
   - **Contract language that reflects SOC values of 50% and membership on Advisory Boards, Committees of Family & Youth**
   - **Everyone included in the Philosophy change of SOC. From top down in all agencies**
   - **Person giving training needs to be clear themselves in values, so that they are educating accurately**
   - **Rely on our own state expertise**
   - Integrating SOC/Wraparound instead of being siloed
   - **Infuse implementation in all state levels down – from top down in all agencies, or even bottom up**
   - Agency culture understanding
   - **Key Agency, BUY-IN!!**
     - **Principles & philosophy need to be taught to line staff in key agencies prior to implementation… (continue education)**
     - Schools need education about SOC philosophy, available services, general mental health awareness in relation to youth
     - **Include parents and youth as partners and EXPERTS in their services and lives**
     - SOC liaison at Child Welfare and Juvenile Justice to bridge gaps, look at blending funds within System Providers so there is automatic BUY IN
     - Youth and family's voice is lost when youth is detained
   - Schools as a primary SOC player
   - **Include chemical dependency provider as key player**
   - Help them understand the relevance of their involvements
   - Stop pointing one finger at other's, extend all of your fingers
   - **Model the behavior we want to see in others**
   - Not only doing it for "work" but implementing it in your everyday life!

2. **Ensure Services are Seamless for Children & Youth who are the Population of FOCUS**

- **Wording in contracts (MOU's)**
    - **Sometimes gets in the way of services, contract conflicts for example, releases, billing, reporting**
- Difference in age consent
- Being clear on population
- Being able to collaborate "our" families not "my" or "your" family
- Integrate building for people coming together to meet with families in a CFS meeting, etc.
- Teaching and modeling shared accountability
- Parents and teens get burned out at the top of the triangle "fix kids" (educating family, youth, and professionals)
- Continuing working with explaining expectations
- People knowing/defining their roles in a CFS meeting and others roles also
- **System Mandates are duplicating "TEAM" meeting recommendation – one team, one plan for family to meet requirements of each system**
- **Team follows family throughout system and services**
- Limiting criteria! Don't qualify for services because they're not "bad" or "needy" enough
- "Not" wraparound youth need service that follows the SOC principles and philosophy
- Be careful not to exclude service providers from teams
- Transitional services for aging out youth
- Transition/aftercare out of hospital planned upon hospital admission
- **Policy change to be reconciled at multiple mandated meetings**
- **Judges and decision makers at the table with SOC planning efforts**
- Willingness to open communication
- Who is the population?
- How do you create something to meet the needs of the family and youth?
- Viewing as strengths-based
- What happened to them, not what's wrong with you? TRAUMA INFORMED CARE
- Willingness from all partners to provide seamless services. Want to! NOT FORCED
- **Seamless means not being able to tell where on system begins and another ends**
- **Let go of egos – everyone functions as one team**
- Need trainings together/cross-training on each other's system
- Everyone's needs are met that come to the table or they don't attend
- More holistic approach!

3. Build Access and Availability of Home and Community Based Services

- **Creativity is critical. Being in more remote areas, services/supports families need may not exist in the community, it needs to be created/developed**

- **Shifting community culture to not just send kids away to get needed "treatment." What can be developed in the community so families don't have to be separated to get what is needed**
- **Systems need to get along and work together to build resources that the kids/families that we share have what they need and come from a <u>united philosophy</u>**
- **Develop practice to incorporate SOC values in all systems, not just provided in Wraparound**
- Collaborate and link services/supports together when a child leaves the community so there is a seamless plan for return
- Build community partnerships prior to brining in SOC
- Incorporate family and youth voice in developing resources
- Bring parent/youth on as "mentors" to assist families in knowing available resources and ensure voice/choice is in plans
- Assist families with logistical issues in designing seamless plans (i.e. trans/child care/expenses
- **Shift community culture from "office based only" services**
- Culture of all involved being willing to attend meetings and appointments beyond 8-5 M-F
- Adopt EBP's that model fidelity that work for rural populations
- Flexibility – not just 8-5
- Revamping access to care – transportation
- Cultural competence
- Meet people where they are at
- Developing a level of trust
- Listening to the family's needs
- Changing the attitude of NO we CAN'T to how can we
- What needs to change to better serve families and youth but also be able to still meet the system's "needs"
- Families are tired of telling their story over and over again!
- **More peer counselors/peer support specialists in the work field**
- How to approach an equitable partnership
- Travel/mileage reimbursement for agencies
- Awareness, availability of community resources for families (EDUCATING parents)
- Philosophy of keeping family together and valuing community resources
- **Unmet needs become a greater issue and cause out of home/community placement**
- Family support services are just as effective and transportation is not available through Medicaid
- No related cost can be billed for
- **Revamping on access to care; diagnosis on who can be served or who cannot**
- Building list of resources/services available to families that are not in Wraparound

4. **Develop/Strengthen Workforce that Operationalizes SOC Values**
    - Keep employee retention to avoid case manager turnover
    - **Effective training to model fidelity and embed values with ongoing consultation**
    - Family involvement and youth guided with intention
    - Executive leadership for state
    - Agencies to commit resources and philosophical change to organizational culture
    - **Partnering with colleges and universities to incorporate SOC values**
    - Cross training workforce
    - Draw on our expertise on our state, family, and youth
    - Partnering with universities, head colleges, learning institutions to educate future clinicians/educators/leaders with leadership in Systems of Care philosophy
    - Trauma-informed care training, constant training and always learning
    - Meeting people where they're at
    - Cultural competence
    - Incorporated within current Mental Health System instead of doing things parallel
    - Incorporating the training/learning into practice in your home community is a challenge
    - Offering training to community, parents and professionals
    - Required supervision levels written into contract for new/best practices
    - Booster sessions for best practice trainings
    - Problematic consulting out of state trainer, utilizing our own expertise
    - **Continued education/training for people on the front line**
    - Train the trainer
    - Ongoing supervision/training/coaching
    - Group coaching (supervision)
    - **Utilizing peers to support peers**
    - Exploring/determining barriers for family and youth to bring voice to the table
    - **Use our own experts from our own state to train/teach each other! People with lived experience doing it or being involved in it**
    - Create infrastructure to support supervision, coaching and training
    - **Peer to peer training specifically regarding being system involved**
    - Create common language around the guiding values so that agencies are on the same page
    - **SOC values need to be operationalized at the management level so that it has the "trickle down" effect**
    - Build in process to hold agencies accountable to adhering to SOC values
    - Create state policies that support workforce stabilization
    - Create opportunities for networking, agency sharing, site visits

- Use our own state peeps as the experts! We have 'em, use 'em!

5. **Strength Build Strong Data Management Systems to Inform Decision Making and Ensure Outcomes**
   - What is meaningful (to community)?
   - **Goes back two 4 things**
     - **What's working**
     - **What didn't work**
     - **What would work**
     - **How would we know it's working (outcome)**
   - Important to have families and youth involved in the development and delivery of the evaluation
   - Access to the results afterwards in "friendly language"
   - Centralized data management
   - Does the data collected truly in service to families/youth or two serve system or administrators to get a grant?
   - Does it inform decision-making?
   - **Having data displayed in a meaningful way**
   - **Where is data coming from? Parents, youth, providers, demographics, relevance to area that it is being used**
   - **How useful and relevant is the data being presented?**
   - **What decisions can be made from the data?**
   - Different data outcomes, "what outcomes are we tracking?"
   - Family surveys
   - Being clear about what data we are looking for
   - Sharing problem about sharing data
   - Is it an expectation for ALL systems to be reporting/collecting data?
   - **Capacity to collect data**
   - Costly to collect data
   - Sustainability
   - Data changes/system changes, but funding runs out!
   - TRAC data from every partner
     - Transformation Accountability System
   - **Child and family teams have DATA! Track and Utilize CFT data (meaningful, immediate, relevant)**
   - More qualitative data (not yes/no – more detail)
   - **Youth and family involved in all stages of data management – get feedback**
   - Smaller organizations don't need extensive management systems – keep it simple
   - Have the most relevant people involved in what is measured (consumer voice)
   - **Balance between Federal and State confidentiality laws (CFR and Substance Abuse Information)**

Washington SOC
Westside / Auburn Event
Lessons Learned
April 24, 2012

1. Infuse SOC Values in all system elements for children, youth and families

- ICM
- Current challenge to connect with juvenile justice in some counties
  - Educate judges
- **A need to educate families on their choices, opportunities, advocacy, etc.**
- Cultural change (education for both facilities and systems)
- A challenge to engage CPS – engagement built slowly on a case by case basis
- **Ensure youth and family voice is invited, heard, shared back and reflected in plans, documents, etc. and evaluation**
- Teaching youth and families to be their own Wraparound facilitators
- **Find ways to integrate more non-traditional supports/services into the system (i.e. yoga, equine therapy, wrap training, non-violent communication)**
- **Make trainings for professionals open to youth and families (trained <u>together</u>)**
- Connecting with counselors and principals are key for successful SOC educator engagement
- IEP doesn't get done due to school placement changes
  - Should be school mandate
- Top down effort – leaders who are champions of SOC
- Booster shots of fidelity
- Positive engagement of youth is an EBP
- **Fund family and youth advocates as part of SOC, independent of agencies**
- Youth and parents can teach providers
- **User/family friendly language**
  - **Culturally competent**
  - **Too many acronyms**
- Funding everyone to come to the table
- Legislative strategies
- Partnership/active communication and process for state to community and vice versa
- The right people, in the right place, at the right time: all members of a person's team are needed
- Respectfully inform each other of our system mandates, drives, cultures
  - "see both sides"
  - Support for individual community values to identify and implement SOC
- Understand reluctance among systems, listen, and TRUST
- Considering SOC values during the hiring process for all systems
- Shared training in values and SOC work
- Implement SOC values in policy development and policy change
- Identify role-personal or professional?

- Need system buy-in – what's in it for them? (cost, savings, work savings, energy savings)
- Be proactive – no "ready, fire, aim" approach
- **Develop good communication structures between families, youth and all systems**
- **Infuse values at legislative level**

2. Ensure services are seamless for children and youth who are the population of focus (13-18)

- Persistence is important
- You have to know what questions to ask
- Sometimes you have to get aggressive (assertive advocacy)
- Can't depend on funding streams
- Bundling is helpful/vital
- Need to know and serve coexisting condition
- We need to ensure the hand off happens effectively
- Information/data needs to be available across systems (appropriately)
    - Access to PPUSM?
- A variety of services need to be available
- Information needs to be provided at a 5th grade level
- **Services need to be truly culturally competent**
- **Services need to support youth through the transition to adulthood (18 and beyond) More than on paper – mentoring, etc.**
- You shouldn't have to be falling apart to qualify for services
- Expectations and changes are publicized in a timely manner
- **Where are the seams? Geography, age, silos, etc.**
- **Support for collaboration (financial too!)**
- **Strong relationships between partners is key**
- Mechanisms to stay connected/align meetings (call-in/video/tete-recorded)
- Everyone increase openness, be open to adapt, change, to give
- If a family does not show up – it is a message that it's not working for them
- Mind the age – why not over 18 too or below 13?
    - Do not forget those who are in transition
- Increase opportunities for flexibility/support for more alternative schools
    - Currently (online/tutoring/etc.) is not enough – not working – based on relationships and starting with support at home + school + advocate
- Ensure schools can be on the same page (share records/transfer/etc.)
- **A need for inter-county networks**
    - **Uniformity across regions – states**
- Flex hours so participants from all system elements can come to meetings
- 60 days may not be enough time to get new team on board with kids coming out of CUP.
- Age 18-24 year olds fall thru the cracks – need a bridge to target young adults
- Who decides criteria for crisis stabilization? Families don't have access

- Parents in crisis should always be linked to the parent organizations
- Involving schools (decision makers/directors) in SOC trainings
- Training/information fades from memory when not used
- **Memorandum of understanding by executives at the top of system elements to support collaborative care**
- Prepare youth in transition for life skills BEFORE age 18
- **Formal peer/parent support that can be accessed outside of a specific system**
- Prepare for <u>any</u> transitions – i.e. hospital-home, home-jail, jail-home
- **<u>Single plan</u> of care**
- Central way to access referral, information, resources across systems
- Youth need mechanism to be informed of cross system rights
- Professionals must be aware and protect youth rights

3. Build Access and Availability of Home and Community Based Services

Aka How to help people get more basic services

- **Having more youth partners to connect kids to kids (youth to youth)**
- Family and youth friendly paperwork and language
- **Methods/plans for transportation to support access to services, including especially rural communities**
- Newsletter/information given out about available programs, supports, resources
- Community team that brings all partners together to identify needs
    - Plan for access
    - Availability
- **Flexible hours (services when people can get there)**
- Services available where people are – use of technology, public TV, etc. These are available – need to use them! Many avenues
- **Train, utilize, and fund more peer-to-peer services at state and local events**
- Need statewide family groups (and youth)
- **Need to utilize + support existing grass-roots advocacy groups**
- Consistent expectations/experiences with practice across geographic areas (core values in action)
- A need for integration of information + services between primary health care and mental health
- **Develop a list of services + let families+ youth select where they want to access (family-friendly/market/pro-active)**
- Stronger link of services + schools
    - Schools can serve as a "hub" for all services
- **Case aides/supportive services in the home are invaluable – not always funded without criteria that are injurious to family**
- **Central repository of services that are easily accessible (phone, internet)**
- All providers are responsible for informing families of all services

- **Flex funds available for teams to decide how to use**

4. Develop and Strengthen Workforce that Operationalizes SOC Values

- Workforce Development in teach DSHS System – shared, central training academy
- Planning for sustainability within systems- not just training, but a plan for what is next. Available internal coaches
- Availability of opportunities for practice once training is complete
- **Monitoring of effective practice**
- A 36-hour day
- **Use of trauma-informed approach – from clerical to clinicians**
- **Address existing barriers – licensing, certification, etc.**
- **Evaluations for workforce include SOC**
- Consistent question – how many other systems, partners are you working with?
- **Youth, adult, parent partner, kin, and ALL need to be connected with + involved in the design + delivery of community-wide training circle (at the peer support level)**
  - **Hired and trained**
- **Free trainings**
  - **Training academy for parents/providers**
  - **Whole weekend trainings change lives**
- Fully fund all initiatives for DBHR
- **Parent & youth support specialists are hired, paid and considered part of the work force**
- More opportunities to meet across systems & families to share information

5. Build Strong Data Management Systems to Inform Decision Making and Ensure Outcomes

- **Parent + Youth Forums (regularly) hosted by parent + youth to RSN to local**
  - **Best practices**
  - **Measure barriers and when barriers are lifted**
  - **What's working**
  - **What they value**
  - **Access experience**
  - **Needs**
- Monthly activity reports
- Surveys
- Management at all levels
  - Executive
  - Management
  - Down to families
- System of Care philosophies/language embedded into all documents/forms
- Regional statistics
- Agreements to share information
- Both qualitative and quantitative data
- Shared definition of terms
- Data management strategies in each domain of SOC principles
- **Family + youth be part of design an delivery of evaluation methods**
- **Family + youth friendly language/strengths-based**
- Equal balance between people + process
  - Remember data is part of a person's life

- **Employ youth + family members to conduct evaluations/monitor contracts**
- Web-based access to reports/local + state
- **Measurement of system + team experiences with SOC and effectiveness**
- **Value experience as much as evidence base (collective experiences)**
- Data needs to be shared across systems (and available)
- Evaluate youth and families in non-clinical setting – i.e. at FY SPRTs, focus groups, etc.
- Ensure that data collected informs practice
- Standardized data system
- Collection needs to be as simple as possible
- A strength is that UW is monitoring data of the pilot – it would be good to have this at the state level
- **All use same tools + systems for reporting data + increase access**
- How can youth, family, partners inform, review + learn from data?
- Person centered – not "we and them"
- Strength-based language (Wrap + around)
- **All data collected focused on direct benefit for youth + families**

Appendix E

Trauma Informed Care

Utilizing UBG dollars, Washington State has made a major investment in trauma-informed treatment models. Since 2007 clinical staff in all 13 RSNs (over 85 community mental health agencies and over 800 clinicians and supervisors, and five Tribal agencies) has been trained in the core treatment model and received a minimum of six months of case consultation. Curricula included cultural competency with special consultation arranged for agencies that serve a primarily Latino population. A special seminar and consultation period was targeted to complex youth involved across systems (child welfare, juvenile justice and chemical dependency). In 2013, this model will be used to increase agency infrastructure support for utilization and fidelity of evidence-based practices (EBP) under the implementation of House Bill ESSB2536. UW Harborview Center for Sexual Assault and Traumatic stress, our partners in the Trauma-Focused CBT Dissemination operates a website that includes screening and other clinical support tools as well as a data repository to track client (de-identified) progress. In addition, the site has a roster containing names of clinicians who have passed training and consultation / fidelity oversight and agencies that provide TFCBT to facilitate referrals.

The Washington State Family Policy Council is a family-community-state partnership that engages communities in reducing major social problems. The Family Policy Council has conducted extensive training throughout the state and has partnered with the Centers for Disease Control and Prevention to improve the state's capacity to address Adverse Childhood Experiences (ACEs). Washington State is the first in the nation to have detailed information about the prevalence of ACEs in the adult population and its relationship to physical and behavioral health. This is one of several innovative partnerships that inform Washington State's evolving public health approach to behavioral health services (Miles 2010). In partnership with Clegg and Associates, the FPC published Adverse Childhood Experiences: Interviews with the Criminal Justice, Early Childhood Development, Faith, K-12 Public Education, and Public Health Communities documenting sector- specific supports to continue generating interest and action related to ACE prevention and mitigation.

In 2011, DSHS educated staff about trauma informed care, motivational interviewing, and wraparound with a "train the trainer" model, piloting initial trainings with DSHS staff and involving leadership as a foundational support. Trauma-informed care will be included in the peer curriculum, ensuring that trauma informed care is addressed in all areas of workforce development.

The SOC team at the Office of the Superintendent of Public Instruction (OSPI) offers several local planning frameworks and prevention approaches supporting SOCs and trauma-informed curricula that are sensitive to language and culture differences. The Compassionate Schools Initiative implementation began in 2007 with funds provided by the SAMHSA-funded Washington State Mental Health Transformation Grant with a study regarding the collaboration between schools and publically funded mental health systems.

(http://www.k12.wa.us/MentalHealthandSchools/pubdocs/MHResourceManual-2008.pdf)
This included educating school staff on the aspects of Adverse Childhood Experiences (ACEs) and how trauma affects brain development and neurology. The WSSOCP will enhance collaboration and integration of trauma-informed care efforts through the governance structure and SOC learning collaborative.

In conjunction with the DBHR children's mental health unit website, we have developed the SOC website as a primary venue for information about SOC values, activities, and involvement opportunities throughout the state. An interactive feature invites comments and contributions. Youth and families have participated in the development of the website that will be maintained by DBHR staff. Further development, supported by the implementation grant will allow flexibility to meet the needs of the project.

The UW EBPI also has a website that promotes and disseminates information about the workforce, evaluation, and policy supports it provides to the SOC at www.UWHelpingFamilies.org . A primary feature of the EBPI website is presentation of resources to providers and families about how to access services that align with research on effective practices.

UW Harborview Center for Sexual Assault and Traumatic Stress, our partner in training dissemination for Trauma Focused Cognitive Behavioral Therapy maintains a website with clinical fact and tip sheets, forms, screening tools, and data repository for clinicians who have been trained and have certificates of completion. The site also contains a roster of clinicians who have completed all fidelity requirements facilitating access for those referring clients for trauma-informed services.

Specific markets identified for outreach will have materials tailored for cultural and linguistic competency, particularly communities of color and lower socioeconomic status, using input from families, youth, tribes and local communities. Specifics of the plan will be formalized in Year 1 of the grant in a collaborative process with family, youth and system partners. Other aspects of our social marketing planning include considerations for expanding SOC communications by linking with targeted websites and non-English media venues.

Appendix F

Administrative Policy 7.22

Subject: Cultural Competence

Information Contact: DSHS Diversity Affairs

Authorizing Source: DSHS Cultural Competence Guidelines

DSHS Administrative Policy
Administrative Policy 7.01 - American Indian Administrative Policy
Administrative Policy 7.02 - Equal Access to Services for Individuals with Disabilities
Administrative Policy 7.20 - Communication Access for Persons Who are Deaf, Hard of Hearing, Deaf Blind and Speech Disabled
Administrative Policy 7.21 - Access to Services for Clients Who are Limited English Proficient (LEP)
Administrative Policy 14.10 - Accessible Meetings
Administrative Policy 18.26 - Reasonable Accommodation Services
Administrative Policy 18.81 - Nondiscrimination in Direct Client Services
Administrative Policy 18.66 – Discrimination and Harassment Prevention

Washington State Rule
WAC 388-271 - Limited English Proficient Services

Governor's Order
Executive Order 96-04

Equal Employment Opportunity Commission
(EEOC) Guidelines

Effective Date: September 22, 2011

Revised: New

Approved By: _____
Senior Director, Policy and External Relations

Sunset Review Date: September 22, 2015

Purpose:

To create and maintain an environment within the Department of Social and Health Services (DSHS) that values and supports cultural competence and embraces respect for the individual differences of our employees and clients. The Department recognizes that everyone has a culture and we have a commitment to promote respect and understanding of diverse cultures, social groups, and individual attributes. Each DSHS administration will ensure cultural competence is integrated into the overall organizational culture and ongoing business.

Scope:

This policy applies to all administrations and employees of the Department of Social and Health Services (DSHS).

Definitions:

Culture: DSHS defines culture in a broad sense, to include values, beliefs, experiences and cultural attitudes contributing to a person's sense of identity. It is the values, attitudes, beliefs, experiences and customs shared and transmitted by a group of people. It is "knowledge and collective experience" shared across generations within a family or community.

Cultural Competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals which enables individuals to work effectively in cross-cultural situations. It promotes respect and understanding of diverse cultures and social groups and recognizes each individual's unique attributes.

Cultural Responsiveness: Cultural responsiveness is the capacity to respond to the cultural differences and issues of a diverse work group, especially within an organization. Those differences may include such subtle items as communication style, problem-solving, values, conflict resolution styles, etc.

Diversity: For the purposes of this policy, diversity includes and is not limited to the following dimensions listed alphabetically:

- Age
- Class
- Communication styles
- Educational background
- Ethnicity
- Family status
- Gender
- Gender identity & expression
- Geographic location
- Group identity
- Job classification, job function
- Language
- Marital status
- Military experience
- Organizational background
- Organizational level
- Parental status
- Physical abilities and qualities
- Race
- Relationships and group affiliations
- Religious beliefs
- Sexual orientation
- Socioeconomic status
- Thinking styles
- Work experience

Policy:

Using the DSHS Cultural Competence Guidelines, each administration will develop action plans that support and guide staff delivering DSHS services in a culturally competent manner by:

1. Training all employees on the relevance of cultural competence in the work environment and providing tools to aide employees in achieving cultural competence.

2. Continually seeking potential improvements and best practices to provide culturally competent and responsive services and identifying ongoing training needs.

3. Building and maintaining partnerships that promote cultural competence by inviting clients and communities to participate in planning, delivering, and evaluating services.

4. Ensuring recruiting, hiring, performance management and retention practices achieve a diverse and culturally competent workforce.

5. Conducting outreach efforts to department employees, sovereign partners and the communities we serve throughout the state.
6. Providing bilingual staff resources and support to remain qualified and appropriately certified.
7. Including the requirement to provide culturally competent and responsive services in the performance contracts with service providers.

While each administration is responsible for developing and implementing their individual plans to enhance and support cultural competence as it pertains to their specific workforce, the Office of Diversity Affairs is responsible for creating guidelines to enhance and support cultural competence within the Department. The Office of Diversity Affairs will ensure standardization by reviewing each administration's plan and providing feedback regarding the thoroughness and implementation strategy of each administration's action plan. All levels of management are expected to implement and support activities that enhance the cultural competence of their staff.

**NOTE: "good faith effort"

Employees are responsible for complying with all applicable state and federal regulations. Employees are also responsible for reporting harassment or discrimination to their supervisor, or to someone in the employee's chain of command if they are not comfortable disclosing the harassment or discrimination to their supervisor.

Appendix G

Cultural Competence
GUIDELINES

EFFECTIVE SEPTEMBER 16, 2011

Washington State Department of Social & Health Services

One Department, One Vision, One Mission, One Core Set of Values

The Department recognizes that everyone has a culture and we have a commitment to promote respect and understanding of diverse cultures, social groups, and individual attributes. The mission, vision, and values of DSHS embrace inclusivity that supports people and communities in reaching their potential. To further that mission, the following guidelines provide a framework for cultural competence and culturally responsive service delivery.

The Department of Social and Health Services (DSHS) is committed to "Cultural Competence" through promoting respect and understanding of diverse cultures, social groups, and individuals. To achieve that commitment we develop and maintain a high performing workforce that provides meaningful service access and improves outcomes for all clients. We deliver culturally responsive services and our workforce reflects the diversity of the communities we serve. Each DSHS administration ensures Cultural Competence is integrated into the overall organizational culture and ongoing business practices.

DSHS defines culture in a broad sense. It is the values, attitudes, beliefs, experiences and customs shared and transmitted by a group of people. It is "knowledge and collective experience" shared across generations within a family or community contributing to a person's sense of identity.

Cultural Competence is the behaviors of individuals and the departments policies that come together enabling individuals to work effectively in cross-cultural situations. It promotes respect and understanding of diverse cultures and social groups, and an appreciation of each individual's unique attributes.

Being Culturally Responsive is the ability and willingness to accept and respond to another individual in a manner that demonstrates an effort to understand such subtle differences as communication style, problem-solving, values, conflict resolution styles, etc.

For the purpose of this guideline, culture includes the dimensions that define the individual. The following are examples of those dimensions, in alphabetical order. There are many other dimensions each of us possess:

- Age
- Class
- Communication styles
- Educational background
- Ethnicity
- Family status
- Gender
- Gender identity and expression
- Geographic location
- Group identity
- Job classification / job function
- Language
- Marital status
- Military experience
- Organizational background
- Organizational level
- Parental status
- Physical abilities and qualities
- Race
- Relationships and group affiliations
- Religious beliefs
- Sexual orientation
- Socioeconomic status
- Thinking styles
- Work experience

PAGE 1

Being Culturally Competent is:

1. Possessing the ability to work and deliver services from a cross-cultural perspective.
2. Continually learning.
3. The way we do business, not just a special program.
4. Identifying and providing a continuum for individuals and organizations to plan and monitor progress.
5. Increased by the actions of all individuals and organizations.

The DSHS vision of Cultural Competence:

1. Continuous self assessment.
2. Applying strategies to mediate and resolve conflicts and misunderstandings that stem from cultural differences.
3. Expanding employees' cultural knowledge, and adapting services to meet culturally unique needs.
4. Developing effective service delivery that includes input from culturally diverse communities and individuals.
5. Advocating for and supporting culturally competent and responsive programs.
6. Measuring the impact that services have on culturally diverse populations.

Objectives

These guidelines seek to increase the effectiveness of DSHS through planned and specific practices that increase Cultural Competence awareness for the department's workforce.

Each administration must ensure Cultural Competence is integrated into its overall organizational culture. Each administration will develop action plans that support and guide staff in delivering DSHS services through the following actions.

1. Each Administration shall provide training to employees to understand the relevance of Cultural Competence in the work environment. The training is.
   a. Based on regularly conducted self-assessments
   b. Designed to help employees acquire and institutionalize cultural knowledge about the diversity and cultural environments of the communities served
   c. Allows DSHS employees' to gain the knowledge/experience to work effectively within culturally diverse communities.
2. DSHS employees shall have access to the Cultural Competence website sponsored by the Diversity Affairs Office.
3. DSHS shall provide public relations materials outlining services to culturally diverse communities.
4. DSHS continually reviews practices in culturally competent services, improves those services, and identifies training needed to implement the improvements.

Under These Cultural Competence Guidelines, Each Administration Will:

1. Increase and maintain the capacity of staff to expand their Cultural Competence skills and knowledge to provide culturally competent services by developing and implementing cultural competence standards, conducting and analyzing organizational self-assessments, and developing and providing cultural competence training.
2. Increase linguistic and translation capacity by identifying core data elements used to report the primary language of applicants and recipients of services:
   a. Continually update data collection systems to improve service delivery
   b. Develop guidelines to disaggregate available data to identify diversity of clients receiving services
3. Ensure performance based contract language requires service providers to provide culturally competent services and monitor for compliance.

Cultural Competence And Performance Management

The DSHS Executive Leadership Team acknowledges that embedding Cultural Competence into the Department structure is an opportunity for DSHS to develop and grow into the agency envisioned by the DSHS Framework for the Future. Human Resources will provide leadership through incorporating Cultural Competence into the Talent Management model.

Talent Management refers to the process of attracting highly skilled workers to DSHS, developing and integrating new workers, and developing and retaining current workers. The Talent Management model illustrates key processes and enhanced practices that recognize and support employees, to include the following: Workforce Planning, Recruitment, On-boarding, identifying and training to Competencies, Performance Management, Employee and Leadership Development, Succession Planning, Career Management, and Retention.

Supervisors are expected to clearly explain the behavior based competencies that support a culturally competent and responsive, accepting environment, and provide coaching and training if necessary. These competencies are incorporated into the Position Description Form, and Performance Development Plan.

Behaviors that interfere with creating and supporting a culturally competent and responsive environment may be corrected through appropriate coaching, counseling, or disciplinary action.

Appendix H

Draft
7/10/12

DSHS welcomes, values, and supports cultural competence and embraces respect for the individual differences of our employees and clients. Our interaction with all segments of society must be transparent and reflective of our commitment to excellence.

We Are...	*Our Commitment...*
ACCOUNTABLE...	Recognizing the impact of our approach, decisions, and actions on ourselves, coworkers, stakeholders, and those we serve.
AMBITIOUS...	Striving to enhance our cultural responsiveness by asking "What are we doing well?" and "What can we do better?"
COLLABORATIVE...	Working cooperatively to promote a culturally competent environment in which everyone has the opportunity to contribute.
INCLUSIVE...	Embracing different races, ethnicities, cultures, identities, orientations, abilities, communication styles, values, world views, problem-solving approaches and thinking styles.
RESPECTFUL...	Welcoming, responding to, accepting, and valuing differences among co-workers, stakeholders, and those we serve.
RESPONSIVE...	Learning, growing, and adapting to changes in our surroundings, professional relationships, and the needs of those we serve.
STRENGTH BASED...	Offering the training, resources, and support needed to build on existing strengths.

Washington State Department of Social & Health Services
DSHS 24-410 (7/12)

Appendix I

Washington State Department of Social & Health Services
CA Children's Administration

Gay, Lesbian, Bisexual, and Transgender Persons–Equity Work Group
CHARTER – The Transformation through Action

VISION
Safe, healthy individuals, families, and communities

MISSION
The Department of Social and Health Services will improve the safety and health of individuals, families and communities by providing leadership and establishing and participating in partnerships.

VALUES
Excellence in Service
Respect
Collaboration and Partnership
Diversity
Accountability

ORIENTATIONS
Early childhood development
Person- and family-centered, strengths-based

OUR IMPACT
Together we will decrease poverty, improve safety and health status, and increase educational and employment success to support people and communities in reaching their potential.

PURPOSE: To actively work with other diversity allies to cultivate an environment of visibility, sensitivity, and inclusion in the DSHS for persons who are or are perceived to be gay, lesbian, bisexual, or transgender by ensuring their perspectives are integrated into policy and practice both within the workplace and throughout the statewide social service continuum by fostering a Departmental culture that is safe, equitable, and affirming for all staff and all clients across a broad spectrum of cultural nuances.

OUTCOMES:

1. The DSHS organizational culture will measurably support and reinforce; and executive leadership will champion and model a foundation of equitable treatment of all employees, clients, and contracted service providers including those who are or who appear to be gay, lesbian, bisexual, or transgender.

2. DSHS policies and practices will be intentionally supportive, not discriminatory, toward gay, lesbian, bisexual, and transgender employees, clients, and contracted service providers.

3. Gay, lesbian, bisexual, and transgender employee, client, and contracted service provider satisfaction will increase in relation to identified diversity issues, safety, equity, and engagement. These outcomes will be measurable through staff and provider surveys, the Department cultural competency survey and client satisfaction surveys.

4. This group in partnership with community experts will continue to explore meaningful ways in which staff and clients who may not wish to reveal their sexual orientation or gender identity may have an active voice in this process.

5. No single "affinity group" will be afforded resources or supports disproportionately to any other. While it is understood that this group is committed to representing the voices of gay, lesbian, bisexual, and transgender persons, we are part of a larger effort to increase safety and improve equity and inclusion for all populations throughout the DSHS workforce and constituency. Our effort here will help other diverse populations to experience improved outcomes as well.

1

"Inclusion is not a strategy to help people fit into the systems and structures which exist in our societies; it is about transforming those systems and structures to make it better for everyone. Inclusion is about creating a better world for everyone." ***~ Diane Richler**, President, Inclusion International* *"When government becomes more inclusive, over time, society will follow."* ***~ Cherie Macleod,** Executive Director, PFLAG Canada*	**ACTION STEPS:** 1. Develop methods to impact policy development, review, and implementation including: • Review new policies as well as those that are scheduled for periodic review through gay, lesbian, bisexual, and transgender designees during policy development and revision. • Utilize the DSHS framework for the future as a foundation upon which our efforts for this staff and client population are built. All outcomes and action steps should be visible in the DSHS Vision, Mission, Values, Orientations, and/or Impacts. 2. Make recommendations to the Executive Leadership Team about how to improve the DSHS environment to be safe, equitable, inclusive, and culturally relevant for gay, lesbian, bisexual, and transgender clients, employees, and contracted providers. • Request that DSHS leadership make known our stance about safe and equitable treatment of GLBT staff and clients in their interactions with statewide offices and partner agencies. • Publish a "fact card" that provides information about what the department has done and what each individual can do to improve the DSHS culture of inclusion and affirmation.
TIMEFRAMES: October 2011 – December 2012 (Phase 1 Action Steps)	
SPONSOR: Susan Dreyfus, DSHS Secretary (and successor)	
PROCESS OWNER: Victor Chacon, Senior Director, Diversity Affairs	

GAY, LESBIAN, BISEXUAL, TRANSGENDER PERSONS EQUITY WORKGROUP

VOTING MEMBERS:

Name	Phone
Marianne Ozmun	**360.902.7928**
Doug North	**360.902.7819**
Dan L Schaub	**360.902.7752**
Katherine Vasquez	**360.664.6097**
Rikki Mordhorst	**253. 571.8855**
Esme Crosson	**360.725.5831**
Victor Chacon	**360.902.7999**

TEAM PROCESS FOR DECISION-MAKING: Proposals submitted to workgroup in writing in advance of meetings or during work group meetings. Proposals open for comments and revisions. Proposals voted on and adopted during workgroup meetings. Must have quorum of more than half of the voting members present to pass motions or adopt proposals.

TEAM MEMBER ROLES:

TEAM LEADER: Marianne K. Ozmun
SCRIBE/RECORDER: Rotating
TIMEKEEPER: Esmeralda Crosson
FACILITATOR: Marianne K. Ozmun/Victor Chacon

TEAM MEMBER ENGAGEMENT AND SELECTION: The committee itself will remain relatively small, a membership group of 8-10 internal representatives from across the Department and representing members of the gay, lesbian, bisexual, transgender male and female, and heterosexual allied community. We will draw from our robust pool of community experts to serve as partner members or ad hoc expert consultants to the group. Prospective members may be referred by a group member, an appointing authority, or may request inclusion in the group as positions open. Invite outgoing members to suggest potential replacements. There is no designated term for membership on the workgroup.

_____ _____

APPROVED **Date**
Susan N. Dreyfus, Secretary

Appendix J

CHRISTINE O. GREGOIRE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 · Olympia, Washington 98504-0002 · (360) 753-6780 · www.governor.wa.gov

EXECUTIVE ORDER 12-02

SUPERSEDING EXECUTIVE ORDER 93-07
WORKFORCE DIVERSITY AND INCLUSION

WHEREAS, Washington State is committed to developing and maintaining a high performing public workforce that provides access, meaningful services, and improved outcomes for all citizens. Our state is unique. Our history and geography place us at the crossroads of domestic and international trade. We are immigrants and indigenous peoples, farmers and financiers, and soldiers and software engineers. Our diversity is enriched by hundreds of cultural traditions, ranges of faith, types of families, expressions of personal identities, personal abilities and talents, and professional and personal experiences. The ever increasing diversity of our population and workforce defines who we are as a people, and drives the public's expectations; and

WHEREAS, all Washingtonians share a collective aspiration to build a better future for current and future generations. As such, it is the policy of Washington State to proactively build a diverse, inclusive, and culturally competent workforce by eliminating barriers to growth and opportunity, allowing each employee to contribute his or her full measure of talent, and building our capacity to deliver innovative, effective, and culturally relevant services to all the people of Washington.

NOW, THEREFORE, I, Christine O. Gregoire, Governor of the state of Washington, by virtue of the power vested in me by the Constitution and statutes of the state of Washington, do hereby order and direct as follows:

1. The Office of the State Human Resource (HR) Director

The State HR Director will serve as the Governor's Chief Diversity Officer with responsibility for establishing diversity policies and strategies as part of Washington's overall talent management framework. To this end, the Office of the State HR Director shall:

(a) In collaboration with agencies and institutions, develop priorities, goals, and strategies for creating a diverse, inclusive, and culturally competent workforce;
(b) Establish both internal and external committees to advise state government on workforce diversity policy and strategy, including convening cross agency/institution work groups to develop and coordinate enterprise-wide diversity and inclusion initiatives;
(c) Establish streamlined agency, institution, and statewide workforce diversity reporting requirements;
(d) Review, evaluate, and approve agency and institution workforce diversity plans, policies, and strategies; and
(e) Develop and deliver an annual report to the Governor on the state's progress towards creating a diverse, inclusive, and culturally competent workforce.

2. General Government Agencies

All cabinet agencies, boards and commissions, and other agencies that report to the Governor are responsible for developing and maintaining a high performing workforce that improves outcomes for customers, delivers culturally responsive services, and reflects the diversity of the communities it serves. To this end, each agency, board and commission shall:

(a) Designate a staff member to oversee and implement workforce diversity strategies;
(b) Maintain current policies on diversity, inclusion, and equal opportunity, which include supervisors' and employees' specific responsibilities for promoting diversity, inclusion, and equal employment opportunity;
(c) Deliver training to supervisors and employees on diversity, inclusion, and equal employment opportunity, including the competencies necessary to provide culturally responsive services;
(d) Develop and implement diversity recruitment, hiring, development, and retention strategies, including strategies to build a diverse cadre of mid and senior level managers; and
(e) Submit reports on the effectiveness of workforce diversity strategies in accordance with requirements outlined by the Office of the State HR Director.

All other elected officials, institutions of higher education, agencies, boards and commissions are invited to follow the provisions of this Executive Order.

This Executive Order, which supersedes Executive Order 93-07, shall take effect immediately.

Signed and sealed with the official seal of the state of Washington, on this 20th day of June, 2012, at Olympia, Washington.

By:

/s/
Christine O. Gregoire
Governor

BY THE GOVERNOR:

/s/
Secretary of State

Appendix K

Readiness Assessment: Detailed summary of recommendations and findings from evaluations, assessments, and reports

Report*	Major Findings/Recommendations
Recent and Relevant Needs Sensing, Evaluation, and Assessment Projects	
Comprehensive Children's Mental Health Needs Assessment (1)	Access to Care Recommendations: • Increase rates to community mental health agencies to provide services out of the office, after hours, and during weekends • Train providers, parents, and youth on evidence based and promising family and youth engagement and empowerment strategies • Address limits to access to services posed by current Access to Care Standards (ACS). • Shift RSN utilization management away from front-end restrictions across all enrollees to proactive care management for the most intensive and costly services. • Increase access to child psychiatrists by expanding the current Partnership Access Line (PAL). Service Recommendations: • More actively promote Family Advocacy, Peer-to-Peer Support, and Youth Support. • Promote Family Support and Advocacy Organizations (FSAOs) to be more self-sustaining and more capable of providing reimbursable services • Establishing a new category of provider type for family and youth peer support • Expand current technical assistance and other supports to FSAOs (e.g., through Center(s) of Excellence) to implement evidence based and promising family support models • Enhance the current peer-to-peer and family/youth support worker certification process • Implement evidence-based practices (EBPs) for youth at risk of out-of-home placement or transitioning home from out-of-home placement setting, including Multidimensional Treatment Foster Care (MTFC), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Family Integrated Transitions (FIT). • Implement EBPs for youth exposed to past trauma, including TFCBT • Implement EBPs for youth with co-occurring mental health and substance abuse disorders, including MST. • Implement evidence based models that target early signs of behavioral problems and assist parents in working with oppositional and defiant behaviors. Specifically recommended models include Parent-Child Interaction Therapy (PCIT) and The Incredible Years. • Implement prevention and early intervention programs with evidence for

	effectiveness that align with stakeholder priorities • Increase availability of Wraparound care coordination statewide • Build infrastructure to support implementation of prioritized EBPs Infrastructure recommendations: • Increase leadership roles of families and youth in system design and accountability monitoring by promoting and supporting cross-system community collaborative teams • Increase leadership roles of families and youth in system design and accountability monitoring by building greater capacity at the DSHS level to use cross-system teams with youth and family leadership
Community Supports for Wraparound assessment (2)	Relative strengths in terms of: • Human resource support and development due to time limited training and coaching being received at the time of CSWI data collection • Accountability due to the data-driven coaching approach used by VVDB and the independent evaluation being conducted Relative weaknesses in terms of: • Community partnership and collaborative action at the local level • Fiscal supports and sustainability for wraparound. These data, and the interviews conducted with stakeholders indicate: • the potential pitfalls of single-agency based (i.e., mental health) wraparound initiatives that focus on the practice model more than a full state and local cross-agency partnership on behalf of youths with complex needs. • Stakeholders perceive that staff charged with implementing wraparound were supported reasonably well by their host agencies, had access to good training/coaching (albeit time-limited) and supervision support, and that the service array was at least minimally adequate to meet needs of teams. • However, local stakeholders perceive significant barriers to true cross-agency oversight of a wraparound-based system of care that can be sustained over time and meet needs of youths in an integrated fashion. Implications: • Washington State needs a coordinated source of training and professional development support • System supports for wraparound are poor relative to the fidelity of implementation. Washington State needs to provide local wraparound initiatives with funding and policy supports that are sustainable • Stakeholders observed that high quality clinical services are not available to wraparound teams. Incentives for developing such services and providing connections to wraparound initiatives should be developed.
Wraparound Washington pilot site evaluations (3)	• Only about 10-15% of youths in each pilot site county had a recent out of community placement. For wraparound to be cost-effective, it must not only be delivered with integrity to the model and in a context of community support, but also to youths for whom this level of intensity is needed to maintain them in the community. This may not be happening in

	the wraparound pilots, again, likely due to a lack of consistent focus in Washington on how to screen, enroll, and serve youths with the most complex, cross-system needs in intensive team based programming such as wraparound. • Consistency in training and coaching support has been lacking in the pilot projects since the first year. Ensuring adequate human resource support will be important to ensure program drift does not occur. Despite substantial presence of wraparound initiatives statewide, Washington State does not have an adequately resourced, local, coordinated source of training and professional development support. Such a resource is needed. • The state should develop infrastructure that can enhance certain elements of wraparound fidelity found to be relatively low in the current evaluation, including setting goals and monitoring progress (Outcomes Based principle), developing individualized plans specific to the needs of each youth and family, crisis planning, and transition planning. • Though the number of youths who experienced out of community placement was reduced overall, the number of episodes and number of overall days in care was not. Better cross-system collaboration statewide and/or in local communities on behalf of youths identified as needing out of community placement, and mechanisms to ensure wraparound care coordination is integrated into out of community placement episodes to ensure more effective transitions home may be effective at reducing the total days in out of home placement found for a small minority of youths.
State wraparound & SOC Summit participant survey (4)	Relative strengths in Washington: • Means to adapt the wraparound model based on the needs of families, communities and local jurisdictions • Capacity for prioritizing, selecting and admitting targeted groups at the local level • Providers are engineered to provide flexible responses to meet youth and families' priority needs • Consensus about what family-driven care means in Wraparound implementation Needs for improvement in Washington: • Clear, coherent and consistent definition of Wraparound across all departments • Consensus about fiscal, outcome, satisfaction, and process indicators of Wraparound success, and we support consistent measurement of these data elements • Information loops that guide policy & procedure development and that reflect the direct experiences of families • Providers who operate with a no reject, no eject policy • Methods to assure that families have information to make informed choices about Wraparound and component interventions, services & supports • Methods to assure the Wraparound workforce has the right tools to do

	the job • Local communities are empowered to redeploy resources in flexible ways • Commitment to seeding, funding and developing resources that could be supportive and helpful for Wraparound implementation (e.g., training structures, family organizations, technology improvements, evaluation, etc.)
Assessment of SOC billing, accreditation, and regulatory context (5)	Licensing and Auditing: • The RFP issued by Washington State for the Children's Mental Health Pilots in 2007 required that agencies responding to the RFP to provide Wrap services be Licensed Mental Health Agencies. However, there is not a Wraparound licensing category. DBHR is choosing to license subcontractors who only provide Wraparound using a licensing category that is not designed for them. Options include: o Urging DBHR to expedite development of an appropriate licensing category o Operating under a licensing category that is a close approximation to Wraparound and requesting an exemption for portions of the criteria that do not conform to Wraparound fidelity o Operating under a license that is "the closest fit" and not complying with fidelity requirements for Wraparound. • As Licensed Mental Health Agencies, the providers of Wrap services participate in regular file audits by DBHR. DBHR uses the Voluntary and Involuntary Outpatient Record Review Tool for these audits. However, there are major discrepancies between requirements for other licensing categories and the requirements for the provision of High Fidelity Wraparound. Billing: • Medicaid requires Family Support Partners to be certified peer counselors with an agency affiliation registration with DOH. If they are not certified, a Wraparound initiative cannot bill Medicaid for medically necessary peer support services delivered by Family Support Partners. • A wraparound initiative or provider organization cannot bill Medicaid for multiple people participating at the same time at the same team meeting (e.g. wraparound facilitator, family support partner, psychiatrist, and/or therapist). • In general, all wraparound sites are confused about how wraparound documentation can be completed in a way that is both adherent to the high fidelity wraparound model that the State contracts require the contracted providers to deliver and compliant with Medicaid rules and CMH rules. Wraparound has its specific documentation requirements that differ from the traditional clinical documentation in many ways. Intake and Diagnosis: • The requirement for a Mental Health Intake Assessment with diagnosis by MA level Child Mental Health Specialist for Counseling and

	Psychotherapy and Case Management for children contradicts SOC and Wraparound values, seems duplicative, is unnecessarily invasive, and forces Wrap staff to designate an "identified patient" for Wrap interventions, which are intended to avoid labeling a "patient" and to address needs for the whole family. • Using an "identified patient" model as required by Medicaid, adds a barrier to the implementation of wraparound as a "family-driven" model. • It seems to violate the recovery principle to require the wrap team to designate who is the identified person in need of recovery when wraparound is for the family to learn autonomy and use natural support network for the increased wellbeing, health and recovery of all family members. • Medicaid requires diagnoses that meet access to care standards, which is an unnecessary barrier to wraparound. Wraparound sites would like to advocate that families in need of wraparound can be accepted into the initiative and/or continue to access the service without needing a mental health diagnosis. • Requiring a mental health diagnosis for wraparound enrollment and requiring the provider to be a CMHA perpetuates the notion that wraparound is a mental health service when it is not. This creates yet more barriers to the "team-based ", community-based" and "collaborative" underpinnings of wraparound. The children and families served are seen as "mental health clients" with a single system bearing full responsibility for assisting multi-system needs. Systems will not share accountability to the family, the community, or the state under this single-system model. • Requiring wraparound to comply with the State and Federal mental health licensing requirements causes another barrier in that under the Federal Mental Health Block Grant rules, Medicaid covered services may not be funded by FMHBG. Such labeling for the mere purpose of satisfying mental health licensing requirements for wraparound that is not a mental health service, appears to be contrary to common sense and against the promised recovery and system of care approach in health transformation that the State promotes.
Washington State Cross-Systems MH Performance Monitoring Dashboard (6)	• After having declined for many years, rate of arrests for youths with MH needs began to increase in 2009. The improvement in this outcome was attributed to the success of the installation of treatment programs by Juvenile Rehabilitation Administration; the subsequent increase in arrest rate has been attributed to reductions in funding for these evidence based programs as well as cuts to juvenile parole and probation. • Level of coordination with other agencies was found to be only 51% as measured by review of files as part of a 2007 EQRO review. • The proportion of children's MH dollars spent on community-based behavioral health services (as opposed to dollars spent on inpatient behavioral health services, avoidable ER visits, and other non-community based services), has decreased steadily over the past decade, from 63% in

	2003 to 58% in 2008. • The rate of children with MH disorders who have a co-occurring substance abuse disorder who received substance abuse services has increased in recent years, to 52% in 2009, from a relative low of 47% in 2005.
System of Care Expansion Planning Grant-Specific Evaluation and Assessment Activities	
Family-driven Care and Practice System Self-Assessment Tool (7)	Results from the Family Driven Care and Practice System Self-Assessment tool showed that: • 44% of system of care stakeholders believe child-serving systems use the vocabulary of family-driven • 36% perceive that child-serving systems understand what family driven means • 64% perceive that child-serving systems believe in family-driven care and practice • 27% feel child-serving systems apply the principles of family-driven care.
East and West Side Lessons Learned Forums (8)	State stakeholder forums focused on five goals for statewide system of care expansion. Major themes within each are presented below: 1. **Infuse SOC Values in all system elements for children, youth and families** • Recent intensive case management and wraparound pilots provide guidance • Leaders (agency, legislators) who understand and champion SOC are needed in this state • Families must be educated on their choices • Hiring at all levels should consider embracing/understanding SOC values **2. Ensure services are seamless for children and youth who are the population of focus (13-18)** • Bundling, cost sharing, pooled funding strategies are critical yet not accomplished • Services must be more transition age youth-appropriate (e.g., mentoring) • Services must support adolescents through the transition years • Information/data systems must cross agency boundaries • Cross-agency coordination is key – MOUs by agency leaders to support collaborative care • Single plans of care for multi-system involved youths **3. Build Access and Availability of Home and Community Based Services** • Need to fund, train, and support family advocates and grassroots advocacy groups • Youth peer support partners needed, none currently available • Transportation options in rural areas, flexible hours, co-located services, and other logistical supports • More centralized point of access and information about available services • Flexible funds for youths and families with complex needs **4. Develop and Strengthen Workforce that Operationalizes SOC Values** • More is needed than one time training – coaching, directive supervision, IT

	supports • Monitoring of effectiveness and quality of practice • Providers, Youth and parent partners and others – all need consistent high quality support **5. Build Strong Data Management Systems to Inform Decision Making and Ensure Outcomes** • Regular local (hosted by RSNs?) and state forums that convene providers, system partners, youth and families • Qualitative as well as quantitative data needed; Better use of existing data • Families and youths should be part of design (and use) of evaluation methods and IT systems • Need to share data across systems • Consistent evaluation, tracking, and reporting system that is in line with SOC principles – e.g., take the UW evaluation of wrap pilots statewide
Regional Family, youth, and system partner Focus Groups (9)	**1. General functioning of the system.** • Biggest issue is coordination across agencies and helpers. Takes months to get anything done. Have to explain everything again with every new contact. • Agencies have no interest in working together. Family/youth has to do it themselves and it takes persistence and perseverance to navigate system. • Family and youth partners would help this. People who are paid to know don't know. **2. Population of focus** • High needs = Youth in transition. Expand available services to those that are most relevant such as job placement • Services that intervene with youths under 13 before troubles get too bad. **3. Organization and management of service system** • Most of the "management" of services is paper-based, not truly collaborative • "Silos within systems that should be working together prevent proper management" • Care coordination committees exist in some areas but youth and families do not participate • Seemingly arbitrary decisions that hurt youth and families: • "a whole [service] area was no longer being able to be provided by RSN so they had to close. And a child place was in the same building but they're coded under the same place, this is where my son an myself were going for counseling. And we had a great report with them and then we were told, "Sorry you can't go there anymore". **4. Array of available services and supports to be provided** • Family members don't even know the services that are available • Youth fall through cracks • Homeless youth - Youth cannot utilize services when they are not getting their core needs met like food shelter and clothing

	• Amazing programs exist in some places but there is no attempt to take statewide: • "I've seen really great things in my time working in this program with King County and some of the other places, with their organizations; it's just amazing what they do. Your organization is fantastic I was so impressed with the kids in your program. And how they turned their lives around and what they're doing for other people now. I just know it's possible to do here, we just got to figure out how to do it and how we seen it" **5. Strategic financing approaches** • Blended funding is not even discussed as an option in this state: • "Providers care and want to work together but are bound by funding" • Systems start over and over again with the same families: • "They're starting all the way over from the beginning having to build the trust and form relationships so we wasted how much money for them to do another report, all that relationship building for nothing" • Restrictions posed by Medicaid; private providers restricted from seeing RSN clients. • "Families should be allowed to see who they want to see, especially if provider is willing to accept their fee." • Kids who were being well served get dumped because providers don't take Medicaid any more. • "So what's better a child who has counseling who's continuing to get their health and the state paying a private provider; or a child that no longer gets any services because they need the person that they have, that's a real travesty" **6. Training and technical assistance for systems of care implementation** • "We need a family organization; it would make a huge difference." • Systems are managed by people who don't know what the youth are actually going through • Systems training on being family and youth driven **7. Workforce Development strategies to prepare future workforce** • Family partners help overloaded clinicians and systems! • "We have a 20 hour week family core partner and it's amazing the things that she can do in that amount of time. But she's got the connection" • "Wraparound Facilitators can bring the systems together in the room and have a team meeting, but it's that peer person that makes all the difference for the families." • "A youth partner would be the same thing and the community does need that." • "And that's what the families need, they need somebody to walk in their shoes and who understands where they've been and understands how to take them by hand and take them to the places that they need to go, that's really important"

Survey of providers and regional support networks (RSNs) (10)	• Nearly all of the RSNs indicated that they have developed plans to support the adoption of the Core Practice Model.
	• More than 40% of RSNs indicated that "All contracted providers serve the age span for the full range of needs" and that "There are several children's mental health providers and one agency specializes in wraparound."
	• When asked about the services offered by providers, Intensive Care Coordination was offered in the highest number of RSNs (91.7%), and Extended therapeutic support services/Case Aides was offered in the least (66.7%).
	  o However, that means that *all* listed services were offered in at least two thirds of RSNs
	• Two RSNs indicated they did not provide wraparound teaming.
	• Half of RSNs indicated that they "offer training to our partners regarding the Principles, Wraparound and/or Child and Family Team participation"
	  o Thus, 10/12 RSNs have Wraparound; 5 out of those 10 ha have internal capacity to train, the other 5 need to develop or obtain that expertise.
	• Nearly two thirds of agency respondents indicated that they have developed plans to support the adoption of the Core Practice Model.
	• The three most common services provided by the agency respondents were Intensive Care Coordination and Child / Family Teams followed by Children's MH EBPs
	• Three agencies indicated that they do not provide wraparound, but for those agencies that do provide wraparound, all but one indicated that "the 10 Principles are infused" in provided children's services

Interviews with Agency Leadership (11)	Ongoing.

Appendix L

Systems of Care Acronym List

Acronym	Long Name
ACEs	Adverse Childhood Experiences
ADSA	Aging and Disability Services Administration
CA	Children's Administration
CANS	Child Adolescent Needs and Strengths
CD	Chemical Dependency
CFT	Child and Family Team
CIIBS	Children's Intensive In-home Behavior Support
CLIP	Children's Long-term Inpatient Programs
CMHA	Community Mental Health Agency
CPM	Core Practice Model
CSIT	Cross-System Initiatives Team
CSO	Community Service Office
DBHR	Division of Behavioral Health and Recovery
DDD	Division of Developmental Disabilities
DEWIS	Dropout Early Warning & Intervention System
DOH	Department of Health
DSHS	Department of Social and Health Services
EBPI	Evidence Based Practice Institute
ELT	Executive Leadership Team (DSHS)
EQA	Evaluation and Quality Assurance
EQRO	Evaluation and Quality Review Organization
FB(G)	Federal Block Grant
FFT	Functional Family Therapy
FIT	Family Integrated Transitions
FSAOs	Family Support and Advocacy Organizations
FYSPRT	Family Youth & System Partner Round Table
GATE	Graduation, a Team Effort
HCA	Health Care Authority
HO	Healthy Options Managed Care Plans
IEP	Individualized Education Plans
ICM	Integrated Case Management
JRA	Juvenile Rehabilitation Administration
LEP	Limited English Proficient
LHJ	Local Health Jurisdictions
LGAN	Looking Glass Analytics Network
MHD	Mental Health Division
MSCC	Multi-System Collaboration & Coordination
MST	Multi-systemic Therapy

MTFC	Multidimensional Treatment Foster Care
NOA	Notice of Action
OSPI	Office of Superintendent of Public Instruction
PAL	Partnership Access Line
PCIT	Parent-Child Interaction Therapy
PIHP	Pre-Paid Inpatient Health Plan (RSNs)
PBS	Positive Behavioral Supports
PSU	Portland State University
QI	Quality Improvement
QMP	Quality Management Plan
RDA	Research and Data Analysis
RFI	Request for Information
RFP	Request for Proposal
ROCM	RSN Oversight & Contracts Management
ROSC	Recovery Oriented Systems of Care
RCL	Roads to Community Living program
RCW	Code of Washington
RSN	Regional Support Network
RSN CCC	Regional Support Network Children's Care Coordinator
SAFEWA	Statewide Action for Family Empowerment of Washington
SAMA	Science and Management of Addictions
SED	Serious emotional disturbances
SERI	Service Encounter Reporting Instructions
SOC	System of Care
SPA	State Plan Amendment (Medicaid)
SUD	Substance Use Disorder
TFCBT	Trauma Focused Cognitive Behavioral Therapy
T/TA	Training and Technical Assistance
TR	Initials of the lead plaintiff in the T.R. vs. Dreyfus lawsuit
TRIP	T.R. Implementation Plan Team
UW	University of Washington
WAC	Washington Administrative Code
WaDads	Washington Dads
WCMHC	Washington Community Mental Health Council
WSSOCP	Washington State Systems of Care Project
WIHMHRT	Washington Institute for Mental Health Research and Training
YNA	Youth 'N Action