Washington

Uniform Application

FY 2011 – State Plan

Community Mental Health Services

Block Grant

Center for Mental Health Services

Division of State and Community Systems Development

September 1, 2010

Contents

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_FY2010 _XX_FY 2010-2011

STATE NAME: Washington

DUNS #: 12-734-7115

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Social and Health Service

ORGANIZATIONAL UNIT: Division of Behavioral Health and Recovery

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP: 98504

TELEPHONE: 360-725-1736 FAX: 360-664-4371

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: David A. Dickinson TITLE: Director

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Division of Behavioral Health and Recovery

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP CODE: 98504

III. STATE FISCAL YEAR

FROM: 07/01/2010 TO: 06/30/2011

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: C. H. "Hank" Balderrama TITLE: Mental Health Program Administrator

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Division of Behavioral Health and Recovery

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP: 98504-5320

TELEPHONE: 360-725-1736 FAX: 360-664-4371 EMAIL: hank.balderrama@dshs.wa.gov

Washington

2 - Executive Summary

The Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) of the State of Washington is pleased to submit its application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2011. This plan meets all of the requirements of the application, has been reviewed by community stakeholders, and is supported by the state Mental Health Planning and Advisory Council (MHPAC). The plan is aimed at achieving the following:

Despite economic uncertainties and multiple organizational changes in the last three years DBHR remains committed to increasing access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports; ensuring the participation of consumers and their families in planning and evaluation of state systems; improving access for underserved populations, including older adults, homeless people and rural populations; expanding the promotion of recovery and community integration of people with psychiatric disabilities; and delivering accountability through uniform reporting on access, quality and the outcome of services.

During the last year and a half, the former Mental Health Division (MHD) merged with the former DSHS Division of Alcohol and Substance Abuse (DASA). The new division was named Division of Behavioral Health and Recovery (DBHR) and operated with the DSHS Health and Recovery Services Administration (HRSA). This spring, HRSA merged with the state Health Care Authority (HCA), which formed the Medicaid Purchasing Administration (MPA). In the process, DBHR was transferred to Aging and Disability Services Administration (ADSA).

In tandem with the federal guidelines, this document encompasses Washington State's commitment to the goals outlined in the Final Report of the President's New Freedom Commission on Mental Health entitled, Transforming Mental Health Care in America.

Americans understand that mental health is essential to overall health. Mental health care is consumer and family driven. Disparities in mental health services are eliminated. Early mental health screening, assessment and referral to services are common practice. Excellent mental health care is delivered and research is accelerated. Technology is used to access mental health care and information.

The New Freedom goals remain integrated with the goals of the Mental Health Planning and Advisory Council and addressed within the Mental Health Division's Strategic Plan which serves as the platform for Washington's aspiration to achieve transformation.

DBHR and its Contractors are continually searching for system improvements; improved access to services that meet individual needs, family and natural supports are utilized, and that community partnerships are strengthened.

Under the guidance of Governor Christine O. Gregoire, Washington is demonstrating a firm commitment to all residents, both in policy and in practice, by dedicating the necessary resources, expertise, and visionary leadership toward a future where transformation of the public mental health system becomes a reality.

The DBHR continues to focus on unmet mental health needs, described in this combined adult and child plan, and to move forward with the plans to implement a system to address these needs. For both populations, the needs are large and the service deliverables will take a period of time to develop. Activities include:

System transformation initiative requirements for employment, housing, benefit redesign and a review of the Involuntary Treatment Act and inpatient utilization management continue.

Collaborative work continues with all Tribes in the state of Washington, including mental health workgroup meetings and Roundtable meetings to discuss planning for major undertakings of system change.

The ongoing funding for two evidence based-pilot-programs both amended to allow for children to remain in their parent's custody while receiving out-of-home care and funding for the Children's Mental Health Act creating three Wrap-Around pilot sites.

Mental Health Clubhouses also were a part of the 2007 legislative focus. Washington Administrative Code (WAC) has established guidelines for certification.

The State of Washington continues to face budget shortfalls and has at the time of this writing a freeze on hiring, travel (both in and out-of-state) and contracting. Nonetheless the mental health system in the State is moving forward in creating quality care for the consumers of services across the lifespan.

Washington

Federal Funding Agreements, Certifications And Assurances

3 - Funding Agreements

4 - Certifications

5 - Disclosure of Lobbying Activities

6 - Assurances

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2010

I hereby certify that Washington agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2010, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

[21]. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved, and (B) ensure that, in the conduct of such peer review, not fewer than *5* percent of the entities providing services in the State under such program are reviewed (which *5* percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section *505* and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant

Susan N. Dreyfus
Secretary, DSHS

9/1/10

September 1, 2010

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

14

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Secretary, WA State Department of Social & Health Services
APPLICANT ORGANIZATION	DATE SUBMITTED
WA State Division of Behavioral Health and Recovery	September 1, 2010

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
[a] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	[a] a. bid/offer/application b. initial award c. post-award	[ ] a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
Prime Subawardee Tier _____, *if known:* **Congressional District**, *if known:*	**Congressional District**, *if known:*
6. Federal Department/Agency: SAMHSA- CMHS	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. Federal Action Number, *if known:*	**9. Award Amount**, *if known:* $
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):* No Lobbying will be conducted	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: Susan N Dreyfus 9/1/10

Print Name: Susan N. Dreyfus

Title: Secretary, WA State Dept of Social & Health Services

Telephone No.: (360) 725-1736 **Date** September 1, 2010

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Standard Form - LLL (Rev. 7-97)

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Secretary, WA State Department of Social & Health Services
APPLICANT ORGANIZATION	DATE SUBMITTED
Washington State Division of Behavioral Health and Recovery	September 1, 2010

7 - Set-Aside for Children's Mental Health Services Report

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994

Data Reported by:

State FY ____XXX____ Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimate/Actual FY 2010
$17,688,942	$30,406,676	$32,186,860

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

8 - Maintenance of Effort (MOE) Report

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1 The State shall request the exclusion separately from the application;
2 The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3 The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY XXX **Federal FY** _____

State Expenditures for Mental Health Services

Actual FY 2007	Actual FY 2008	Actual/Estimate FY 2009
$236,727,429	**$274,739,059**	**$275,363,596**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

9 - Table 1. Council Membership List 2010

	NAME/ADDRESS	REPRESENTATION	APPOINTMENT DATE	APPOINTMENT EXPIRE
	Traci Adair	State Employee DSHS/Aging and Disability Services Administration/Home and Community Services	October 2006	Required Department appointed
	Starcia Ague	Consumers/Survivors/ Ex-patients	July 2010	July 2013 (1st term)
	Kathryn Carlton	Family Member of Adults with SMI	January 2009	January 2012 (1st term)
	Annie Conant	State Employee Housing Division, Department of Commerce	November 2005	Required Department appointed
	Carolyn Cox	Family Member of Children with SED	July 2010	July 2013 (1st term)
	Brien Critchlow	Consumers/Survivors/ Ex-patients	July 2007	July 2010 (1st term)
	Cheri Dolezal	Consumer Advocate; Provider	April 2008	March 2011 (1st term)
	Judie Ebbert-Rich	Family Member of Children with SED	January 2009	January 2012 (1st term)
	Danny Eng	State Employee DSHS/Division of Vocational Rehabilitation	October 2003	Required Department appointed
	Diane Eschenbacher	Consumers/Survivors/ Ex-patients	January 2009	January 2012 (1st term)
	John Furze	Other (not state employee or provider)	August 2007	August 2010 (1st term)
	Tamara Johnson	Consumers/Survivors/ Ex-patients	September 2008	September 2011 (1st term)
	Vanessa Lewis	Family Member of Adults with SMI	January 2007	January 2013
	Michael Luque	State Employee DSHS/Children's Administration	Not Applicable	Required Department appointed

	NAME/ADDRESS	REPRESENTATION	APPOINTMENT DATE	APPOINTMENT EXPIRE
	Dwight McClain	Consumers/Survivors/ Ex-patients	July 2007	July 2013
	Don Nichols, Vice-Chair	Consumers/Survivors/ Ex-patients	November 2007	November 2011 (1st term)
	Helen Nilon, Chair	Consumers/Survivors/ Ex-patients	August 2007	August 2013
	Michael Paulson	State Employee DSHS/Health and Recovery Services Administration	January 2007	Required Department appointed
	Carrie Huie-Pascua	Advocate; Ethnic Multicultural Subcommittee	February 2010	February 2013 (1st term)
	Annabelle Payne	Consumer Advocate; Provider	November 2008	November 2011 (1st term)
	Tom Saltrup	State Employee Director of Behavioral Health, Dept of Corrections	November 2007	Required Department appointed
	Dorothy Trueblood	Family Member of Adults with SMI	January 2008	January 2011 (1st term)
	Ann Varpness	Family Member of Adults with SMI	February 2010	February 2013
	Andy Toulon	State Employee DSHS/Division of Behavioral Health and Recovery	June 2009	Required Department appointed
	Bill Waters	Consumer Advocate Capitol Clubhouse	June 2007	June 2013
	Megan Winston	Consumers/Survivors/ Ex-patients	July 2010	August 2013 (1st term)
	JoEllen Woodrow	Consumers/Survivors/ Ex-patients	October 2005	October 2011
	Vacant	State Employee WA Office of Superintendent of Public Instruction	Not applicable	Required Department appointed
	Vacant	Tribal Representative		

10 - TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	29	
Consumers/Survivors/Ex-patients(C/S/X)	9	
Family Members of Children with SED	2	
Family Members of Adults with SMI	4	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers) Tribal Liaison	3	
TOTAL C/S/X, Family Members and Others	19	66%
State Employees	7	
Providers	2	
Vacancies	1	
TOTAL State Employees and Providers	10	34%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

Two Council members, who have served as Family Members of Children with SED, have children who became adults. Those two members now are serving as Family Members of Adults with SMI. The Council is recruiting members who are Family Members of children with SED. Three consumers on the Council also are Youth in Transition.

11 - Washington Planning Council Charge, Role and Activities

Washington Planning Council Charge, Role and Activities

The Mental Health Planning and Advisory Council established the following Vision, Mission and Goals to guide the work of the council:

VISION:
Plan, Advocate, Evaluate

MISSION:
To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

GOALS:
The Goals of the Mental Health Planning and Advisory Council shall be to transform the mental health system consistent with the goals of the President's New Freedom Commission on Mental Health, as follows:

Primary Goals:

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

Other Goals:

1. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.

2. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.

3. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care.

Support research and use of promising practices through continuous quality improvement.

4. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults.

Services shall be focused on Recovery and Resiliency**.**

5. Support education about mental illness and other mental disorders in an effort to reduce stigma.

Due to recent restructuring by the Council and significant reduction in meetings as a cost saving measure, final re-structure of Council sub-committees has not yet been completed. It is anticipated that revised By-laws will be adopted by the Council in November 2010.

Mental Health Planning & Advisory Council

Vision

Plan, Advocate, Evaluate

Mission

To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

Helen Nilon, Chair
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http://www.dshs.wa.gov/MentalHealth/mhpac.shtml

August 26, 2010

Mr. C.H. "Hank" Balderrama, Mental Health Program Administrator
Department of Social and Health, Division of Behavioral Health and Recovery
PO Box 45320
Olympia, WA 98504

RE: 2011 State Plan

Dear Mr. Balderrama:

We are pleased to be able to provide support for the final Draft of the State Plan we received on August 19th. We do have a few items of concern which we would like to have addressed:

- In the Council letter of August 18, 2010 regarding the July 23rd Draft of the Plan, the Mental Health Planning & Advisory Council has yet to receive a list of proposals for the State's 20% share of monies received from the Substance Abuse Mental Health Services Administration (SAMHSA), although on May 13th, 2010 we were told the list would be forthcoming (soon).

- We would like it noted in the State Plan that due to the dramatic and radical reductions of meetings *(due to severe budget reductions)* by the Council and its Subcommittees that $100,000 will be set-aside for a Council approved Consumer/Family Project(s) for FFY 2011.

- Council was unable to discern where the State has incorporated the Vision that was presented by SAMSHA during the June 2010 Conference into FFY's 2011 Federal Block Grant funding.

- In the future, Council proposes that we receive a "final" draft of the State Plan to review on or before July 15th to enable the Council and its Subcommittees to review a reasonable draft of the proposed State Plan being submitted to SAMSHA and in order to provide viable and timely comments to the Plan.

- Significant percentages of the State's population are Older Adults (17 %), Sexual Minorities (8%) and Veterans (9%) whose needs and available services have not been adequately addressed in the proposed Plan for FFY 2011.

On the other hand, the FFY 2011 State Plan reflects Washington's best effort to augment services in these dire economic times. The Council gives this Plan and the State our full support to implement this Plan.

If you have questions, please do not hesitate to contact me at 206.972.7647 or via email at WAMHPAC@yahoo.com.

Very Truly Yours,

Helen E. Nilon, AICP, PSS
Chair, Mental Health Planning & Advisory Council

CC: Mr. David Dickenson, Director Division of Behavioral Health and Recovery
Mr. Andrew Toulon, Chief, Planning, Development and Decision Support
MHPAC Council Members

Washington

12 - Adult - Overview of State's Mental Health System

As the public mental health authority for the approximately 6.5 million residents of Washington State, the Division of Behavioral Health and Recovery (DBHR) operates an integrated system of care for people with mental illness who are enrolled in Medicaid as well as for those individuals who qualify as “low income” who also meet the statutory needed requirements.

DBHR has gone through multiple and significant organizational changes in the last three years. In 2007, it was transferred from the former Department of Social and Health Services (DSHS) Division of Health and Rehabilitation Services Administration to the Health and Recovery Services Administration (HRSA).

In May, the Mental Health Division (MHD) was merged with the former DSHS Division of Alcohol and Substance Abuse. The two divisions were transferred to HRSA and were named Division of Behavioral Health and Recovery (DBHR).

In May, the former Health and Recovery Services Administration consolidated Medicaid physical health operations with the Washington Health Care Authority (HCA), which is responsible for procurement of health services other than Medicaid, such as state employee and Basic Health Plan benefits. DBHR was transferred to the DSHS Aging and Disability Services Administration (ADSA).

The public system operates the mental health crisis and involuntary treatment act for the citizens of the State. The DBHR operates two adult state psychiatric hospitals; one is in western Washington and one in eastern Washington. A children’s psychiatric hospital is operated in western Washington immediately adjacent to the adult hospital. Within the adult hospitals, there are two systems of care: civil and forensic.

Patients can enter the civil wards of the hospital through a voluntary admission (though this is rare as voluntary admissions are addressed through community hospitals) or through an involuntary civil commitment. There are processes whereby a patient may be civilly committed upon being discharged from the criminal justice system, or patients may be civilly committed without entering the criminal justice system.

Since the state hospitals are funded at a level tied to a legislatively defined “funded capacity” or census, the adult hospitals are at risk of over-expenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. As state hospital civil capacity is an integral part of the community’s resource for treating persons with mental illness, the RSNs are responsible for maintaining their use of state hospital capacity within contractual limits.

The current community mental health system operates under the following statutory authority:

- Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.

- Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

- Chapter 71.24 RCW - Establishes community mental health programs through regional support networks that operate systems of care.
- Chapter 71.32 RCW – Authorizes mental health advance directives.

- Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.

- Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.

- Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.

- Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies; and,

- A 1915 (b) Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model. Within the managed care framework, thirteen (13) RSNs operate under two contracts to provide mental health services to persons across the lifespan with MHD. One contract is a Prepaid Inpatient Health Plan (PIHP) for Medicaid enrollees and the other is a State funded contract for non-Medicaid eligible persons or for non-Medicaid services to Medicaid enrollees called the State Mental Health Contract (SMHC). Under both contracts the RSNs are to ensure the provision of community inpatient and outpatient mental health services. While a few RSNs provide some direct crisis services to consumers, the majority of services are provided through contracts that the RSNs hold with Community

Mental Health Agencies (CMHA) which then in turn deliver the services in their respective communities. Each RSN has a single separate Federal Block Grant contract.

There are thirteen (13) regional mental health authorities in Washington. Each operates under two sets of authority: state legislative mandates and Medicaid waiver requirements under approval of a 1915 (b) waiver from Centers for Medicare and Medicaid Services (CMS). State mandate is carried out through Regional Support Network (RSN) functions; Medicaid requirements are carried out through Prepaid Inpatient Health Plan (PIHP) functions, although regional authorities more commonly are referred to as Regional Support Networks irrespective of which function is at hand.

DBHR provides policy and collaboration with other agencies and departments providing mental health services. Collaborative arrangements include but are not limited to:

- Division of Alcohol and Substance Abuse
- Physical health
- Department of Health
- Division of Aging and Disability Services
- Children's Administration
- Division of Vocational Rehabilitation
- Office of the Superintendent of Public Instruction
- Department of Corrections.

Implementation of evidence-based, research-based and promising practices is occurring across the state for older adults, adults and children. The mental health system has been looking at the cultural barriers of implementation for certain populations.

Washington is unique in that it requires, by state regulation, services to children, older adults, racial/ethnic minorities and developmentally disabled individuals to be provided by or in consultation with a person who qualifies as a mental health specialist in the applicable consumer service group, e.g. child served by or in consultation with a Children's MH Specialist or African-American served or in consultation with African-American Specialist.

Last year the DBHR contracted with Tri-West for a review of practice nationally and locally of interventions that tend to address disparities in access and outcomes. The study involved a literature review of specialist and consultation and related practice. Interviews will be conducted with practitioners and administrators statewide from a representative sample of individuals. Discussions were held with PAC sub-committees,

and a work group was convened to review preliminary findings and to guide formulation of the report. The work is part of an Action Plan related to Washington's participation in a Policy Summit to address mental health disparities sponsored by CMHS.

A stronger relationship is developing with Washington's 29 federally recognized tribes and three non-federally recognized tribes as an important part of the mental health system for Tribal members. The DSHS Administrative Policy 7.0, American Indian Policy, ensures MHD operates in a government-to-government relationship with the tribes. RSNs are also required to comply with the 7.01 Policy and must submit comprehensive plans to the MHD detailing tribal/RSN relations.

The Washington Medicaid Integration Project (WMIP) (operating in Snohomish County) contracts with Molina Health Care to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

The Chronic Care Management Program (CCMP), which began January 1, 2007 is a program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs; 37% of those identified as appropriate for the program have been determined to have co-occurring mental health issues. The goals of the program are to improve access to appropriate services, outcomes and cost effectiveness of care for clients with chronic illness through care management interventions and to evaluate the program carefully to determine if CCMP interventions improve health outcomes and cost-effectiveness.

In addition to the work of the MHPAC, shifting the thinking of the RSNs for federal block grant to more transformative activities, the MHD called out priority focus areas for mental health 2009 federal block grant funds with the support of the Council. Those priorities are:

- Homeless populations (with a focus on youth and families and where no PATH funding exists);
- Older adults;
- Consumer/family run programs,
- Local Tribal relationships, and added to this for MHD are:
- Consumer, advocate, and family directed/driven promoted activities,
- Vocational initiatives,

• Residential support that promotes safe and affordable housing;

From the RSN proposals, it is estimated that $1,864,282 will be spent on homeless related projects including housing, and housing assistance as well as medication management and case management. This amount is almost 3.5 times the amount for services to homeless people compared to last year's plan, which appears to be related to the continued economic downturn nationally.

Approximately $716,887 will be spent on programs for older adults including gatekeeper projects, outreach, medication and case management, and geriatric depression screening.

About $465,623 will be dedicated to Tribal projects which include suicide prevention, supported education, mental health services for and non-Medicaid individuals.
We project that about $1,118,504 will be used for consumer and family run programs such as clubhouse services, consumer education and training, warm lines and peer mentoring.

Approximately $1,456,651 will be used for children and youth programs such as crisis outreach response, wraparound, and a teen talk hotline.

The RSNs have also requested $277,930 to treat co-occurring disorders.
Additionally, $300,000 will be used to help transition mentally ill offenders, who are being discharged from prison, back into the community.

Adult general services such as supported education, outreach and long term stabilization, about $317,540 is proposed.

Of the $8,463,723 in Mental Health Block Grant funds awarded to Washington, 5% is for administration ($423,186). RSNs are awarded 80% of the remainder ($6,517,417). DBHR dedicates the remainder ($1,376,107) to projects with state level impact such as training and conferences, consumer satisfaction surveys, mini-grants to Tribes, advocacy groups (NAMI, WA-DADs), peer counselor support and Mental Health Planning and Advisory Committee expenses.

This year the state Office of Financial Management (OFM) announced mandatory cost reduction measures as a result of the state's economy. The Mental Health Planning and Advisory Committee (MHPAC) has cooperated in reducing Council expenses in accordance with OFM directives. DBHR leadership has agreed that the MHPAC may recommend up to $100,000 of MHBG funds directed by DBHR.

Washington

13 - Adult -Summary of Areas Previously Identified by State as Needing Attention

Adult -A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

The following were identified in the 2010 Plan as areas needing attention:

Housing: Lack of safe and affordable housing

Benefits: Too many individuals need mental heath treatment, yet are not eligible. State only dollars are insufficient to meet the need for services services from this population.

Inpatient Capacity: Secondary to the first two issues, rates of hospitalization are increasing.

Vocational or Meaningful Activities: Too few employment related skills trainings are offered as well as employment placement and retention services need to increase. The same is true for other endeavors that give one's life purpose and meaning.

Understanding of Recovery and Resiliency: Need for more training and culture change in the mental health system to move toward transformation.

All of the above areas are large system changing issues and have been identified through focus groups, collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State Study, URS and Developmental Tables, RSN reporting, hospital reports and jail reports. The subjective input of DBHR staff, the Planning and Advisory Council, consumers and advocates, providers, and allied systems have further contributed to the understanding of these issues and potential solutions.

Through the System Transformation Initiative, (STI) there were many planning processes to establish goals to address areas needing improvement. These issues will continue to be areas of focus through this biennium and the next. The recent merger of mental health and substance abuse divisions into a combined division and the accompanying emphasis on integrated health services will part of the focus.

The DBHR continues to collaborate closely with the DSHS Division of Vocational Rehabilitation (DVR) and other employment service partners. An example is the

implementation of a statewide employment initiative and co-facilitation of DVR and DBHR of a number of regional forums focused on increased coordination between mental health agency programs and local DVR offices. DBHR and DVR both participate on the Medicaid Infrastructure Grant (MIG) advisory committee. The grant supports state level efforts to enhance employment options for people with disabilities. DVR is an active participant on the Planning and Advisory Council.

DBHR works closely with the Department of Commerce (COM), the state agency that administers Housing and Urban Development (HUD) funding, and several state financed capital and rental assistance grants to promote the development and expansion of housing for low income and homeless individuals and families, including supported housing models. Collaboration over the last three years included co-sponsoring the Supportive Housing Institute, participation in the Mental Health Housing Consortium, joint planning around transitional housing and funding to end homelessness, review and comment on each agency's strategic plans, and most recently, cooperation on a SAMHSA Transformation grant application to expand permanent supportive housing in three counties in the state (including COM committing $300,000 per year in TBRA/HOME vouchers to support the project).

DBHR continues to participate with the DSHS Economic Services Administration (ESA) and Washington Association of Sheriffs and Police Chiefs in the statewide implementation of efforts to expedite the reinstatement of Medicaid eligibility for individuals with mental illness who are transitioning from jails and state hospitals. In addition, DBHR has promoted with FBG and PATH funds a project conducted by the state Department of Veterans Affairs (DVA) which provides training on expedited access to SSI/SSDI and veterans benefits.

The Inpatient Roundtable, a technical assistance group composed of staff from DBHR, Health and Recovery Services Administration (HRSA), Regional Support Networks (RSNs) and community hospitals meet regularly to improve community psychiatric hospital resource management.

DBHR works closely with the Department of Corrections (DOC) in statewide efforts to coordinate services for individuals with mental illness being released from prisons. This effort is coordinated through the Washington State Behavioral Health Partnership for Reentry, which is a multi-agency task workgroup. The DOC and Department of Social and Health Services staff, utilizing a subcommittee format, are tasked with improving the coordination of care during consumer reentry into community care.

Washington

14 - Adult - New Developments

Behavioral Health and Primary Care Integration Collaborative

The intent of the integration collaborative is to build a knowledge base within Washington State government regarding the integration of Mental Health/Substance Abuse (MH/SU) services in primary care and the integration of primary care into specialty MH/SU settings, with the expectation that the program, policy and financing decisions of DSHS (and Medicaid Purchasing Administration, Department of Health) and other agencies) would be shaped by a consistent vision of how integrated services would be delivered, and how program, policy and financing decisions can align to this vision. The product will be the Washington State Integration Policy Framework—a compendium of policy ideas not exclusive to any specific agency or part of an agency—that will provide a pathway to 2014.

During the fall of 2009, the State of Washington initiated a series of regional community-based forums to gather direct feedback to a potential state policy initiative in support of behavioral health (mental health and chemical dependency) and health care services integration. Approximately 300 representatives of consumer groups, families, providers, health plans and advocacy organizations attended the four meetings that were held in Pasco, Mt. Vernon, Olympia, and Spokane. One of the primary concepts shared with participants was the Person-Centered Health Home, where each person's healthcare needs would be provided for and/or coordinated with other service providers. The overall feedback from participants was positive towards this new and innovative way to provide and coordinate services. Following up on these forums, the state is currently now providing information internally to department staff on this innovative approach to better and more appropriately provide services to improve behavioral healthcare outcomes.

Implementation of the integration policy began this year in partnership with Transformation Grant project staff. There have been a series of two 3-hour trainings of over 400 state employees in the fundamentals of person-centered health homes and the four quadrant model of MH/SU healthcare integration. The general trainings are followed with eight more intensive sessions involving a smaller group of 50 key staff. All sessions are videotaped for wider distribution and information will be disseminated across the divisions by the small group members participating in the intensive training.

In December, the Washington State Integration Policy Framework will be reviewed with behavioral health and primary care stakeholders.

Disability Lifeline

HB 2782, the "Security Lifeline Act," creates an integrated approach to the delivery of basic support services, education, and training programs for low-income individuals and families. Among its provisions, the General Assistance-Unemployable (GA-U) program ended, and a Disability Lifeline Program was established, with multiple strategies to improve employment and basic support outcomes for those receiving benefits under the program:

• Individuals who are homeless and have mental health or chemical dependency (CD) problems are provided housing vouchers as an alternative to cash grants. Persons receiving housing vouchers will also receive a cash stipend of $50/month. In State Fiscal Year (SFY) 2008, 25% of individuals on GA-U were homeless when admitted to CD treatment.
• Individuals found in need of CD treatment will be required to participate in treatment as a condition of benefits. DBHR and treatment providers will be required to give individuals in the program high priority for admission, with first priority to pregnant women and parents.

• Penalties are established for those failing to participate in required programs.

• Benefits under the Disability Lifeline Program are limited to 24 months with a five-year period.

Individuals who are terminated from benefits are provided the opportunity to complete their current course of CD treatment.

Training to Better Respond to Returning Soldiers

Two state departments are working together to train mental health workers, police, drug treatment counselors, tribal representatives and other community service personnel in how they can better serve troubled veterans returning to the United States after traumatic service in Iraq and Afghanistan.

Mental health and crisis experts with the Department of Veterans Affairs (DVA) and the Department of Social and Health Services partnered with community organizations to deliver a series of trainings summer 2009.

"The Veterans Collaboration Group," as they have dubbed themselves held trainings in Tacoma, Yakima and Bellingham, each community with a high concentration of returning soldiers.

Partner agencies include DVA, the DSHS divisions that coordinate substance abuse treatment and mental health services, Washington Association of Designated Mental

Health Professionals (CDMHPs) and the federal Veterans Administration as well as local groups.

The workshops focus on the basics – what works and what doesn't – and instructors encourage participants to look ahead at the kind of crisis situations in which they may face a returning soldier losing control or posing a threat. Other topics in the curriculum include veteran and military cultures, war trauma, traumatic brain injury, war-related post traumatic stress disorder and combat-related mental illness and stigma.

For 2010, the Veteran's collaboration group is selecting pilot sites around the state to begin a coalition process with local providers to better serve the returning soldiers within existing community resources while at the same time trying to create a more seamless and easily accessible resource network. DBHR will be offering initial training and ongoing technical assistance in coalition building and community building. It is the department's intent to offer technical assistance and consultations on staffing individual cases as the new coalitions begin serving their constituencies.

Willing Partner Initiative – Improving Employment Outcomes

Through use of Medicaid Infrastructure funds the Division of Behavioral Health and Recovery has worked with two national employment consultation firms Advocates for Human Potential (AHP) and the Institute for Community Inclusion (ICI) to provide comprehensive technical assistance to three communities that expressed interest in improving employment outcomes, the King County, North Sound, Pierce County, Clark County, Peninsula and Greater Columbia Regional Support Networks. In total the communities represented in the effort represent approximately over 60% of the public mental health consumers in the State.

Using a combination of strategies that include development of Evidence-based Supported Employment; emphasis on Clinical Interface and Integration with Employment; review and possible revision of State, Regional Support Network (RSN) and provider specific policies and procedures; developing long range financial models to support employment activities; and cross systems collaboration primarily with Vocational Rehabilitation(VR) the initiative intends to improve employment outcomes in these areas. An additional step, creating "urgency" around employment is also a component – expressed through one of the partners in a goal of doubling employment outcomes in five years.

Supportive Housing Institute

Based on the successful Corporation for Supportive Housing (CSH) "Opening New Doors" Supportive Housing Institute, the Washington State Supportive Housing Institute is a comprehensive, highly interactive project development initiative to deliver targeted technical assistance to selected development teams from the State of Washington. Two full Institutes will have been completed, involving 16 county-based teams from throughout the state. Each team will include a lead for development, services, project

management and project ownership. The curriculum for the Institute was adapted for Washington State through a collaboration of the technical assistance firms Corporation for Supportive Housing, Building Changes, and Common Ground. Each Institute's curriculum spanned nine months and included five multi-day training and work sessions plus on-the ground consultation on each proposed project.
The Institutes were jointly funded by the Department of Commerce, DBHR, Impact Capital and Washington Families Fund a unique partnership among the State of Washington, several counties and cities and several philanthropic and corporate partners, led by the Bill and Melinda Gates Foundation.

Additionally each team was required to contribute to offset the on-site technical assistance. Sixteen capital permanent supportive housing projects have been designed and are in some phase of development. If fully implemented as proposed, over 400 individuals will be provided permanent supportive housing, many of whom will have a psychiatric disability.

The first project developed during the Institute will open on June 8, 2010 in Lewis County, Washington and a second is scheduled to open in March 2011 in Chelan/Douglas counties.

Mental Health Housing Consortium

The Mental Health Division in partnership with and funding from the Governor's Mental Health Transformation Project is sponsoring a Mental Health Housing Consortium. The intent of the MHHC is to:

- Inform DBHR about the various housing activities taking place on the regional and local level.
- Coordinate those activities with many partners around a common vision.
- Share and formalize training and educate those involved in mental health housing about models and funding of housing and support services.
- Increase coordination among other state and local agencies.
- Advise DBHR on its implementation of strategic initiatives related to housing.
- Identify state, regional, and local gaps and needs.
- Facilitate direct collaboration with consumers and advocates.

The Consortium holds quarterly day-long meetings and has a membership in excess of 50 organizational representatives including Department of Commerce, the primary state funding agency for low income housing and homeless projects, representatives from every Regional Support Network, from the DBHR Planning and Advisory Council (PAC), the Association of Washington State Housing Authorities, county housing planners, numerous community mental health agencies and housing providers, consumers and family advocates. Block grant funding is used to support technical assistance provided by Common Ground.

Strategies for Developing Consumer and Family Run Services

The Division of Behavioral Health and Recovery engaged Tri-West Group (Tri-West) to facilitate a multi-stakeholder Work Group to collaborate with MHD to respond to the requirements of Substitute House Bill (SHB) 2654. SHB 2654 directed DSHS to prepare a report on strategies for developing consumer and family run services. In response to that legislation, Washington State MHD convened a Work Group of mental health consumers, youth in transition, family members, PAC representatives and other mental health stakeholders to develop the report in cooperation with MHD.

Mental Health First Aid

Mental Health First Aid (MHFA) is the initial help given to someone developing a mental health problem or in a mental health crisis before appropriate professional or other assistance, (including peer and family support), can be engaged. The 12-hour course teaches people how to give first aid to individuals experiencing a mental health crisis situation and/or who are in the early stages of a mental health disorder. Participants learn the signs and symptoms of the most common mental health problems, where and when to get help, and what type of help has been shown to be effective.

This course is designed to increase mental health literacy, to decrease stigmatizing attitudes in our communities and to increase appropriate and early help-seeking by people with mental health problems.

Certified MHFA instructors deliver the 12-hour course, which can be scheduled flexibly. These Instructors have successfully completed an intensive authorized 5-day training course to become accredited MHFA instructors.

In June 2009 the Mental Health Division, in collaboration with the Washington Institute for Mental Health Research and Training (WIMHRT), and the Washington Community Behavioral Health Council organized and provided the 5-day MHFA Instructor Certification course in collaboration with Master Trainers from Missouri. Twenty-two consumers participated in the inaugural training and nineteen of them became certified to present MHFA trainings.

In July 2010, DBHR co-hosted a two-day, 12 hour MHFA training in conjunction with WIMHRT, for the Medicaid Purchasing Administration and DBHR employees, specifically, workers who were members of the former Division of Alcohol and Substance Abuse, who have not had direct experience working with consumers who have mental illness. The training will also target call-center workers who respond to 800 line calls from consumers who have questions about benefit packages and coverage. If there is sufficient interest, subsequent trainings will be scheduled.

WA-PACT

Guided by improvements within the National Assertive Community Treatment Standards, the development of an enhanced ACT fidelity tool facilitated ongoing performance improvement within the WA-PACT teams. The Dartmouth Assertive Community Treatment Scale (DACTS) had been the primary tool by which fidelity to ACT has been assessed nationally. The DACTS has been found to be a useful and widely disseminated fidelity tool, particularly for performance improvement purposes. However several gaps and limitations have been identified. These limitations within the tool have led to some teams scoring well on the DACTS, while continuing to do mainly case management without the requisite evidence-based approaches to skill-building and fostering recovery and independence in the community.

In an effort to fill these gaps, Washington State developed an enhanced version of the DACTS (the Tool for Measurement of Assertive Community Treatment [TMACT] and piloted it with all 10 WA-PACT teams during the first year of implementation. Enhancements include standards and measures for: 1) development of role expectations for each team member; 2) enhanced team communication and functioning (e.g., the quality of the daily team meeting); 3) other evidence-based practices (e.g., application of supported employment principles); and 4) recovery-oriented processes (e.g., person-centered planning, fostering of consumer self-determination).

Washington

15 - Adult - Legislative Initiatives and Changes

The following legislation was enacted during the 2009 and 2010 sessions of the Washington State Legislature

2010

Substitute House Bill (SHB) 2422: Changing escape or disappearance notification requirements

In the event of a person escaping from a Department of Social and Health Services (DSHS) mental health facility, or the disappearance of a person on conditional release or any other unauthorized absence, the list of persons that must be notified is expanded and clarified

SHB 2533: Adopting the interstate compact on mental health

This legislation requires Washington to adopt the uniform act for the extradition of persons of unsound mind (not interstate compact on mental health, which is in Ch 72.27 Revised Codes of Washington or RCW). The act is an agreement among states allowing the transfer of mentally ill patients apprehended in a state to the state where the patient is a fugitive.

SHB 2717: Restricting Outings from State Facilities

Prohibits certain off grounds trips for a person committed to DSHS's custody for the determination of competency to stand trial, for the restoration of competency for trial, or following an acquittal by reason of insanity.

ESB 6610: Improving procedures relating to the commitment of persons found not guilty by reason of insanity
An independent public safety review panel is established to review DSHS's proposals for conditional release, furlough, temporary leaves, or movement around the grounds concerning persons found Not Guilty by Reason of Insanity. The panel is responsible for:

- Recruiting for panel members
- Beginning recruiting for a panel coordinator
- Establishing a stakeholder workgroup
- Contract in place with WSIPP to find tools for risk and competency assessment

2SHB (Second Substitute House Bill) 3076: Evaluations of persons under the involuntary treatment act

This legislation identifies factors that designated mental health professionals (who are authorized to order individuals to be ordered for detention and evaluation) and courts should consider when determining whether a person should be detained under the Involuntary Treatment Act. The factors include both information and symptoms; Legislation takes effect January 1, 2012.

Designated mental health professionals and judges are allowed, when making a determination for detainment under the Involuntary Treatment Act, to consider information provided by credible witnesses that may include family members or others who have had significant contact with the individual or who are familiar with the individual's history.

2SHB 2882: Detaining Persons with Mental Disorders

This law establishes procedures for notice of discharge whenever a person who is involuntarily committed for mental health treatment is discharged from an evaluation and treatment facility or a state hospital.

2009

HB (House Bill) 1349: Renewing orders for less restrictive treatment

Creates additional grounds for a petition to continue a court order for less restrictive treatment when:

1) the person has a history of lack of compliance with treatment for mental illness which precipitated the current period of commitment and at least one other involuntary commitment for mental health treatment during the 36 months preceding the current involuntary commitment period;
2) the person is unlikely to voluntarily participate in outpatient treatment without an order for less restrictive treatment, in view of the person's treatment history or current behavior; and
3) outpatient treatment that would be provided under a less restrictive treatment order is necessary to prevent a relapse or deterioration that is likely to result in serious harm or the person becoming gravely disabled within a reasonably short period of time.

The grounds to extend treatment pursuant to an order for less restrictive treatment are less than those required for the initial order for less restrictive treatment. The petitioner does not need to show that the respondent is likely to commit serious harm to himself, herself or others, or that the respondent is gravely disabled.

HB1373: Relating to equitable access to appropriate and effective children's mental health services

Amends RCW 74.09.521 to include mental health professionals who are regulated by Title 18 RCW to provide mental health services to children, youth and families as long as they are under the direct supervision of a licensed mental health professional as defined in RCW 71.34.020. It reinforces federal early periodic screening, diagnosis and treatment requirements related to the receipt of medically necessary services identified through developmental screening. Requires the department to collaborate with the children's mental health evidence-based practice institute to encourage and develop incentives for the use of prescribing practices and evidence-based and research-based treatment practices by mental health professionals serving children under this section and reinforces quality and access requirements established in law under 2SHB1088 (2007).

HB 1498: Provisions Governing Firearms Possession by Persons Who Have Been Involuntarily Committed

The crime of unlawful possession of a firearm in the second degree is amended to include persons who have been involuntarily committed for mental health treatment, either as an adult or juvenile, under the 14-day commitment procedures. When a person is involuntarily committed for mental health treatment, the court must forward a copy of the person's driver's license or other identification information to the National Instant Criminal Background Check System (NICS) within three judicial days. When a person who was prohibited from possessing a firearm due to involuntary commitment has his or her right to possess a firearm restored, the court must forward notice of the restoration to the Department of Licensing (DOL), the DSHS, and the NICS within three judicial days.

The standards and processes that apply to the restoration of firearm rights when a person was involuntarily committed are revised. The involuntary commitment statutes are amended to require notice regarding the loss of firearm rights when a person is involuntarily committed. In a 14-day commitment proceeding for an adult or a minor, Notice also must be provided in the petition and during the proceeding of the loss of firearm rights if the person is involuntarily committed.

HB 1589: Addressing venue for hearings to modify or revoke an order for conditional release

Adds language to 71.05.340 RCW that may enable Designated Mental Health Professionals to file petitions related to conditional release either in court of original commitment or with the court in the county in which the person has been detained by the DMHP and states that that the court venue relating to petitions for modification or revocation of conditional release shall be in the county in which the petition is filed.

HB 2025: Sharing of Health Care Information to Promote Coordination of Behavioral and Medical Services

In addition to the existing statutory provisions for the release of mental health treatment records without a patient's consent, treatment records of a person may be released without informed consent to:

1) A licensed health care professional who is providing care to a person, or
2) a health care professional who is providing care to a person, or
3) a licensed health care professional to whom a person has been referred for evaluation & treatment ,or
4) a health care professional to whom a person has been referred for evaluation & treatment.

Treatment records may only be released for the purpose of assuring coordinated care and treatment of that person. Psychotherapy notes may not be released without authorization of the person who is the subject of the request

SB (Senate Bill) 5546: Regarding parental or guardian access to juvenile records

Previously under state law, information or records pertaining to the provision of counseling, psychological, psychiatric, or medical services to a juvenile aged 13 to 17 may not be disclosed to the parents of the juvenile unless the juvenile provides informed consent to the disclosure. A juvenile aged 13 to 17 may consent to receive such services without the consent of a parent.

Under SB 5546 the parents, guardian, or custodian of a juvenile must be given access to information or records pertaining to mental health treatment provided to the juvenile, with or without the consent of the juvenile. Information or records may still be withheld if the agency holding the record determines that release of the information is likely to cause severe psychological or physical harm to the juvenile or to the juvenile's parents, subject to court order.

Recent Prior-years' Significant Legislation

Since 2004 significant research, legislation, policy interpretation and funding patterns have impacted the public mental health system dramatically in Washington State and the conditions to which much of the former Mental Health's Division's strategic plan responds and upon which it is built.

In 2006, the Washington State Legislature began providing $10.3 million annually for the statewide implementation of 10 Program of Assertive Community Treatment (PACT) teams, part of the comprehensive package to transform the delivery of Washington State's public mental health services. Besides improved outcomes for the most difficult-

to-serve clients, the PACT teams are expected to result in eventual reductions in overall State Hospital utilization. Between Sept 2008 through Oct 2009, 4 State Hospital wards (3 Western State and 1 Eastern State) are expected to close due to PACT success.

In July 2007, the Legislature provided funding for RSNs to develop community alternatives for many of the individuals living in the PALS program at WSH. The Legislature directed DBHR to begin charging RSNs for the cost of any individuals remaining in PALS. RSNs have utilized the funding to develop a variety of innovative community alternatives and the average daily census at the PALS program has dropped from 110 beds to 33 beds.

In 2006 SHB 1088, the Children's Mental Health Act, was passed with legislative intent to shape the Division's activities relating to children's mental health program and planning for the next several years. By 2012, the Department is required to increase and improve substantially the delivery of children's mental health services.

Over the last several years the Washington State Legislature has provided state funding to lessen the impact of federal actions as well as enhancing funding for additional services and increases specifically for mental health line staff wages and cost of living. Additional people will be income eligible to receive Medicaid mental health services in 2009 because of Legislative action in 2008 (SSB 6583) to increase the income eligibility ceiling for Categorically Needy to 85% of the federal poverty level.

Between 2005 and 2009 $27.5 million was provided for community hospital in-patient rates for psychiatric services to reverse the trend of community hospitals eliminating psychiatric beds due to inadequate reimbursement rates.

In 2008 SHB 2654 directed the Division to submit a report to the Legislature by January 2009 that lays out strategies for the development and funding of consumer and family-run services, including possible changes to the state plan and federal waiver. The report entitled *Strategies for Developing Consumer and Family Run Services* was completed and submitted to the Legislature.

The 1999 Washington State Legislature passed SSB 5011/RCW 71.24.470 to improve the process of identifying and providing additional mental health treatment for mentally ill offenders who are being released from the Department of Corrections (DOC) and who pose a threat to public safety. The program is called the Dangerous Mentally Ill Offenders Program (DMIO) Community Integration Assistance Program (CIAP).

Through interagency collaboration, the legislation intends to promote a safe transition to the community by having state funds support intensive mental health treatment with intensive case management, chemical dependency treatment and other services. Since April 2000 there have been more than 500 individuals designated as Dangerous Mentally Ill Offenders. As of 2008 only 8 of 39 counties in the State were served by CIAP/DMIO contractors. Limited funding may require reduced service and potentially

effect community safety in the future. The Washington State Institute for Public Policy, February 2008 Update found that the DMIO Program reduced overall felony recidivism rates by 37% and generated $1.24 for every dollar spent.

Due to extreme budgetary pressures, funding for non-Medicaid consumers was cut by 9% during this biennium ($11.6 million). Many individuals still need mental health treatment and State-only dollars are now prioritized for non-Medicaid crisis, inpatient and residential services. As a result of this cut in funding, the number of individuals who are not Medicaid eligible receiving non-crisis outpatient services each month dropped by 13% during the latter half of 2009. Economic circumstances locally and nationally do not portend immediate improvement in these circumstances.

Washington State faces a significant shortage of community psychiatric inpatient beds. A recent study published by the Washington State Hospital Association identified there were 637 community psychiatric inpatient beds in the state in October 2008. This comes out to approximately 9.7 beds per 100,000 residents. Data from an American Hospital Association survey from 2006 identified that the national average was 25.2 community psychiatric inpatient beds per 100,000 residents, and at 9.7 beds, Washington's rate is one of the lowest, if not the lowest of any state.

From 2008 to 2010, Washington's unemployment rate doubled, going from 4.5% to 9.9% (Governor's Report). In that same period, 28,000 more people were provided income assistance by Economic Services Administration, a 23% increase. A 2005 study by Washington State Institute of Public Policy on adults served by the state's public mental health system found much lower employment rates for these clients. Clients who do work tend to work substantially fewer hours, have considerably lower total earnings, and work for far lower wages than adults in the general population.

Washington

16 - Adult -Description of Regional Resources

Adult -A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Each Regional Support Network (RSN) is a county or group of counties with one exception, OptumHealth, a private for profit organization, was chosen to serve as the RSN for Pierce County through competitive procurement after Pierce County officials declined to continue to serve in that capacity. Some counties within the RSNs have specific taxes dedicated to mental health. These are Clallam, Clark, Island, Jefferson, King, Okanogan, San Juan, Skagit, Snohomish, Spokane, Thurston, Wahkiakum and Whatcom. These tax dollars are outside of the scope of the public mental health system administered by the DBHR. They do use these tax dollars for specific mental health projects. Several RSNs contribute local funds as part of their matching dollars for their capitation Medicaid payment. There are currently 152 licensed Community Mental Health Agencies, most of which contract with RSNs. The community mental health providers also have available donation and other funds that they use for Non-Medicaid consumers. The spreadsheet below displays the funds distributed by the DBHR. Totals are rounded. Funds cannot be separated by age.

RSN Estimated Revenues					
Fiscal Years 2010 and 2011					
	Fiscal Year 2010		**Fiscal Year 2011**		**2010 FBG**
RSN	Medicaid	Non Medicaid	Medicaid	Non Medicaid	
Chelan Douglas	6,529,528	2,539,819	6,264,786	2,539,819	108,865
Clark	23,049,482	8,767,111	25,427,770	8,767,111	423,288
Grays Harbor	5,724,499	1,428,522	6,035,268	1,428,522	70,748
Greater Columbia	41,211,974	12,873,223	42,561,102	12,873,223	669,757
King	100,682,761	40,009,096	103,952,428	40,009,096	1,880,150
North Central	15,983,652	3,735,700	14,950,310	3,735,700	216,633
North Sound	45,798,397	22,995,396	47,765,190	22,995,396	1,098,134
Peninsula	21,556,758	7,144,474	22,373,976	7,144,474	344,059
Pierce	40,649,304	17,696,259	43,773,318	17,696,259	803,669
Southwest	7,138,371	1,886,462	7,740,957	1,886,462	98,787
Spokane	39,493,137	10,967,662	38,987,713	10,967,662	458,013
Thurston Mason	14,847,241	6,912,326	15,477,000	6,912,326	300,952
Timberlands	7,112,510	1,992,807	7,472,983	1,992,807	100,384
Total	369,777,615	138,948,857	382,782,800	138,948,857	6,573,440

Note: Non-Medicaid revenue also includes funding related to Expanding Community Services (ECS), PALS, PACT, and Jail Services. Medicaid funding includes funding for b (3) services and Local Match Option. Medicaid FY11-13 budget is scheduled to be developed in October 2010 following the release of official forecasted eligibility numbers.

The Table provides estimates of the amount of funding available through the state to each Regional Support Network (RSN) for State Fiscal Years 2010 and 2011 based upon funding distribution formulas. This table does not include MHBG funding, the distribution table which may be found in Adult–Grant Expenditure Manner. For the 2009–2011 biennium RSN state funds were cut 9% ($11.6 million). RSNs are required to prioritize remaining state funds on non-Medicaid crisis, inpatient, and residential services. It is anticipated that state general funds will again be cut next biennium, starting July 2011.

Many RSNs apply for grants, partnering with counties or other community agencies to increase their resource base. Additionally, the Community Mental Health Agencies with whom they contract may apply for grants, partner with nonprofit organizations or conduct other activities in support of enhancing their fiscal resources.

Washington

17 - Adult -Description of State Agency's Leadership

Adult -A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

As noted in the overview of the state's mental health system, the Division of Behavioral Health and Recovery (DBHR) is the state authority for the administration of the public mental health system in Washington. The Secretary of the Department of Social and Health Services (the Department or DSHS) is appointed by the Governor to this Cabinet Level position and oversees all administrations within the Department, which include Medicaid Purchasing Administration (MPA) a new consolidation of the Health and Recovery Services Administration and the Healthcare Authority, Aging and Disability Services Administration (ADSA), Children's Administration (CA), Economic Services Administration (ESA) and Juvenile Rehabilitation Administration (JRA).

Mental health and substance abuse were incorporated into one division as of June 1, 2009, and on May 1, 2010 the Division of Behavioral Health and Recovery (DBHR) was moved into the ADSA in order to strengthen the integration of community services across the life span. However, the initiative to better integrate primary care and behavioral health continues to be a high priority of the State. Beginning in May 2010 and continuing throughout the calendar year the Department will be engaged in a learning and planning process with the eventual determination of specific action steps and structural changes to begin the integration of behavioral health and primary care – with the recently passed national health care bill serving as the driver and platform on which to build the State's new approach.

The DBHR operates with many partners, including the 13 designated Regional Support Networks (RSN) and their network of over 150 subcontracted community-based mental health providers. The DBHR operates an integrated public mental health system for persons experiencing mental illness who are enrolled in Medicaid, for those who are low income and meet the statutory need definitions, and for those in psychiatric crisis.

MISSION

The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community by administering a public mental health system that promotes recovery and resiliency as well as personal and public safety.

VISION

DBHR is committed to creating a seamless system of care that is timely, effective and efficient, that treats each person holistically and embraces each person's ability to recover and gain the skills, insight and personal and interpersonal reserves needed to be resilient as circumstances and symptoms change. The hope is that people living with a mental illness will live, work, learn, and participate fully in their communities and without fear of discrimination.

OVERVIEW OF PEOPLE SERVED

Mental health consumers include Medicaid eligible individuals, publicly funded people not eligible for Medicaid, and all residents of the state (for crisis, ITA and disaster response services). Tribal mental health consumers who receive care in tribal clinics are not reflected in DBHR service data unless they are contracted by an RSN. The percentage of tribal consumers who receive both tribal and RSN services is presently unknown.

Following is an overview of statistics related to individuals served in the public mental health system in fiscal year 2009:

- A total of 128,705 people, approximately 101,190 of whom were covered by Medicaid, utilized mental health services in community outpatient settings.
- 8,045 people received services in community hospitals.
- 3,239 people received inpatient services in state hospitals.
- Medicaid eligible people received about 87 percent of service hours delivered.
- Some non-Medicaid consumers receive outpatient services (these tend to be minimal hours as would be consistent with a mental health evaluation.
- Many mental health consumers tend to be customers of other human service programs.

In 1989, the Washington State Legislature enacted the Community Mental Health Reform Act, which consolidated responsibility and accountability for individuals' community mental health treatment and care through Regional Support Networks (RSNs), which carry out state legislative mandates. The same entities also are known as Pre-paid Inpatient Health Plans (PIHPs), which carry out federal Medicaid requirements.

This consolidation included crisis response and management of the involuntary treatment program. Beginning in October 1993 through 1996, the former MHD

implemented capitated managed care for community outpatient mental health services through a federal Medicaid waiver, creating prepaid health plans operated by the RSNs, now known as Prepaid Inpatient Health Plans (PIHPs). In 1996, the waiver was amended to include community inpatient psychiatric care. By 1999, all RSNs were responsible for full risk management of inpatient community mental health care.

Under a Federal managed care 1915 (b) Medicaid waiver, RSNs enter into full risk PIHP contracts with the state to provide community inpatient and outpatient services to Medicaid eligible children and adults. As prepaid inpatient health plans, the RSN/PIHPs provide community mental health services described in the State Plan to consumers who meet the Access to Care standards for authorization into public outpatient mental health services.

The Access to Care Standards were developed as a response to a condition of the 1915 (b) Medicaid waiver renewal which required the state to:

> "Develop and implement a standard set of criteria, and a standard set of methods of implementation, to be used statewide in all RSNs/PIHPs for screening, assessment and authorization of services. Criteria and methods for implementation must assure that all Medicaid enrollees in need of medically necessary mental health services have access to needed services. Treatment activities must be designed to support consumer goals as documented in the consumer's individual recovery plan".

Services provided through the Medicaid waiver include:

- Individual counseling and psychotherapy services
- Medication management
- Crisis and stabilization services
- High Intensity Treatment teams, and evaluation and treatment centers (E&Ts)
- Peer Support services
- Respite care for caregivers, clubhouses, and supported employment as funding allows
- Day treatment (day support) for individuals needing an intensive rehabilitative program

The State Legislature has provided additional state funding designed to address the gaps in services created by restrictions in the Medicaid program. Key state funded services for all residents not covered by Medicaid include:

- Crisis and limited outpatient services for primarily low income individuals who are not eligible for Medicaid
- Room and board for mental health consumers in licensed residential treatment programs

- Services to individuals in and transitioning from jails
- Community integration assistance program services for individuals with mental illness identified as high risk who are transitioning to the community from state prisons
- Innovative service grants for clubhouse and other consumer directed services
- Select evidence based practice pilot programs for children
- Ten Program for Assertive Community Treatment (PACT) Teams (5 full teams; 5 half teams), all of which are high fidelity, are supported by $10.5 million in state funds. Nine RSNs have PACT Teams; two teams are in King County, the most populated RSN in the state.

RSNs are also required to promote access to safe and affordable housing and provision of services to individuals who are homeless and to support the active search of comprehensive resources to meet the housing needs of consumers. RSN community support services emphasize supporting consumers in their own homes, and RSNs provide and/or coordinate with rehabilitation and employment services to support consumers seeking employment.

RSNs must ensure that eligible consumers in residential facilities receive mental health services consistent with their individual service plan and that they are advised of their rights, including long-term care rights. If supervised residential services are needed they are provided only in licensed facilities that may include an adult family home, boarding home facility or an adult residential rehabilitation center facility.

INVOLUNTARY TREATMENT AND INPATIENT SERVICES

RSNs administer the Involuntary Treatment Act and the crisis response system for all people in their service area regardless of income or eligibility status. In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour per day crisis line and in-person evaluations to the people of the community presenting mental health crises. Crises are to be resolved in the least restrictive manner and should include family members and significant others as appropriate to the situation and at the request of the consumer.

Involuntary treatment act services are available in all of the communities of the state 24-hours per day, 365 days a year. These services include in-person evaluation of the need for involuntary psychiatric hospitalization. This evaluation is used to determine if a person meets any of the following criteria as the result of a mental disorder: is gravely disabled (as defined in 71.05 RCW) or may pose likelihood of serious harm (to self, others, or to property). In order to be hospitalized involuntarily, the person must meet the evaluation criteria and have refused or failed to voluntarily accept evaluation and treatment to address the presenting symptoms.

Adult acute services begin in community psychiatric hospitals or in freestanding evaluation and treatment centers (E&Ts.) Freestanding E&Ts are stand alone psychiatric treatment facilities certified to provide short term involuntary treatment services. For individuals requiring longer periods of treatment than community hospitals and E&Ts are able to provide, long term treatment services are provided by the two adult psychiatric hospitals operated by the state. Eastern and Western State Hospitals provide care for approximately 1100 individuals each day. Approximately 70% of individuals at the state hospitals are under civil commitment orders. The remaining 30% are receiving court ordered forensic services. These include:

- Evaluation of individuals for competency to stand trial
- Treatment to restore competency for those deemed not competent to stand trial
- Ongoing treatment for individuals judged not guilty by reason of insanity

The Division provides leadership to oversee and implement the Governor's and State Legislature's intentions and initiatives; and, helps to ensure the success of programs by working in consultation and collaboration with the Mental Health Planning and Advisory Council (MHPAC), allied systems, other state agencies, the Transformation Work Group (TWG), RSNs, other formal providers of services to children and families, medical providers, consumers, families, and advocates at large. DBHR is responsible for resolution of consumer grievances and Fair Hearings; and, during incidents such as natural disasters or acts of terrorism, to coordinate mental health service responses.

Washington

18 - Child - Overview of State's Mental Health System

Child -A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

This is a largely joint response. Please also see Adult –Overview of State's Mental Health System.

Regional Support Networks (RSNs), through their contracts with community mental health agencies, provide a complete array of services to severely emotionally disturbed (SED) children and youth under the age of 19 who meet medical necessity criteria. One in five children birth to 18 have a diagnosable mental health disorder. Of those, one in 10 have mental health problems that are severe enough to impair functioning at home, school and or the community.

The Access to Care Standards are the Centers for Medicare and Medicaid Services (CMS) approved criteria to establish medical necessity. Eligibility involves use of a definition of medical necessity as well as a structure that prioritizes severe emotional disturbance by virtue of diagnosis and functional impairment.

Children and youth under 21 also have access to mental health services under a fee for service system and an expanded health plan benefit. Licensed providers with core Medicaid agreements can provide up to 20 sessions of mental health treatment for children who do not meet the eligibility standards for the RSN managed care system, as can Health Options Plans contracted providers. A child who may need beyond 20 sessions must be authorized as an exception.

Many youth receiving mental health services have multisystem needs that can only be addressed by multi-system planning and system integration. Washington Administrative Code and RSN contracts require intersystem agreements to anchor and inform coordination and adherence to EPSDT regulations. Through the lens of the recovery model, systems of care and person centered health homes this work is moving forward. Gains in WA service delivery system have been made in the delivery of evidence-based practices many of which correspond with specific age or diagnostic categories.

The state legislature has supported 3 pilot projects (Multidimensional Therapeutic Foster Care, Multi-systemic Treatment, Wraparound Pilots) administered by Division of Behavioral Health and Recovery (DBHR) over the last 5 years. Although funding has decreased, they have been sustained. Sustainability for all state funded programs is uncertain. Therefore the availability of Evidence Based Practices (EBPs) in Washington is inconsistent and mostly dependent on provider or local community funding resources.

Legislative intent continues to signal strongly and consistently that EBPs should continue to be implemented.

RSNs provide access to inpatient services in community psychiatric hospitals and evaluation and treatment centers. Such hospitalization is typically short term (around 2 weeks) and discharge planning focuses on aftercare, crisis and treatment planning that may consist of a period of authorization for high intensity team services.

Children's Long-Term Inpatient Programs (CLIP) consist of the state-run Child Study and Treatment Center and three contracted psychiatric long-term residential treatment programs, located in Seattle, Tacoma and Spokane. The total bed capacity for CLIP for the state is 91 children. Historically, there has been a wait list for admission during which the RSN and community provides short term hospitalization and high intensity community services, coupled with intense outpatient services. A systemic approach to reducing waits to less than 30 days has been focused by the Governor's Management and Accountability Program. In the last year the wait list dropped to historic lows and while it still varies has continued to evidence shortened waits for admission.

Greater availability of community and home-based intensive services continues to be a priority along with expanded use of EBPs, early and consistent discharge planning for all youth, parent involvement and closer coordination with the DSHS Children's Administration for resumed out of home placement for foster children. Dialogue, collaboration and the development of communication tools are progressing.

Transition Age Youth are a developmental group of the youth served within the children's as well as the adult mental health population that require coordinated cross system planning to address unique system gaps. At this time there is a department level group looking at transition age youth from a cross system perspective. A report that will have impact on policy and programming is due in October of this year.

Parents, family members, Tribal representatives and youth are partners in policy development on many levels. Parent, family and youth involvement is recognized as an important part of the state's mental health system operating in formal and informal ways to provide direct services as certified peer counselors and advocates.

Parent –professional partnership trainings have increased in number and strategic development as have the apportioning of funding for projects conducted by current and emerging family support organizations. These projects and support programs empower help parents and caregivers to be effective advocates for their children and youth. It assist them to become empowered to communicate needs and to advocate for their own rights using effective methods that work for them.

"Youth N Action"(YNA) is a youth advocacy model that brings the voice of youth to public policy and empowers at risk youth ages 14-24 bring their viewpoint to public

policy and empower at-risk youth ages 14-24 to make positive differences in their lives, their communities, and systems that serve youth. YNA is a youth-driven organization surrounded by youth-friendly adults and professionals who provide support to the youth to help them create the positive outcomes they desire. YNA provides youth with a variety of opportunities to make a positive difference.

This past year, mental health block grant funding supported the foundation of two additional centers of excellence for YNA, one in eastern and one in western WA. Funding was also directed to a two-county area for development of a new YNA "site" for which the Western Washington YNA Center of Excellence will provide technical assistance. This model will expand and continue to provide support to communities with existing youth organizations as well as those who have emerging interest and capacity to sustain the needed enthusiasm, vision, structure and mentorship.

In 2005, E2SSB-5763 was passed into law to address the increasing numbers of homeless persons with mental illness, high psychiatric impatient hospitalization rates and limited local treatment options resulting in inappropriate use of jails and emergency rooms. Known as the "1/10" on one-percent sales tax, this new revenue stream, when passed by counties, is to support mental health, chemical dependency, and therapeutic court services. Out of thirty-nine counties, thirteen have passed and are actively utilizing these funds.

Washington

19 - Child - Summary of Areas Previously Identified by State as Needing Attention

Child -A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year

The following points were previously identified as areas needing attention in the 2009 MHBG Plan:

Inpatient Utilization: Utilization of Inpatient Care spans several system issues that involve involuntary commitment, age of consent, managed care structures, community hospitalization and children's long term inpatient programs (CLIP) hospitalization. In recent years the Governor's Management and Accountability Planning (GMAP) identified the "CLIP waiting list" as a target for study and improvement. With only 92 beds for children and youth who need long term inpatient treatment, capacity is stretched; however, a shared philosophy of community based treatment and diversion exists, while community programs to back that up vary. Washington is examining the availability of resources and variations of utilization across regions in the state as well as the continuum of intensive community based services and crisis stabilization, and respite.

With an eye towards strengthening intensive community based services, the Division of Behavioral Health and Recovery (DBHR) convened a stakeholder workgroup to study crisis and stabilization services, best practices in community-based Evidenced Based Practices, support for families, and diversion from hospitalization and transition services. With consultants a schema of "packages" was devised that will be utilized to seek funding addressing and increasing the availability, consistency and cost-effectiveness of these services.

Juvenile Justice – There are programs that operated in the RSNs through collaboration with the county-run juvenile justice system. These include evidence based practices such as Family Integrated Transitions and the use of Wraparound.

Current efforts to affect mental health and juvenile justice systems positively have been enhanced by a grant from the McArthur Foundation that is supporting a core study group and sites that are addressing disproportionality and developing programs for diversion, workforce development, and increased family involvement. Through this effort specific trainings are being developed in partnership with families, youth and University of Washington, to assist families and youth experiencing the juvenile justice system, titled 'Juvenile Justice 101.' The focus is on educating families and youth about the justice system and what to expect. In addition, again in partnership with University

of Washington, families and youth, a workforce development 'Juvenile Court Instructional Video,' as well as curriculum for training of Juvenile Justice Staff, has been developed with initial trainings to begin in the Fall of 2010.

Expedited medical eligibility established by legislation 2SHB1088 for youth leaving Juvenile Rehabilitation Administration (JRA) facilities, is working well at getting youth signed up for Medicaid, since they are eligible before release; and this helps to smooth the pathway into community mental health services.

A "Youth in Transition workgroup" that is funded by the Mental Health Transformation grant and led by the Juvenile Rehabilitation Administration as a collaborative cross-system study of capacity and program gaps, and prospective practice improvement, was instituted in 2010 with the support of a full-time staff person.

Training in Trauma Focused Cognitive Behavioral Health included Juvenile Rehabilitation Administration staff this year to discuss how well this EBP could be integrated with the predominantly utilized Dialectical Behavioral Therapy (DBT).

The Allied System Coordination Agreement between the RSNs and Juvenile Rehabilitation Administration facilities will be reviewed and updated in the coming year.

Family Engagement /Involvement:

Family and youth voice must be the integral force that drives policy and legislative decision making as well as implementation at the local community level.

The Children's Mental Health Reform bill, 2SHB1088, firmly establishes the involvement of families in the treatment of their child.

A long-standing CLIP Parent Steering Committee has been integrally involved in communicating voice/advocacy for children/youth and families involved in long term treatment. Two training weekends are held each year for families to learn from each other and get help in navigating outpatient systems as well as working with inpatient staff and participating in family therapy.

The Federal Block Grant supports an annual "Connectors' Retreat" with workshops on advocacy, Wraparound planning, Partnering and a training on legal aspects of Individual Education Plans (IEPs). This conference includes parents as leaders and planners and develops a resource for parents who are newly involved in the system through networking that occurs during and after the conference.

The DBHR Family Liaison sent out a survey to families and youth leaders from across the state titled "What Families and Youth Want' the purpose of which was to gather information about how families and youth want their voices to be heard. The current survey responses were compared to the outcomes derived from the community forums hosted by the Mental Health Transformation Project in the Spring and Fall of 2006 and will be incorporated into direct work in the coming year with RSNs.

Washington has several alumni recipients of System of Care (SOC) grants. In addition, two communities (including a Tribe) were funded and are now in their second year of implementation. There are two communities that are currently in the grant application process including another Tribe.

Washington

20 - Child - New Developments and Issues

Child -New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, State Children's Health Insurance Program (SCHIP) and other contracting arrangements, managed care.

As described throughout this plan there continues to be a growing focus on children's mental health and system transformation. New and ongoing issues that continue to affect service delivery are centered on continued implementation of the Children's Mental Health Act (2007 Legislation “2SHB1088”) and 2008 Legislation (2SHB1373)

- June 30, 2010 marks the completion of the second year of operation of 3 Wraparound pilot sites established contracted to 3 Regional Support Network (RSNs): North Sound Mental Association, Grays Harbor RSN and Southwest RSN.

- The training contract with Vroon Vanden-Berg ended June 30, 2009 and was not renewed due to a budget reduction in the 2009 Legislature. The University of Washington Children’s Mental Health Evidence-Based Practice Institute (UW-EBPI) was allocated $30,000 to continue to provide technical assistance in concert with their ongoing role as evaluator of the pilots. Preliminary data continues to demonstrate that pilots are being operated with high levels of fidelity to National Wraparound Initiative standards. Parent outreach and partnerships were established in all three sites. DBHR provides support to encourage, sustain and grow family partnerships.

- Last year’s “Wraparound Summit” was successful and is being expanded to double the attendance this year under Federal Block Grant funding with an emphasis on sustaining Wraparound and establishing “state-wideness” in the context of budget reductions and health care reform.

- As referenced above, the 2009 Legislature reduced funding to Children’s Mental Health EBP Pilots. This affected the three Wraparound Pilots, the CMH EBP Pilot Program in Thurston Mason that had instituted Multi-systemic Therapy, Triple P, Parent Empowerment and Trauma Focused Cognitive Behavioral Therapy with the Skokomish Tribe, and Multi-dimensional Treatment Foster Care. All three pilots are continuing to function with reduced budgets. Counties have leveraged state tax levy support, and relationships with other systems to augment the State money. MTFC capacity was reduced from 10 youth to 5, but still is sustaining their utilization

- The Washington Trauma-Focused Cognitive Behavioral Therapy dissemination, training and consultation program continues under the support of Federal Block Grant funding. Over 1,000 clinical staff from public providers across the state has

attended annual core, advanced and supervisor training and consultations in the last three years. This year the concept of CBT training as the base for application to trauma and other serious histories and age related issues was introduced. In the last year, the UW Harborview Center for Sexual Assault and Traumatic Stress has conducted one standard core training with consult groups, : "CBT-+ TF",core training with consult groups, TFCBT with parents who abused or did not protect 1 general and one learning collaborative with consultation groups, an advanced and a supervisor training. This year, a data base was established to facilitate outcomes studies.

- Two SAMHSA SOC grantee communities (Yakima County and Lummi Tribe) completed their second year of implementation. Yakima Co. is supporting the attendance of the DBHR Children's Senior Program Manager at the 2010 Georgetown Training Institutes as a member of their Advisory Council. DBHR is supporting the attendance of 4 parent/caregivers and 2 parent-youth pairs to this year's Georgetown Training Institute with MH Block Grant funding.
- A report to the legislature required as part of 2SHB1088 was submitted providing the results of actuarial analysis of variations of the access standards for the public mental health system, and input provided by a 1,000 survey respondents and attendees at 2 Children's Mental Health Forums in 2009 to the public mental health benefits package.

- Ongoing work between the DBHR and the Mental Health Transformation Grant regarding trauma-informed care, parent involvement, employment and youth in transition continues.

- Our submission of a SAMSHA grant to bring Youth in Transition (YIT) programs to two Regional Support Networks in rural western Washington was not successful. However, the Mental Health Transformation Grant (MHTG) is supporting a workgroup to study services available to transition-aged youth. DBHR's Program Administrator for Innovative Youth services and our Family Liaison attend the workgroup under the leadership of the Juvenile Rehabilitation Commission.

- Expansion of DSHS provider network to include providers of mental health services to children, youth and their families, who do not meet SED definition or medical necessity under the access to care standards for services under Washington's 1915 (b) managed care waiver continues. Further work is being done to support this network and promote its use through RSNs and their contracted providers. , expanding DBHR added two management level staff to its Children's Mental Health Program Unit and have dedicated federal funding to sustain family liaison duties and program planning. The RSN Children's Administrators and Family Representatives workgroup is in its second year of quarterly meetings. RSNs are represented by their Children's Program Specialists and their regional family partners.

- The Partnership Access Line "PALS" continues in two of the largest Regions in the state. Since its inception in 2008, 393 providers have received peer consultations regarding children and adolescents with emotional or behavioral disturbances, PAL consultants have made 17 outreach presentations and marketing of the program has been successful in engaging continued use.

- The Children's Mental Health Evidence-Based Practice Institute operating under the University of Washington's Division of Public Behavioral Health and Justice Policy (PBHJP),has accomplished much as it is about to complete its third year of operation. It has provided training and technical assistance, support in launching evidence-based practices and system of care approaches, stakeholder work with parents and youth and has been a lead in a MacArthur Models for Change grant operating in several Washington Counties. It has also been successful in leveraging funding from private corporations or foundations to support research in improving, expanding interventions for foster children in WA, an offshoot of which has been major funding for the implementation of Wraparound for foster children.

Parent and Youth Support
Federal Block Grant funded the Statewide Parent Organization, the expansion of WADADS (Washington Dads) and a number of other activities including Wrap-Around Training, children's mental health planning participation, attendance at national conferences and other events in FFY 2010.

Washington did not re-contract with the statewide family organization "SAFE-WA" as it attempted re-organization in the fall of 2009. SAFE WA was disbanded in early 2010. Without a statewide family organization, DBHR is utilizing federal block grant funding to sustain all the family and youth activities that were previously contracted out incorporating parent voice and participation in planning. DBHR is also utilizing new MHTG funding to support existing regional family and youth organizations and provide TA and funding to develop family leadership and expanded support opportunities where they don't currently exist. The following parent and youth activities are ongoing:

- Technical Assistance to support emerging youth and family organizations, including training for improved parent-professional relationships and parent-initiated Wraparound.
- Release of an updated Parent Resource Guide
- Annual Family Connector's Training
- Funding of grants to support Community Connector work plans
- Parent trainings for parents with youth in the Children's Long Term Inpatient Program and those on the waiting list.
- Expansion of Youth N Action Network in Eastern and Western Washington
- Sustainability of a Clubhouse in Eastern Washington and research on the design and implementation of a consumer run drop-in center
- Support to a provider-run housing program for transition-aged youth – technical assistance for the youth coordinator position and implementation considerations.

Youth 'n Action:
Federal Block Grant funding supported a major accomplishment for youth empowerment - Three contracts were executed for establishing two centers of excellence, one in eastern WA and one in western WA and a new YNA organization in a two-county area. These are contracted respectively with Volunteers of America, the University of Washington and Mason County under the supervision of the 4H program. The "centers of excellence" will form the base for expanding support for new youth organizations in WA with the TA being provided to Mason County as a template.

WA Dads has continued to expand its presence in Washington supporting new memberships groups in several counties on either side of the mountains. In addition to their routine deliverables below, this year they are also developing an information resource for families that can be put on the DBHR website.

WA Dads' activities this year included:

- Facilitation of two Father's Training weekends
- Cross system collaboration with other organizations supporting families and youth
- Monthly regional support group meetings
- Weekly Teleconference meetings
- Organization membership education (i.e., peer counselor certification, law enforcement trainings)
- Attendance at national and local conferences (i.e., Federation of Families, Building on Family Strengths Training)
- Train-the-Trainer in Law Enforcement (Right Response)
- Consumer outings
- Legislative advocacy
  WA Dads had two significant accomplishments this year: 1) becoming a 501c (3) organization and 2) winning a contract with King County as the family organization in support of that county's major Wraparound expansion under county tax increase funding.

Cross system initiatives
DBHR continues involvement in a number of study and workgroups including:

- Children of Incarcerated Parents – that produced a tool kit
- Settlement compliance plans and activities for foster children – Braam
- Juvenile Offenders Re-Entry from Rehabilitation facilities
- MacArthur Grant Mental Health and Juvenile Justice
- Project Launch promoting wellness of young children birth to eight
- Statewide Coordinating Council for Infants, Toddler Early Intervention Programs
- Combating Autism Advisory Council (Federal Grant)
- Integration of Primary Care and Behavioral Health

- EPSDT compliance and rule writing workgroup
- Implementation of dropout reduction legislation
- MHTG funded Youth in Transition Workgroup
- Formation of new health program for foster children (Fostering Well Being)
- MacArthur "Models for Change" State Core Team
- MHTG Prevention Advisory Group
- Recently the State of Washington completed involvement in the NRI YSS-F survey project.

Washington

21 - Child - Legislative Initiatives

Child -Legislative initiatives and changes, if any.

The following legislative initiatives affect the operating environment for children's mental health services.

2SHB 1373: Eliminates the 7/1/2010 sunset date for 1) increasing the annual number of office visits (from 12 to 20) available to children needing outpatient mental health therapy in managed care programs and under fee-for-service and 2) permitting outpatient mental health therapy in under fee for service to be delivered by licensed mental health professionals with Medicaid core provider agreements. Calls for provider incentives and further expansion of access by adding mental health providers under regulation by the Department of Health and supervised by a licensed mental health professional.

HB 2161: No longer requires DSHS to pay for child care under the MSS program, based on Governor's budget.

HB 2341: Prohibits individuals enrolled in DSHS medical programs from being enrolled in Basic Health Plan (BHP). The legislation allows the Health Care Authority (HCA) to disenroll individuals from the BHP according to established criteria.

HB 2342: Establishes the Universal Vaccine Purchase Account for the purpose of purchasing vaccines for children not eligible for federal vaccine purchasing programs. Most of DSHS children are on Medicaid, which will not be impacted by the elimination of universal vaccine coverage. But SCHIP and CHP are not included in the Vaccine for Children program. Therefore, HRSA will need to pay for vaccines for these children.

HB 2377: Increases the sales and use taxes by 0.3 percent from 1/1/2010 to 12/31/2012. Establishes and makes appropriations from the Health Care Trust Account to fund the Basic Health Plan, public health services, health care, mental health care, hospitals, and long-term care nursing homes. Appropriations are made to fund the Working Families' Tax Rebate program.

SSB 5360: Establishes the CHCC Grant Program to further efforts of community-based coalitions to increase access to appropriate, affordable health care, especially for employed, low income persons and children in school who are uninsured and underinsured. HCA is authorized to award 2-year grants. Eligibility criteria is outlined for these competitively awarded grants along with evaluation reports by HCA to the Legislature and Governor. In-line with HRSA's Re-Thinking Care Project, which focuses on intensive chronic care management.

SSB 5891: DSHS and the Health Care Authority will lead a multi-payer effort of payers, purchasers and providers to implement primary care medical home reimbursement pilot projects.

2SSB 5945: Establishes the Washington Health Partnership Advisory Group, to include representatives from the healthcare arena to advise the Governor on progress toward implementation of this bill and the findings of the Governor's Blue Ribbon Commission on Health Reform. This bill requires:

- DSHS to seek a waiver to have one eligibility standard for all, phased-in to cover low-income parents and individuals over time with a goal of offering coverage to persons up to 200% of FPL;
- Expansion of categorical eligibility to childless adults;
- Single seamless application and eligibility determination system, including electronic apps and signatures;
- Delivery of a single program for all low-income persons, with a common core benefit package, approved by CMS, including optional supplemental benefits for specific categories such as children, aged, blind, disabled;
- An enhanced medical home reimbursement and bundled payment methodologies;
- A premium assistance program for employer-sponsored insurance enrollees, if cost-effective;
- Mandatory enrollment in employer-sponsored insurance to the extent allowed under federal law;
- DSHS to serve as a Medicare special needs plan (either directly or by contract, through the waiver process, if allowed) for those eligible for both Medicaid and Medicare;
- Legislative authority to implement any waiver approved by CMS under the bill. The bill also requires DSHS to maximize federal funds for vaccines for low-income children and family planning services. DSHS must seek a family planning waiver to: (1) Provide coverage for sexually transmitted disease testing/treatment; (2) Restore eligibility standards to those used in 2005; and (3) Within available funds, increase income eligibility to 250% FPL, to correspond with income eligibility for publicly funded maternity care services.

SB 6181: This pilot for children with significant needs in foster care remains suspended until there is funding.

Due to extreme budgetary pressures, funding for non-Medicaid consumers was cut by 9% during this biennium ($11.6 million). Many individuals still need mental health treatment and State-only dollars are now prioritized for non-Medicaid crisis, inpatient and residential services. As a result of this cut in funding, the number of individuals who are not Medicaid eligible receiving non-crisis outpatient services each month dropped by 13% during the latter half of 2009. Economic circumstances locally and nationally do not portend immediate improvement in these circumstances.

Washington State faces a significant shortage of community psychiatric inpatient beds. A recent study published by the Washington State Hospital Association identified there were 637 community psychiatric inpatient beds in the state in October 2008. This comes out to approximately 9.7 beds per 100,000 residents. Data from an American Hospital Association survey from 2006 identified that the national average was 25.2 community psychiatric inpatient beds per 100,000 residents, and at 9.7 beds, Washington's rate is one of the lowest, if not the lowest of any state.

From 2008 to 2010, Washington's unemployment rate doubled, going from 4.5% to 9.9% (Governor's Report). In that same period, 28,000 more people were provided income assistance by Economic Services Administration, a 23% increase. A 2005 study by Washington State Institute of Public Policy on adults served by the state's public mental health system found much lower employment rates for these clients. Clients who do work tend to work substantially fewer hours, have considerably lower total earnings, and work for far lower wages than adults in the general population.

Washington

22 - Child - Description of Regional Resources

Child -A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

This is a combined response. Please see also the Adult Resources section of this plan and note that Washington operates a capitated payment system. As a result, funds cannot be separated by age categories.

State funding to the existing children's mental health Evidence Based Practice (EBP) pilots was reduced this past legislature but the contractors are continuing to provide the same level of core services as they did in the last state fiscal year and are establishing partnerships and local funding to augment their state resources.

The Fidelity Wrap-Around pilot projects continue in Cowlitz, Skagit and Grays Harbor Counties. The training contract was cut to a level that dictated a change in the training contract which shifted to the University of Washington Evidence Based Practice Institute (EBPI). The evaluation will continue under EBPI funding. Evidence is showing high fidelity.

The "Partnerships for Success" EBP pilot projects in Thurston and Mason Counties' reduced is now concentrated on one EBP: the practice and fidelity monitoring of Multi-systemic Therapy (MST).

Multidimensional Treatment Foster Care funding cut resulted in reduced capacity from10 foster homes to 5. The rural program struggles in recruitment of licensed foster homes that will take just one child, but services continue, at a level commensurate with numbers served in the last state fiscal year and continue to include aftercare.

Regional Support Networks submitted their proposals for block grant funding which will be directed in part to children's programs.

The following programs are examples:

- Workshop course taught by family members of adolescents with mental illness to other like family members
- Single Parent Support Group
- Teen Talk – a youth suicide telephone prevention program
- Tribal youth suicide and dropout prevention and school based curriculum on early intervention
- Manuals for children and youth in mental health services "Navigating Life"
- Trainings for law enforcement agencies on Crisis Intervention with Mentally Ill Children,

+ Crisis services expansion, stabilization, follow up expansion and Wraparound
+ In-school and in-home outreach
+ Support for clinicians to obtain “Child Mental Health Specialist” (Washington distinction)
+ Increase in evidence-based practices for foster children, (e.g. Parent Child Interactive Therapy).
+ Evidence-based practice training
+ Support of existing parent support services.
+ Parent partner trainings.
+ Juvenile justice support and transitions
+ Support of new parenting network providing advocacy resources and support for families

Other regional (RSN) projects include:

- Wellness Project – a free clinic for families and children who don’t have insurance that provides health, mental health, developmental disabilities services and referrals to local social service providers
- RSN contracted provider “ Adolescents for Change group has tripled in size evidencing successful youth/family partnering
- Local “shared resources meetings” that partners with Child Welfare, Schools, Juvenile Justice, Parent Advocacy, Developmental disabilities , etc. to address children and youth involved in multiple systems and referrals for children’s long term inpatient program requests; and shared trainings;
- Implementation of new support models for children and caregivers.
- Expansion of Wraparound,
- Increased availability of EBPs,
- Financing of new family support organizations
- Wellness Recovery Action Plan training for transition aged youth.
- Drafting of proposed legislation to support parent empowerment re IEPs
- New programs for infant mental health and training initiatives
- Navigating Systems training for families and collaborative problem solving class
- New Youth Inpatient Evaluation and Treatment Center for 12-18 for voluntary and involuntary youth
- Redesigned Children’s Hospitalization Alternative Program
- SAMHSA System of Care Grant
- WA Dads expansion,
- Innovative use of new Tax money
- Information sharing Guide for child serving systems
- School-based Wraparound initiated
- WA Dads a parent organization for outreach to fathers was granted FBG funding to work with regional family support networks to complete a resource roster for the DBHR website in FFY 2010.

Washington

23 - Child - Description of State Agency's Leadership

Child -A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

This section, too, is a combined response. Please see also Adult Leadership.

In May 2009, the structure of the Health and Recovery Services Administration (HRSA) under DSHS umbrella was changed structurally to integrate the Mental Health Division and the Division of Alcohol and Substance Abuse, now called the Division of Behavioral Health and Recovery (DBHR). Planning and collaboration efforts are in progress to enhance program policy and planning where our work units can achieve efficiencies and our programs benefit from integration efforts (such as treatment for co-occurring mental health and substance abuse.

In May 2010, the former Medicaid function of HRSA was combined with Health Care Authority functions, which included responsibility for state employee, Basic Health Plan and other state administered health purchases. The new administration is known as Medicaid Purchasing Administration. DBHR was transferred to the Aging and Disability Services Administration (ADSA).

DBHR provides leadership to 13 Regional Support Networks (RSNs) via policy and standards, contract negotiation, development, execution, and monitoring. The Division also provides technical assistance upon request as well as offers support and trainings in areas of identified need.

With heightened focus on children's mental health issues and supportive legislation in 2007 (2SHB1088), DSHS expanded access to children and youth who do not meet the “Access to Care Standards” for the waivered population (SED). This legislation mandated that the department increase the service benefit available to enrollees in the Healthy Options plans from 12 to 20 sessions.

At the same time, the Department was mandated to increase Medicaid core provider agreements by broadening the credentialing standards beyond psychiatrists and Advanced Registered Nurse Practitioner (ARNPs) to include licensed (masters level) mental health professionals. DBHR is involved in ongoing quality management, updates and technical assistance to RSNs and other DSHS Administrations about access to the providers.

DBHR is working collaboratively with the Children's Administration, Juvenile Rehabilitation Administration and the Office of Superintendent of Public Instruction and with physical health care to integrate programs for all service populations. Recently the “Person Centered Health Home” approach has been introduced as a concept and structure to integrate various health systems mutual efforts to serve individuals.

A progress report required by 2SHB 1088 was submitted to the Legislature in 2010 reflecting activities and policies being formulated to support advances in children's mental health prescribed by the bill.

The DBHR – RSN Administrators meeting chartered a subgroup for children's mental health that is made up of DBHR Children's program managers, RSN children's care coordinators and regional family representatives. This group addresses current issues related to children's mental health and family involvement, operating from an annual work plan and RSN administrator/DBHR requests.

One such issue in the last year has been the review of allied system coordination plans that RSNs are required to have with each of the DSHS child serving systems. The plans with the Children's Administration (CA) are under review and each RSN is working with their local CA regional office to update the agreements and dialogue about best practices to ensure access to and coordination of care. .

DBHR collaborates with the University of Washington (UW) on a number of EBP implementations, training, family /youth involvement and quality improvements. One such collaboration has been a successful model of EBP implementation piloted in one RSN that encompasses two counties. The model (Partnerships for Success) was leveraged to implement three evidence-based practices defined by the community as corresponding to their greatest need.

The core children's mental health evidence based practice is Multi-Systemic Therapy (MST), and it has in fact obtained additional money from the county to sustain it as a result of cutbacks from the state reducing the original funding. This model was also used with one Indian Tribe to implement a culturally competent adaptation of Trauma Focused Cognitive Behavioral Therapy.

The University of Washington partnerships include the Washington Institute of Mental Health Research and Training (East and West) which are contracted to produce and conduct special trainings and symposiums: e.g. Washington's Peer Support Certification program, which has reached out to parents of children and youth and to adults to participate in training and update of the curriculum to include more emphasis on peer counselors for parents of young children and youth.

DBHR has also contracted with the Washington Institute of Mental Health Research and Training to revise the Children's Mental Health Specialist training. DBHR staff provided extensive technical assistance in the formulation of the new training and conducted several presentations.

The parent liaison role within the DBHR in concert with the structural integration described above is being reviewed with the intent to expand parent support programs

and services to parents of youth with substance abuse, and or co-occurring disorders. Visibility of the parent liaison over the course of the last year contributed to leadership acknowledging the contribution this role makes to operations, planning and stakeholder satisfaction. Federal funds are being incorporated to support more family programs and cross-system innovations.

The Children's Mental Health Services unit has participated in numerous cross system planning activities for the benefit of children, youth and families as reflected in Section 20 of this plan. This has included participation on the cross-system Prevention Advisory Group of the Mental Health Transformation Grant (MHTG). The Prevention Advisory Group is anticipated to have an ongoing home, potentially in DSHS.

The DBHR mental health children's services supervisor is also on a Department of Health Family Policy Council workgroup for capacity building and a national committee studying public health approaches to mental health. The latter position stems from her role as representative to National Association of State Mental Health Program Administrators, Child, Youth and Family Division. DBHR is supporting the attendance of parent and youth advocates and program staff to the Georgetown Training Institutes this year and will convene other Washington representatives while there for discussions of strategic planning for children and youth related to systems of care and Wraparound.

DBHR has led in cross-system training, two examples of which are the Wellness Recovery Action Plan training (in which the Parent Liaison participates as a trainer) DBHR continues to expand the reach and depth of the statewide Trauma-Focused Cognitive Behavioral Therapy dissemination which included a cross-system training this year for colleagues in child welfare, juvenile justice and chemical dependency.

With an eye towards strengthening intensive community based services, DBHR convened a stakeholder workgroup in 2008 to study crisis and stabilization services, best practices in community based EBPs, support for families, diversion from hospitalization and transition services. With consultants a schema of "packages" was devised that will be utilized to seek funding addressing increasing the availability, consistency and cost-effectiveness of these services.

Washington

24 - Adult -Service System's Strengths and Weaknesses

Adult -A discussion of the strengths and weaknesses of the service system.

Washington's strengths include:

- An active, vocal and collaborative Planning and Advisory Council, composed of a diverse group of people and centered by strong consumer-family participation
- A diverse and inclusive community support system
- A cross-system, legislatively driven, resource for co-occurring disorders including crisis intervention and treatment through the Omnibus Bill
- Legislation that has required more rapid implementation of mental health parity
- A steady increase in consumers becoming Peer Counselors
- A commitment to provide increased support and training for use of evidence based practices across all populations including children, older adults, other vulnerable populations with severe mental illness and serious emotional disturbances
- A strong working relationship with the Medicaid Purchasing Administration in coordinating efforts working with Indian Tribes to develop an enhanced mental health service delivery system for the Alaska Natives and American Indians in Washington
- A collaborative relationship with the Department of Social and Health Services (DSHS) Indian Policy Service and Support (IPSS) unit and with Indian Tribes
- Continued operation of ten PACT teams statewide, which includes training and external fidelity reviews
- Training for workforce development through conferences both in state and nationally
- Implementation of a cross-system co-occurring disorders screening
- Intensive chemical dependency case management projects in two RSNs
- Strong partnership with the federally sponsored Transformation Grant
- Medical and dental services
- Flexibility in use of funds on behalf of Medicaid recipients as a result of operating under a capitated payment system with clearly stated deliverables

The major systemic weakness involves the economic downturn nationally and locally, which has afforded lessened capability to provide services to individuals who do not qualify for Medicaid benefits and the according lessened ability to serve others through staff turnover and reductions in force.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment area, funding is not identified to specific clients, nor is it targeted for certain services or programs. The RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive. Increased funding and greater consistency between RSNs is a constant goal. Efforts are underway to create efficiencies in State rule and changes in the RSNs' contracts to affect greater evenness in statewide service capacity.

Washington

25 - Adult - Unmet Service Needs

Adult -An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

All of the issues below have been identified previously as unmet needs and continue to apply. These are, however, large undertakings that cannot be completed in a year or even two.

The greatest unmet need is the decreasing overall system capacity as the need for system capacity steadily increases. Both of these factors are related to the current economic downturn. Decreased availability in state funding for low-income consumers who are not eligible for Medicaid services is rapidly increasing while the capacity to provide services decreases. This increased need for services is due to recently unemployed individuals seeking services as they attempt to cope with the stressors of unemployment and providing for themselves and their families. It is exacerbated by the under-reported stressor of long-term unemployment. Service providers are stretched to capacity as they try to meet the increasing service needs of their Medicaid consumers who are deleteriously impacted by the economy.

These unmet needs all have been identified through focus groups, through the collection and interpretation of data derived from Consumer Satisfaction Surveys, from analysis of the Prevalence of Serious Mental Illness in Washington State study, from the Uniform Reporting System and Developmental Tables, RSN reported service data, hospital reports, jail reports, and through the subjective input of DBHR staff, the MHPAC, consumers, family members, advocated, providers, multiple other community organizations and allied providers.

Housing: There is insufficient safe and affordable housing available.

From 2008 to 2010, Washington's unemployment rate doubled, going from 4.5% to 9.9% (Governor's GMAP report). In that same period, 28,000 more people were provided income assistance by ESA (EMIS report), a 23% increase. A 2005 study by WSIPP, on adults served by the state's public mental health system, found much lower employment rates for those clients. Those clients who do work tend to work substantially fewer hours, have considerably lower total earnings, and work for far lower wages than adults in the general population.

Benefits: As mentioned above, many individuals need mental health treatment, yet are not eligible for them. State-only dollars are prioritized for crisis services and insufficient to meet the need for services. Economic circumstances locally and nationally do not portend immediate improvement in these circumstances. Funding for non-Medicaid consumers was cut by 9% during this biennium. As a result, the number of individuals who are not Medicaid eligible receiving non-crisis outpatient services each month dropped by 13% during the latter half of 2009.

Inpatient Capacity: Washington State faces a significant shortage of community psychiatric inpatient beds. A recent study published by the Washington State Hospital Association identified there were 637 community psychiatric inpatient beds in the state in October 2008. This comes out to approximately 9.7 beds per 100,000 residents. Data from an American Hospital Association survey from 2006 identified that the national average was 25.2 community psychiatric inpatient beds per 100,000 residents and at 9.7 beds, Washington's rate is one of the lowest if not the lowest of any state.

Vocational or Meaningful Activities: More employment related skills trainings are offered.

A recent Washington State Department of Commerce report notes that the number of households requesting housing subsidies has surpassed their own annual estimates by 33%. Many report serving a new type of household with these funds as their clients speak of being affected by the recession. Paying rental arrears for households who have fallen behind after a job loss is a common story (Most recent report on Homelessness Prevention and Rapid Re-Housing).

A 2009 WSIPP study on the effectiveness of housing programs for persons with mental illness found that housing assistance for persons with mental illness significantly reduced homelessness, hospitalization, and crime when compared to similar individuals who did not participate in a housing program.

Understanding of Recovery and Resiliency: There is a need for additional training and culture change in the mental health system to move toward Transformation.

Washington

26 - Adult -Plans to Address Unmet Needs

Adult -A statement of the State's priorities and plans to address unmet needs.

Washington continues to experience a heightened focus on its public mental health system. The merging of the previously separate mental health and substance abuse divisions into the Division of Behavioral Health and Recovery continues to flourish. The new division is now developing strategies to move towards integrated behavioral and primary health care.

As is the case in a great many public mental health systems nationally, Washington is confronted with limited resources to meet the basic needs of its consumers. As we move forward in implementation of changes intended to promote consistency and more equitable access to quality services, we remain aware of potential systemic shortcomings that must be addressed as a priority in order to carry out other intents.

The DBHR continues implementation of a comprehensive package of budget and legislative initiatives in the delivery of Washington's public mental health services for adults with severe and persistent mental illness and children with serious emotional disorders, based on unmet service needs.

Strategies include:

- Continued statewide implementation of Program of Assertive Community Treatment (PACT) teams with newly blended state and Medicaid funds with training to provider agencies on how to maintain PACT fidelity with blended funds
- Implementation of the results of a Medicaid benefits design and managed care rates study
- Implementation of a plan for expanding housing options for individuals with mental illness
- Refinement of a utilization review system to assure people receive medically necessary levels and durations of state hospital and community psychiatric inpatient care
- Possible insertion of Disability Lifeline and its implementation of mental health treatment benefits for eligible low-income individuals who do not meet threshold for Medicaid coverage
- Possible insertion of information on healthcare integration/person centered health care home

Housing: In 2006/2007, DBHR contracted with Common Ground, a non-profit housing consulting firm focused on creating and preserving housing for people with low income and special needs, which resulted in development of a statewide mental health housing plan. The Mental Health Housing Action Plan promotes recovery and addresses the

increasing demand for housing after stays at Eastern and Western State Hospitals. A goal of the Plan is to create or secure an additional 5000 housing units by providing technical assistance to Regional Support Networks (RSNs), providers and consumers to build capacity locally to develop housing. This includes designing and implementing housing programs; establishing partnerships with landlords; and, creating strong collaborative relationships with the state agencies that manage funds for the construction and subsidization of housing for low income, disabled and homeless individuals, and families.

The focus of the Housing Action plan is on Permanent Supportive Housing, the community based housing models that have demonstrated success at increasing stability, reducing episodes and lengths of stay in hospitals and jails while promoting recovery, and is now a newly announced SAMHSA Evidence-Based Practice. The Plan contains a description of necessary supports, barriers and potential outcome. Among implementation strategies are landlord education and incentives and coordination of housing and service funding. Barriers to housing access are high rental costs, felony convictions, cultural and language differences between consumers and landlords and housing operators.

Examples of desirable outcomes are 1) an increase in the number of consumers who secure stable, permanent housing; 2) an increase in the average length of tenancy; and 3) reduction in the frequency and duration of hospital or jail stays.

Benefits Design: DBHR continues to contract with Tri-West to review and make recommendations for redesign of its benefits package for publicly funded, managed behavioral health care and to assist with study of consumer run businesses. The first phase of the work involved literature of best practices, an analysis and comparison of Washington State's to other states' Medicaid benefits plans and input and guidance from Washington stakeholders.

The second phase of the project focused on refining initial recommendations and developing a transition plan that incorporates the statewide system transformation initiative that is in progress. The transition plan addresses both recommended benefits and financial implications. The project report includes recommended benefits and financial implications. DBHR is in the process of determining specifics of implementation, which will be affected by legislative directive in the coming year.

Utilization Review: The System Transformation Initiative (STI) Utilization Review (UR) Project produced recommendations for statewide criteria and processes for external utilization review of State and community hospitalizations for the State of Washington. The goal of an external utilization review criteria and processes will be to ensure appropriate levels of state and community psychiatric inpatient and community-based services which support the recovery of individuals with severe and persistent mental illness.

As part of the process of developing criteria, the UR Project accomplishes the following:

- Establishes acuity levels and criteria for individuals to be supported in community and psychiatric inpatient settings as well as for individuals to be supported in community outpatient programs based on current access to care standards, involuntary treatment statutes, and other state and industry standards;
- Develops standards for review of short-term hospitalizations; and
- Develops sampling methodologies and processes for independent review of 90 and 180 day commitments in community and state hospitals and freestanding Evaluation and Treatment Centers.

Vocational and Other Meaningful Activities: Enhanced supports will be afforded to help consumers who want to work, attend educational opportunities and pursue other meaningful activities. Evidence demonstrates that feeling productive and having purpose is critical both to decreasing psychiatric symptoms and to attaining recovery. Expansion of Peer Counselor certification will continue to be a focus. The Peer Counselor training manual was updated and is expected to be translated into Spanish.

Wellness Recovery Action Plan (WRAP) overview training is provided to certified Peer Counselors and others interested in this dynamic, consumer focused program. Credentialed peer specialists will have the opportunity to receive additional WRAP training as part of the department's continuing education efforts for peer counselors working in the field.

Pierce College, located near Western State Hospital, will continue to provide supported education services for consumers wanting to attend or return to college. The program serves 40 individuals at a time.

Understanding Recovery and Resiliency: Continued training will be provided in the areas of intervention and prevention, cultural competence, and community education thereby decreasing discrimination and stigmatization. DBHR will continue to encourage and solicit involvement of consumers in guiding the mental health service delivery system in Washington, with a goal of empowering them to take responsibility for and achieve their recovery.

State legislation passed in 2007 provided for DBHR to certify clubhouses. Federal Block Grant funds were used by DBHR to support technical assistance to clubhouses in preparation for certification review. The state certification process began in September 2008 and to date nine clubhouses have been certified and are operational.

Consumer and Family-Run Organizations Technical Assistance

Substitute House Bill (SHB) 2654 directed the Washington State Department of Social and Health Services (DSHS) and DBHR to prepare a report on strategies for developing consumer and family run services. The submitted January 2009 report recommended:

1) Washington State needs a more broad and diverse array of consumer and family run organizations, 2) needs to fund technical assistance to develop consumer and family run organizations across the state at multiple levels of development, including dedicated funding for both the start-up of new organizations and to enhance existing organizations and 3) fund and implement a pilot with at least two consumer run and two family run organizations to establish their initial certification under the new requirements by January 1, 2011.

The DBHR allocated federal block grant to provide consumer and family-run technical assistance. DBHR subsequently consulted with national experts on technical assistance to consumer run organizations, including the role of technical assistance centers to provide that service; consulted with local and state non-profit firms that provide such assistance and direct support to non-profit agencies; and sought out information on how this alternative would work in our state. Advice will soon be gathered in collaboration with consumer and family run organization representatives prior to finalizing an approach to the provision of technical assistance, anticipated to be implemented in late 2010, or early 2011.

DBHR provides scholarships for consumers, including Planning and Advisory Council and sub-committee members, to attend the annual statewide behavioral health conference. Approximately 140 individuals were sponsored this year, and a comparable number is expected to be supported to attend the 2011 conference.

The Mental Health Transformation Project and the Office of Consumer Partnerships collaborated on the selection process for award of scholarships to the annual behavioral health conference as well as training and recovery conferences.

RSNs each provide consumer focused training and education opportunities through a variety of activities. Some examples of those activities are NAMI conducted training (In Our Own Voice, Peer to Peer, Family to Family); Pebbles in the Pond; recovery and resiliency focused training; developing budgets and financial skills, understanding medication and management of it; board training; and, culturally focused training such as Canoe Journey and cultural nights.

Washington

27 - Adult -Recent Significant Achievements

Adult -A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

SAMHSA 2010 Transformation Grant Sought to Support Permanent Supportive Housing

The Permanent Options for Recovery-Centered Housing *(PORCH)* project is designed to transform service delivery by promoting sustainable access to evidence based Permanent Supportive Housing. PORCH provides consumers with meaningful choice and control of housing and support services, utilizes Peer Housing Specialists, reduces homelessness, and supports the recovery and resiliency of individuals with Serious Mental Illnesses.

The PORCH project is a partnership between the Washington State Division of Division of Behavioral Health and Recovery (DBHR), OptumHealth-Pierce Regional Support Network, the Chelan-Douglas Regional Support Network and local mental health and housing provider agencies. The project will provide evidence based Permanent Supportive Housing throughout one urban and two rural Washington Counties, serving 100 to 150 individuals per year with a total unduplicated count of 232 individuals over the five years of the grant.

Over 50% of the services will be provided by Peer Specialists. Services available through the program will be leveraged to obtain rental subsidies (e.g. “bridge” vouchers) through state and local funding sources to ensure housing is affordable for all individuals served. If funded, the teams funded through this grant will utilize the Permanent Supportive Housing Toolkit scheduled for release by the Substance Abuse and Mental Health Services Administration in 2010.

House Bill 1456: Chapter 360, Laws of 2007 – Update
Known as the “Marty Smith Bill” in honor of a mental health professional killed on the job, this legislation is intended to provide greater personal safety to mental health professionals. Provisions include:

- Annual training on safety and violence prevention for all community mental health workers who work directly with clients;
- Policies to ensure that no mental health crisis outreach worker will be required to conduct home visits alone;
- Employers will equip mental health workers who engage in home visits with a cell phone or other communication device; and mental health workers dispatched on crisis outreach visits will have prompt access to any known history of dangerousness or potential dangerousness on the client they are

visiting.

Enhanced opportunity for system and community collaboration
The Division of Behavioral Health and Recovery (DBHR) continues to work actively to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support networks (RSNs) consumers, families, Planning and Advisory Council, Transformation Work Group, community mental health providers, and allied systems. Some of the allied systems are the DSHS Children's Administration (CA), Aging and Disability Services Administration (ADSA) Division of Developmental Disabilities, the State Office of the Superintendent of Public Instruction (OSPI) and Department of Corrections (DOC)

DBHR leadership and staff members meet regularly with RSN administrators and ensure that there is representation from RSNs on committees created to develop or establish policy. These committees may also include consumers, family members and advocates, providers, and allied system partners. Policy issues range from system transformation to legislative initiatives to state regulation or Washington Administrative Code changes.

Reaching Out to Older Adults
DBHR in partnership with the Home and Community Services Division (HCS) will provide regional events aimed at increasing the awareness and understanding of public mental health services for older adults by residential care providers. These events will be based on regional need and will include local Regional Support Networks, HCS, and Area Agency on Aging staff in their planning. The goal of these events is to improve collaboration and access with regard to the mental health needs of older adults in residential settings, an underserved population in Washington State.

Training to Better Respond to Returning Soldiers
Two state departments are working together to train mental health workers, police, drug treatment counselors, tribal representatives and other community service personnel in how they can better serve troubled veterans returning to the United States after traumatic service in Iraq and Afghanistan.

Mental health and crisis experts with the Department of Veterans Affairs and the Department of Social and Health Services are partnering with community organizations to sponsor a series of trainings this summer. "The Veterans Collaboration Group," as they have dubbed themselves held trainings in Tacoma, Yakima and Bellingham, each community with a high concentration of returning soldiers.

Partner agencies include WDVA, the DSHS divisions that coordinate substance abuse treatment and mental health services, Washington Association of Designated Mental Health Professionals and the federal Veterans Administration as well as local groups. The workshops focus on the basics – what works and what doesn't – and instructors encourage participants to look ahead at the kind of crisis situations in which they may

face a returning soldier losing control or posing a threat. Other topics in the curriculum include veteran and military cultures, war trauma, traumatic brain injury, war-related post traumatic stress disorder and combat-related mental illness and stigma.

Willing Partner Initiative – Improving Employment Outcomes

Using Medicaid Infrastructure funds the Division has worked with two national employment consultation firms Advocates for Human Potential (AHP) and the Institute for Community Inclusion (ICI) to provide comprehensive technical assistance to three communities that expressed interest in improving employment outcomes, the King County, North Sound and Greater Columbia Regional Support Networks. In total the communities represented in the effort represent approximately 65% of the public mental health consumers in the State.

Using a combination of strategies that include development of Evidence-based Supported Employment; emphasis on Clinical Interface and Integration with Employment; review and possible revision of State, RSN and provider specific policies and procedures; developing long range financial models to support employment activities; and cross systems collaboration primarily with Vocational Rehabilitation the initiative intends to improve employment outcomes in these areas. An additional step, creating "urgency" around employment is also a component – expressed through one of the partners in a goal of doubling employment outcomes in five years.

Mental Health Housing Action Plan

This plan was developed through a contract with Common Ground. The Plan presents the consultant's recommended package of budget and policy initiatives to address one critical element of the high utilization of Eastern and Western State Hospitals: the lack of appropriate community based housing for people with mental illnesses. In 2007 the plan estimates the unmet need for community based housing for people served in the public mental health system at approximately 5000 units and proposes a way that approximately 40% of that need would be met over the next eight years. This includes housing for single adults, families where a parent has a mental illness or a child has a serious emotional disturbance, and seniors. People who are served by the public mental health system with a history of cycling through the streets, shelters, hospital emergency rooms, jails, and/or local and state hospitals are emphasized. Current available service capacity is calculated as is housing currently "in the pipeline" when determining the remaining need.

Current data suggests that the development called for in the plan is on track. Between 2007 and 2010 760 additional units of permanent supportive housing was to be developed, including new construction and existing units with subsidies. By mid-2009 430 new units are "in service" and 194 new units are in development and scheduled to open by 2010 and at least 260 existing units with subsidies are projected to be produced due to the increase in homeless funding via the federal stimulus legislation.

Local Partners Team Together to Develop Supportive Housing

In 2008 and 2009 fifteen teams of local housing and social service agencies came together to create permanent housing for homeless families, veterans, families that are experiencing domestic violence and people with mental illness. Representing sixteen counties the teams participated in intensive hands-on training led by national and state experts on every aspect of designing, financing, building and managing Permanent Supportive Housing. This Washington Supportive Housing Institute is based on the successful curriculum from the Corporation for Supportive Housing (CSH) "Opening New Doors". Besides the Corporation for Supportive Housing the Washington State-based consultants included Common Ground and Building Changes.

At the conclusion of the training each team will have designed the intended project, developed a financing plan and some have gone so far as to acquiring the property on which the project will be built. If all projects reach completion as intended over 400 new units of housing for people in need will have been built. Each team's commitment is to participate in over a dozen days of training at a central location over a nine-month period, complete between class "homework" such as develop formal written agreements among the partners to be responsible for an aspect of the project and utilize, the expertise of the consultants often in the project community, for example on selecting the location of the project. But what is most unique about the Institute is the mix required of the partnering teams. Each team must have members willing to serve as the project developer, owner, manager or service provider. Teams often include local government and housing authorities.

Also unique is the emphasis on Permanent Supportive Housing focusing of people who have some of the most challenging obstacles to overcome to be successful in housing. As the name implies the housing is permanent with no arbitrarily-imposed time limit. Services and support is provided specifically aimed at helping people remain in housing and be good tenants. The housing is always subsidized to make if affordable for low-income tenants and each tenant signs and must abide by the requirements of a lease. The range of support includes working toward employment or staying in school in order that greater independence can be achieved.

The 2008 Institute was jointly funded by the Department of Commerce (formerly Community Trade and Economic Development), Department of Social and Health Services/Mental Health Division and Washington Families Fund a unique partnership led by the Bill and Melinda Gates Foundation along with the State of Washington, King, Snohomish, and Pierce Counties, the cities of Seattle, Everett, and Tacoma and several philanthropic and corporate partners - United Way of King County, Boeing, Microsoft, the Campion Foundation, the Greater Tacoma Community Foundation, and the Ben .B. Cheney Foundation. The 2009 Institute added Impact Capital, a Community Development Financial Institution (CDFI) providing real estate financing products and

community building support to non-profit community-based organizations throughout the Pacific Northwest.

DSHS emphasized housing for persons with a mental illness as part of the drive to implement a 2007 housing action plan that estimates the unmet need for community based housing for people served in the public mental health system at approximately 5000 units and proposes a way that approximately 40% of that need would be met over the next eight years.

The counties that had teams complete the 2008 and/or 2009 Institutes include Pierce (2), Cowlitz, Okanogan, Clark, Benton-Franklin, Walla Walla, Spokane, *Yakima,* Lewis, Pacific, Clallam (2), Chelan-Douglas and Skagit.

Mental Health Housing Consortium

The Mental Health Division, in partnership with and funding from the Governor's Mental Health Transformation Project, is sponsoring a Mental Health Housing Consortium. The intent of the MHHC is to:

- Inform DBHR about the various housing activities taking place on the regional and local level
- Coordinate those activities with many partners around a common vision
- Share and formalize training and educate those involved in mental health housing about models and funding of housing and support services
- Increase coordination among other state and local agencies
- Provide advice to DBHR on its implementation of strategic initiatives related to housing
- Identify state, regional, and local gaps and needs
- Facilitate direct collaboration with consumers and advocates
- Assist and support implementation of the housing development funded by FBG funds

The Consortium holds quarterly day-long meetings and has a membership in excess of 50 organizational representatives including Commerce the primary state funding agency for low income housing an homeless projects, representatives from every Regional Support Network, from the Planning and Advisory Council, the Association of Washington State Housing Authorities, county housing planners, numerous community mental health agencies and housing providers, consumers and family advocates.

Report to the Legislature on Substitute House Bill (SHB) 2654: Strategies for Developing Consumer and Family Run Services

The Washington State Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) engaged Tri-West Group (Tri-West) to facilitate a multi-stakeholder Work Group to collaborate with DBHR to respond to the

requirements of Substitute House Bill (SHB) 2654. SHB 2654 directed DSHS to prepare a report on strategies for developing consumer and family run services. In response to that legislation, Washington State DBHR convened a Work Group of mental health consumers, youth in transition, family members, and other mental health stakeholders to develop the report in cooperation with DBHR.

The principle of recovery undergirds the values of consumer and family run organizations serving adults, and System of Care values guide the operations of youth and family run organizations focusing on children, youth, youth in transition, and families. The report that was delivered to the Legislature in January 2009 centers on the concept of Consumer and Family Run Organizations that emphasize self-help as their operational approach and that are owned, administratively controlled, and operated by mental health consumers or their families.

The Work Group concluded:

> *"Washington State needs a broader and diverse array of consumer and family run organizations to develop and provide an ever-expanding array of services and supports grounded in the priorities of the consumers and family members that live in the communities where those programs operate."*

To promote the development of such organizations, the following recommendations are made:

- Fund technical assistance to develop consumer and family run organizations across the state at multiple levels of development, including dedicated funding for both the start-up of new organizations and the enhancement of existing organizations.
- Develop certification requirements to ensure accountability for consumer and family run organizations building on the successful structure and approach developed for DBHR's clubhouse certification requirements.
- In order to ensure the provision of adequate technical assistance, coordinate with existing services, and evaluate the effectiveness of the organizational development process, fund and implement a pilot of at least two consumer run and two family run organizations to establish their initial certification under the new requirements by January 1, 2010.
- Refine the certification requirements through an evaluation to assess the effectiveness of the certification requirements and technical assistance in supporting the development of the pilot sites, as well as their potential for replication by July 1, 2011.

<u>Mental Health First Aid</u>

Mental Health First Aid (MHFA) is the initial help given to someone developing a mental health problem or in a mental health crisis before appropriate professional or other assistance, (including peer and family support), can be engaged. The 12-hour course

teaches people how to give first aid to individuals experiencing a mental health crisis situation and/or who are in the early stages of a mental health disorder. Participants learn the signs and symptoms of the most common mental health problems, where and when to get help, and what type of help has been shown to be effective.

This course is designed to increase mental health literacy, to decrease stigmatizing attitudes in our communities and to increase appropriate and early help-seeking by people with mental health problems.

Certified MHFA-USA Instructors deliver the 12-hour course, which can be scheduled flexibly. These Instructors have successfully completed an intensive authorized 5-day training course to become accredited MHFA-USA Instructors.

In June 2009 the Division in collaboration with the Washington Institute for Mental Health Recovery and Training and the Washington Community Mental Health Council organized and provided the 5-day MHFA Instructor Certification course in collaboration with Master Trainers from Missouri. Twenty-two consumers participated in the inaugural training and nineteen of them became certified to present MHFA trainings.

WA-PACT

Guided by improvements within the National ACT Standards, the development of an enhanced ACT fidelity tool facilitated ongoing performance improvement within the WA-PACT teams. The Dartmouth Assertive Community Treatment Scale (DACTS) had been the primary tool by which fidelity to ACT has been assessed nationally (16). While the DACTS has been found to be a useful and widely disseminated fidelity tool, particularly for performance improvement purposes, several gaps and limitations have been identified (19-21). These limitations within the tool have led to some teams scoring well on the DACTS, while continuing to mainly do case management without the requisite evidence-based approaches to skill-building and fostering recovery and independence in the community.

In an effort to fill these gaps, Washington State developed an enhanced version of the DACTS (the Tool for Measurement of Assertive Community Treatment [TMACT] (5) and piloted it with all 10 WA-PACT teams during the first year of implementation. Enhancements include standards and measures for: 1) development of role expectations for each team member; 2) enhanced team communication and functioning (e.g., the quality of the daily team meeting); 3) other evidence-based practices (e.g., application of supported employment principles); and 4) recovery-oriented processes (e.g., person-centered planning, fostering of consumer self-determination).

Increased Efforts to Coordinate Physical and Mental Health

Washington's Medicaid Integration Project (WMIP) continues through the collaboration of the Department of Social and Health Services with Molina Healthcare of Washington. The goal is to manage and provide medical, mental health and chemical dependency services through Molina's provider network. An initial requisite enrollment of 6,000

individuals was established, with an option for individuals to dis-enroll. The focus of this project is to make available a care coordination model through a team approach to work with consumers to help identify and address physical health needs early, coordinate services and help consumers adhere to prescribed treatment

Coordination of these services is expected to prevent unnecessary hospitalizations; reduce placement in more restrictive settings, eliminate duplicate prescription of medications and prevent and reduce the use of emergency room visits for conditions that are more properly addressed in physicians' offices.

Expansion of Peer Counselor and Recovery Training

Consumer training and employment continue through comprehensive training and certification programs of peer counselors. As of June 4, 2010, over 726 individuals have received the state approved peer counseling training, of which at least 269 are certified. An additional 263 individuals have completed the training and passed the peer counselor exam but have not submitted a Department of Health counselor credential in order to be certified. There are two more training sessions scheduled for 2010 which will train 50 individuals.

In the interest of developing opportunities for peer counselors to receive continuing education, the Division has planned local Wellness Recovery Action Plan (WRAP) training for up to 125 certified peer counselors. Individuals who complete this 3-day training will be certified to teach WRAP in a one-to-one setting. These trainings began in July and conclude in October of 2010.

For the first time, the Division hosted a "Peer Support Reception" at the state behavioral healthcare conference. This event enabled peer counselors from across the state to meet and network, as well as to provide feedback to the state regarding the services they provide and their continuing education needs.

Increase Resources for People with Co-Occurring Disorders

Division of Behavioral Health and Recovery staff work closely with the Co-Occurring Disorders Interagency Committee (CODIAC). This group has been in existence for approximately thirteen years and continually seeks to address co-morbidity issues of mental illness and substance related disorders.

Mental Health Insurance Parity

With the passage of House Bill 1460, comes another significant transformation activity. This legislation holds the requirement that insurance carriers in Washington State provide parity between mental health services and medical-surgical services. Specifically, co-payments, prescription drug benefits, out of -pocket expenses, deductibles, and treatment limitations for mental health conditions must be the same as those for traditional physical health conditions. This is a significant step forward in strengthening the continuum of care, increasing access to mental health services, and for thousands of Washington's residents who have need for mental health treatment.

Developmental Disabilities/Mental Health Divisions Collaborative Work Plan
Through this innovative working agreement DBHR and the Division of Developmental Disabilities (DD) have worked to improve access to services, appropriateness of treatment, and accountability for services. Keys to success have been that the agreement is formalized in writing, funded through the legislature and facilitated by the DD/DBHR Cross-System Committee, with the support of statewide regional coordinators and written reports from monitors with national expertise.

The results of this program have been profound. Over 173 residential slots have been created in the community for this population; more people are leaving the hospital, and fewer are being admitted. Of those being admitted, fewer are entering the hospital for the first time, fewer are being re-admitted once discharged, and the length of time between hospitalizations has increased dramatically:

Support of Evidence Based Practices
In addition to the development of PACT teams, MHBG funds are being used to support development of EBPs specific to Older Adults, which includes training on use of Program to Encourage Active Rewarding Lives for Seniors (PEARLS) and Improving Mood and Promoting Access to Collaborative Treatment (PEARLS) for late life depression. DBHR will continue to actively enhance the outreach capacity and specialized services needed by this historically underserved population.

Increased focus on MHBG funds
DBHR has continued conducting on-site program and fiscal reviews of each RSN related to the use of MHBG funds. These reviews, which are resulting in improvements in accountability and consistency, are followed up with technical assistance from DBHR for those RSNs needing help in the development or enhancement of their tracking and monitoring policies, procedures, and accounting practices. Additionally, the review process of RSN MHBG plans, which began in 2007, continues.

Washington

28 - Adult - State's Vision for the Future

Adult – A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

The Division of Behavioral Health and Recovery (DBHR) remains committed to creating a seamless system of care that is timely, effective and efficient, that treats each person holistically and embraces each person's ability to recover and gain the skills, insight and personal and interpersonal reserves needed to be resilient as circumstances and symptoms change. The hope is that people living with a mental illness will live, work, learn, and participate fully in their communities and without fear of discrimination.

DBHR continues efforts to strive toward a transformed system inclusive of the following guiding principles and core values embedded in the Division's strategic plan:

- Promote the understanding that mental health is essential to overall health for all Washington residents.
- Encourage consumers, their families, and advocates to drive their own mental health care and to be involved in their own individual recovery and resiliency process supported by the mental health system.
- Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
- Establish early mental health screening, assessment, and referral to services as common practice;
- Utilize data to drive decisions to continuously improve health care services and accelerate research;
- Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information

DBHR currently sits within the Aging and Disability Services Administration of the Washington State Department of Social and Health Services (Department). The Department has adopted a unified vision, mission, and core set of values to promote high-performing programs in an integrated organization working in partnership for statewide impact. The key elements of this framework include:

- 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
- 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.

In accordance with this framework, DBHR is working toward a vision in which Washington's system of care for individuals with mental illnesses supports person centered, integrated and coordinated care using promising and evidence based practices, the foundations of which are prevention, early intervention, treatment, and resiliency and recovery services. This vision for the Washington state mental health system is one in which:

- Behavioral and primary health care are integrated through person-centered health care homes;
- Both outpatient and inpatient care is based in Recovery and Resiliency;
- Staffing is available at adequate levels to meet the needs of persons living with mental illness in the community;
- State Psychiatric Hospitals are right sized and their role is redefined to best support and facilitate consumer recovery;
- Housing is safe and affordable for those we serve and there is an adequate array and capacity of community living options and placements;
- Meaningful employment and vocational opportunities are available for adults and youth with mental illness along with adequate supports which allow for success;
- Services are culturally competent and accessible to all who are eligible;
- Services are person-centered and self-directed;
- Access to services that are cohesive and well coordinated, demonstrating enhanced relationships between state agencies, RSN's, providers, Tribes, consumers, families, and communities, facilitating a seamless continuum of care;
- Transparency and accountability is achieved at the state and local level.

To achieve these goals, DBHR will continue to focus on transformation. Accordingly, in determining how MHBG funds are utilized, the Division uses the guiding principles below. Proposed uses of MHBG funds must:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;
2. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;
3. Link well to other resources and transformation activities;
4. Meet needs in our system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and
5. Align well with other Division initiatives or legislatively mandated expectations.

Washington

29 - Child -Service System's Strengths and Weaknesses

Child -A discussion of the strengths and weaknesses of the service system.

Washington State has the following strengths in its child/youth system

+ DSHS is fortunate to have a leader in Susan Dreyfus who was appointed to the role of department Secretary just over a year ago. Susan Dreyfus is a champion for all children with a commitment to improving foster care and mental health services statewide. She has instigated programmatic changes for foster care, including a consolidation of health care coordination within a program unit in HealthCare Services under a new program for foster children (Fostering Well Being). She is supporting changes in performance based contracting for Children's Administration providers towards greater accountability for care. She has developed stronger relationships with the Dept. of Health and the Dept. of Early Learning particularly to address prevention and early influences of adverse childhood experiences.

+ Counties that have passed and implemented the 1/10th of 1% sales tax to support mental health service expansion and outreach. King County is a model, directing their "Mental Illness and Drug Dependency" Tax funding to a county wide dissemination of high-fidelity wraparound services.

+ A cross system, legislatively driven, resource for implementing Wrap-Around pilot sites – now entering their third of operation are robust examples of integrated system of care planning and development. Early evaluation by the University of Washington shows that the pilots are exemplary in their adherence to fidelity principles. Process measures have been refined as have contracting and reporting structures.

+ A statewide planning group with MHD and University of Washington leadership from nationally respected Dr. Eric Bruns to expand training and implementation of Wrap-Around statewide. The "Second Annual Wraparound Summit" is currently being planned with a request for the Secretary's involvement. The summit will be held in a semi-rural area, where successful wraparound has been the product of intensive partnership with families, youth, RSN's, County leadership, community safety and non-profit resources.

+ University support and vision including a strong involvement of parents and youth in planning efforts with their monthly meetings of the Parent and Youth advisory committee. The UW has taken a role via contract as a center of excellence for the expansion of youth leadership and voice under the rubric of "Youth 'n Action"

+ Legislators with a strong tie to children's mental health and parent stakeholders

+ A steady increase in Peer Counselors, including parents – parents were involved in the updating of the Peer Counselor Curriculum.

+ A commitment including funding sustained over three legislative sessions to provide increased support and training for use of evidence based practices

+ MHD, in partnership with Indian Policy Service and Supports (IPSS) has reinstituted the Monthly Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between the MHD and the Tribes, address policy issues and concerns and to improve tribal mental health services including children and youth issues.

+ Training for workforce development through conferences both in state and nationally

+ Workforce development and training at the university level as a major activity of the Children's Mental Health Evidence-Based Practice Institute

+ Workforce development, diversity and front end diversion as part of pilots funded by the MacArthur Foundation

+ Private funders willing to support children's mental health initiatives

+ Ongoing cross-system co-occurring disorders screening, current work with the developer of the GAIN SS to identify ways to expand the tool's usefulness in WA.

+ Active statewide support for family organization networking among parents and youth leadership across the state, trained and available to support parents and youth.

+ An increasing number of RSNs that employ parent partners to inform services and provide direct support and advocacy to local parents

+ Growing recognition at the state level, not just in DBHR, but Juvenile Rehabilitation Administration, Children's Administration, Developmental Disabilities and Substance Abuse, of the importance of parent and youth voice in shaping policies, including opportunities to reach out and support families

+ An exceptional and growing network of fathers of children with complex needs (WA-Dads) that have brought new light to the need for support for dads raising children with serious emotional disturbance. With Federal Block Grant funding, this organization has grown, become recognized nationally and is conducting training in the state in addition to their annual training retreat.

+ A growing Youth movement across the state recognized nationally for their mission, organizational and engagement model awarded for their efforts in WA by recognition from Governor Gregoire and featured in a chapter in the 2009 release of "The System of Care Handbook" by Beth Stroul and Gary Blau

+ Three contracted leadership "sites" for "Youth 'n Action" – the state's largest youth empowerment entity. MHTG support of a Youth Summit to develop a statewide strategic plan for youth.

+ Continued workforce development under the MHBG for treatment of children with trauma histories.

Weaknesses include:

- While the community mental health system in Washington holds a strong and positive foundation, there are always opportunities for improvement. The state has been actively seeking extensive input from stakeholders in the three years and has seen an increase in support by formal organizations of including parent and youth voice.

- Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment area, funding is not identified to specific clients, nor is it targeted for certain services or programs. The RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive. Increased funding and greater consistency between RSNs is a constant goal. Efforts are underway to create efficiencies in State rule and changes in the RSNs' contracts to affect greater evenness in statewide service capacity.

- Parent Peer Counselors are not in every area of the state and recent legislation in the certifying agency (Dept. of Health) have created some logistical challenges for Peer Counselors in the MH system. These are being worked out.

- Children and youth who do not meet the RSN Access to Care Standards under managed care can now be referred to a network of providers of Medicaid fee for services. The network, however, is small, not robust statewide and in need of outreach that is being planned for the coming year.

Washington

30 - Child - Unmet Service Needs

Child -An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

While considerable progress has been made in many parts of our system, the following are areas targeted for ongoing study, partnerships and development:

Inpatient Utilization: Utilization of Inpatient Care spans several system issues that involve involuntary commitment, age of consent, managed care structures, community hospitalization and children's long term inpatient programs (CLIP) hospitalization. In recent years the Governor's Management and Accountability Planning (GMAP) identified the "CLIP waiting list" as a target for study and improvement. With only 92 beds for children and youth who need long term inpatient treatment, capacity is stretched, however, a shared philosophy of community based treatment and diversion exists, while community programs to back that up vary. Washington is examining the availability of resources and variations of utilization across regions in the state as well as the continuum of intensive community based services and crisis stabilization, respite, etc.

With an eye towards strengthening intensive community based services, DBHR convened a stakeholder workgroup to study crisis and stabilization services, Evidenced-Based Practices (EBPs) in communities, support for families, options for diversion from hospitalization, and transition services. Utilizing consultants, option "packages" were devised to seek funding to increase the availability, consistency and cost-effectiveness of services.

Juvenile Justice – There are programs that operated in the RSNs through collaboration with the county-run juvenile justice system. These include evidence based practices such as Family Integrated Transitions and the use of Wraparound.

Current efforts to affect mental health and juvenile justice systems positively have been enhanced by a grant from the McArthur Foundation that is supporting a core study group and sites that are addressing disproportionality and developing programs for diversion, workforce development, and increased family involvement. Through this effort, specific trainings are being developed in partnership with families, youth and the University of Washington (U of W) to assist families and youth experiencing the juvenile justice system, titled 'Juvenile Justice 101'which will focus on educating families and youth about the Juvenile Justice system and what to expect. In addition, again in partnership with U of W, families and youth, a workforce development 'Juvenile Court Instructional Video' as well as curriculum for training of Juvenile Justice staff has been developed with initial trainings to begin in the Fall of 2010.

Expedited medical eligibility established by 2SHB1088 for youth leaving Juvenile Rehabilitation Administration (JRA) facilities is working well, getting youth signed up for

Medicaid as they are eligible before release and smoothing the pathway into community mental health services.

A “Youth in Transition workgroup” that is funded by the Mental Health Transformation grant and led by the Juvenile Rehabilitation Administration as a collaborative cross-system study of capacity and program gaps, and prospective practice improvement was instituted in 2010 with the support of a full-time staff person.

Training in Trauma Focused Cognitive Behavioral Health included Juvenile Rehabilitation Administration staff this year to discuss how well this EBP could be integrated with the predominantly utilized Dialectical Behavioral Therapy (DBT).

The Allied System Coordination Agreement between the RSNs and Juvenile Rehabilitation Administration facilities will be reviewed and updated in the coming year.

Washington

31 - Child - Plans to Address Unmet Needs

Child -A statement of the State's priorities and plans to address unmet needs.

Through the efforts below, the goal of Division of Behavioral Health and Recovery (DBHR) is to ensure that children with Serious Emotional Disturbance (SED) are treated and strengthened by the services provided to them so that they do well at home and school, enjoy better health and ultimately come to realize their dreams, and those of their family.

Formal Systems Use: There are multiple cross-system collaboration workgroups in progress re: access, difficult-case problem resolution and coordination with field offices and program development. Matrix management and collaboration and reporting examining community based services is taking place. Remodeling of the Children's Long-Term Inpatient Program (CLIP) inspection of care process and tools was conducted over the last two years with contracted project management and professional/parent input. A cross-system workgroup on juvenile rehabilitation is in progress along with progress in county projects under a MacArthur Mental Health Juvenile Justice grant.

A Secretary level workgroup has been convened to discuss and plan cross-system programs to address youth in transition. A Memorandum of Understanding has been struck relevant to the development and support of a "Fostering Well Being" program in the Medicaid Authority for integrated case management for high risk foster youth stemming from predicting risk monitoring.

Natural Supports: DBHR will continue to support activities and trainings which are geared toward enhancing family empowerment and participation in the care and treatment of children and SED. A statewide symposium was held this year on legislation and utilization of support for "parent-initiated admissions" for youth 13 and above. Support is afforded to parents to attend national training and conferences. A data base for parent to parent and agency/program referrals has been developed. The annual "Connector Conference" has evolved to systematize "new" parent inclusion and formal peer parent access. WaDads, a primarily father-to-father support group has been supported under FBG for infrastructure development, trainings, attendance and presentation at national conferences and a successful grant application. Parents and parent organizations are eligible to apply for FBG funds to support local organizing and natural support outreach in their communities.

Understanding of Recovery and Resiliency: The need for a comprehensive Recovery and Resiliency training and the relationship to children and youth is well understood. DBHR has formed a collaborative workgroup with members of the

Transformation Work Group to address the need for such a state-wide initiative. The vision of educating consumers, families, providers, administrators, as well as the general public is held in hopes of realizing meaningful outcomes and reducing stigma. DBHR will continue to work to ensure that language is consistently used. Statewide planning and program development continues in rural and semi-rural areas of the state with training in parent-initiated Wraparound and train-the trainer models.

Educational/Vocational Activities: DBHR is in strong agreement with RSNs providing more educational and vocational assistance and opportunities for youth. More support to help children and youth stay in school, achieve decent grades, develop meaningful activities and discover as they grow up will only instill hope for the future which is the core of resiliency.

DBHR is involved in a cross-system coordination to implement drop-out reduction legislation, and a "youth-in-transition" workgroup that was mandated by the Secretary of DSHS and includes a cross-DSHS system workgroup. Federal Block Grant funding has been supporting the start up of three pilot sites for "Youth 'n Action" a model of youth empowerment that has been successful in WA for engagement of youth in their treatment, personal goals and future stability and influence.

The sum of $94,000 was dedicated to develop two centers of excellence in Western and Eastern Washington in partnership with Volunteers of America and the University of Washington. A third group is being formed under a contract with Mason County in a subcontract with the 4-H Organization, already responsive to youth growth. This new peer run organization will receive technical assistance and support from the University of Washington hired youth advocate and trainer. DBHR plans continued FBG support to three projects to continue to expand their outreach and organizational outcomes in coming years.

Evidence Based Practice: Training will continue to be offered around EBPs and research of promising best practices. In the current fiscal environment much of our effort must be on sustaining current treatment levels and special programs. Wherever possible we are planning enhancements to implementation of evidence based practices, for example developing effective and efficient channels for children's mental health planning and improvement efforts, many of which are related to legislated, but not necessarily funded deliverables.

Statewide dissemination of Trauma Focused Cognitive Behavioral Therapy continues to engage clinical teams from community mental health agencies across the state. Training has reached providers in all thirteen RSNs and now Washington boasts over 900 individuals trained and participating in statewide consultation. Training has diversified in the last year to a model that emphasizes the cognitive therapy base and the application of CBT within each of the TFCBT modules. This has been a popular approach in that the application of TFCBT is not the only therapy that is necessary for multiple, complex problem presentation in the public sector. Washington's training

model of TFCBT has gained national exposure and stands as one of the few successful community mental health dissemination demonstrations. An evaluation component was added this past year with expansion of evaluation planned for next year's resources if obtained.

Concerted efforts are taking place to identify the existence of EBPs across the state that in place in local communities. Past parent training supported by FBG have been successful in parent acceptance of EBPs and interest in increased access to these. Cross-system partnerships are steadily improving with focus on specific projects as well as shared goals. Private funding and UW evaluation has been accessed for implementation, particularly of programs with direct impact to foster children who are served by the community mental health agencies.

The UW Evidence Based Practice Institute developed a Parent and Youth Advisory group which have been integrally involved in program development related to EBPs. The UW staff is working closely with DBHR to develop priorities for EBP and family support program development.

DBHR is educating decisions makers for program and budget development about innovative practices and solutions for intensive community based, home based and crisis services resulting from the "High-Intensity Children's Mental Health Services" workgroup identified in last year's MHBG application.

DBHR's decision support capacity has grown significantly in the last year. In general data will inform understanding and focus efforts. Specifically performance based outcome measurements, as identified by 2SHB 1088 will be incorporated into existing reporting mechanisms.

Washington

32 - Child -Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care

The most significant event of this past year has been continued progress toward implementation of the Children's Mental Health Act.

As described throughout this plan there continue to be a growing focus on and accomplishments in children's mental health and system transformation. Achievements considered to be particularly significant are the following:

- Successful implementation of fidelity Wrap-Around pilots resulting in 85 new families receiving Wrap-Around services in the first two years of the project despite reduction in state funding in this, the second year of the grant. Fidelity outcomes as determined by the University of Washington's (UW) evaluation being conducted by Dr. Eric Bruns continue to be positive and expansion in the premise of the annual Wraparound Summit this year promises increased DSHS intersystem collaboration and higher level exposure of pilot outcomes and ongoing locally supported wraparound models.

- Evaluation of family engagement and barriers to successful transition of youth involved in the Children's Long-Term Inpatient Programs (CLIP) back to their home community was conducted this past year in collaboration with the University of Washington. Parent partnership was present in the internal inspection of care of the State Children's Hospital. Family and professional partner voice was honored in an evaluation and update of the evaluation tool and reporting mechanism.

- WA Dads became a 501(c) (3) this past year and successfully answered a county grant to become the selected family organization in a larger wraparound initiative. They presented a paper and poster session at the Federation of Families convention and have also been working with DBHR to support two fathers and their sons to attend the National System of Care Institutes put on by Georgetown University this summer. were engaged to review and improve the DBHR "Parent Guide to the Public Mental Health System" and to prepare a data base for referrals that could be on the state website

- Expansion of FBG funded Trauma Focused Cognitive Behavioral Therapy training and consultation has expanded to include over 800 participants, growth in the number and sophistication of our WA Consultants and increased support from Administrators and community mental health agency leadership. Expansion of the model relevance to a broader slice of the community mental health population and early evaluation constructions.

- Positive evidence based outcomes such as graduations from Multidimensional Therapeutic Foster Care (MTFC) and individual accomplishment of personal goals for education and independent living with no admissions to children's long term treatment, which all of these youth would otherwise have needed continue despite a 50% reduction in state funding.

- Multi-systemic therapy in one community has now served over 200 families, an increase of 120 over last year's cumulative unduplicated count. The provider has added one new multi-systemic treatment (MST) team, so service potential is advancing. The county was able to obtain funding from new tax legislation dedicated to mental health programs – directly related to the community engagement in the development and implementation of the EBP and its cross-system impact. In this year of reduced state funding, the ability to leverage local funding is even more impressive due to the promise it holds for sustainability in rocky financial times. While the outreach to the local Skokomish tribe and the implementation of Triple P was suspended, the county is formulating ways to reintroduce support to the tribe in a subcontract with the UW next year.

- Creation of a fee for service network of licensed clinicians to work with children and youth who do not meet the access requirements for the managed care network is growing along with plans to strengthen the network with additional outreach and support.

- The RSN Administrator-chartered workgroup of children's care coordinators and family representatives meets quarterly and has developed internal consistency and focus in this first year of organization.
- Successful application of two Washington communities, Yakima County and the Lummi Tribe for System of Care Grants and their completion of a robust second year of implementation
- Planning for statewide application for a system of care (SOC) grant in 2010 achieved a good support but was not able to be submitted due to financial restrictions effecting available State match.

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Washington

33 - Child - State's Vision for the Future

Child -A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Washington State leadership, from the Governor to the Secretary of DSHS to all child-serving administrations and divisions, has a strong commitment to the health and well being of children. This commitment is driven by the principles of safety and health care for all children, transformation of mental health services, integration of primary, mental health and substance abuse/chemical dependency programs, particularly those that are evidence, research, and consensus based.

Through a shared respect and understanding of how systems, families and natural supports must work together to achieve outcomes we endeavor to ensure that children, youth and families are wholly supported with all available resources to live to their fullest potential, become contributing members of society, and secure healthy and productive futures.

Children are our future and, as such, they have an inherent right to experience an environment wherein everyone works collaboratively to ensure their well-being and their development as healthy and happy individuals. The Division of Behavioral Health & Recovery is moving forward with the requirements to have in place by 2012 a "new" children's mental health system and by 2014 a fully functioning system within the context of national health care reform. The Department of Social and Health Services Secretary, Susan Dreyfus is committed to the highest level of integrated health care for children and youth and has such has spearheaded many cross-system workgroups. These work to ensure her vision of “One System-One Mission”.

Washington

34 - Adult - Establishment of System of Care

Adult -Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

The Division of Behavioral Health and Recovery (DBHR) is a division of the Aging and Disability Services Administration (ADSA) within the Department of Social and Health Services of the state of Washington as of May 2010. The Assistant Secretary of ADSA and the DBHR Director (The director of the combined divisions of mental health and substance abuse) are appointed by the Secretary of DSHS.

In 1989, the Washington State Legislature enacted the Community Mental Health Reform Act, a measure that moved from a county based to a regionally based system of care, and which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of Regional Support Networks (RSNs). The DBHR contracts with RSNs to administer quality outpatient services for individuals who have need of mental health services, primarily crisis response and administration of involuntary treatment services. These services are funded through state funds and are supplemented with Federal Block Grant funding.

Beginning in October 1993, the former Mental Health Division (MHD) implemented a capitated managed care system for community mental health services through a federal Medicaid waiver thereby creating prepaid health plans operated by Regional Support Networks. More recently federal waiver provisions have incorporated inpatient services in Medicaid contract provisions with prepaid health plans, and they now are referred to as Prepaid Inpatient Health Plans (PIHPs). Thus RSNs carry out state legislative mandate; PIHPs carry out Medicaid requirements.

The current community mental health system operates under the following statutory authority:

Chapter 10.77 Revised Codes of Washington (RCW) provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other people or that there is a likelihood of that person committing acts that will jeopardize public safety or security unless the person is under control of court orders. It also provides an indigent person the right to be examined by court appointed experts.

Chapter 71.05 RCW provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.

Chapter 71.24 RCW establishes community mental health programs through regional

support networks that operate systems of care.
Chapter 71.32 RCW authorizes mental health advance directives.

Chapter 71.34 RCW establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment and ensures parents or guardians of minors are given an opportunity to participate in treatment decisions.

Chapter 72.23 RCW establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.

Chapter 74.09 RCW establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.

Chapter 38.52 RCW ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies

A 1915(b) Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS) allows the state to operate a managed care system of care.

In the last five years, the mental health system has undergone many changes, and the next several years will involve more changes. In 2005, the state was set for change in Washington in terms of the energy, discussion and challenges that transpired through the following activities:

The creation of a Mental Health Task Force (MHTF) were charged with assessment of the mental health system and challenged to formulate recommendations for improvements.

In 2006, through direction and support of the state legislature, the former MHD conducted a regional competitive procurement process for its community services. Involvement of the MHTF continued through oversight of the procurement process. Completion of the procurement process resulted in there being 13 RSNs. Two small RSNs in rural eastern Washington, Northeastern Washington RSN and North Central RSN are now combined as North Central Washington RSN.

In 2008 Pierce County officials elected not to continue to contract with the state to provide RSN and PIHP administration. MHD temporarily established a fee for service option and contracted directly with community mental health agencies to provide medically necessary services. The stage legislature established a process for MHD to conduct a competitive procurement process for another entity to provide RSN and PIHP administration in Pierce County. OptumHealth became the RSN as of July 1, 2009

Washington became one of the recipients of the Substance Abuse Mental Health Services Administration Mental Health Transformation Grants. Under guidance of Governor Christine O. Gregoire, Washington is demonstrating a firm commitment to all state residents, both in policy and practice by dedicating the necessary resources, expertise and visionary leadership toward a future when transformation of the public mental health system has become a reality.

In 2009, Washington conducted benefits design studies and other preparation for further system changes. Currently a study of practice and consultation methods among individuals and groups specialized mental health practitioners is being conducted. The intent is to learn what works well and to consider establishment of state practice and consultation guidelines that will help to address disparities in access and outcomes across population groups.

As of June 1, 2009, the former Health and Recovery Services Administration (HRSA) merged mental health and substance abuse divisions into one division. It also began a move towards an integrated care model, combined with the HRSA Division of Healthcare Services (DHS).

In May 2010, HRSA consolidated operations with the former state Health Care Authority and became known as the Medicaid Purchasing Administration. At that time, DBHR was transferred organizationally to the Aging and Disability Services Administration.

Washington

35 - Adult - Available Services

Adult -Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

The Regional Support Network (RSN) responsibility for services is described in state statutes RCW 71.24, 71.34, and 71.05. These services include community support, employment, and residential services for individuals who meet statutorily defined categories based on need.

Community support services are described in Chapter 71.24 RCW but must cover at least the following six service areas:

- Emergency crisis intervention services;
- Case management services;
- Psychiatric treatment including medication supervision;
- Counseling and psychotherapy services;
- Day treatment services; and
- Consumer employment services.

With regard to residential and housing services, Regional Support Networks must ensure:

- The active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs
- The provision of services through outreach, engagement and coordination or linkage of services with shelter and housing to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, including a full range of residential services and residential supports described in the consumer's treatment plan
- The eligible individuals residing in long-term care and residential facilities are apprised of their rights and receive mental health services consistent with their individual service plans

RSNs and their sub-contracted licensed community mental health agencies coordinate with rehabilitation and employment services to ensure that consumers who are able to

work are provided with employment services. Case managers then assist consumers in achieving the self-determined goals articulated in their individual service plans by providing access to employment opportunities such as:

- A vocational assessment of work history, skills, training, education, and personal career goals
- Information about how employment will affect income and benefits the consumer is receiving because of their disability
- Active involvement with consumers served in creating and revising individualized job and career development plans
- Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required
- Interaction with the consumer's employer to support stable employment and advice about reasonable accommodations in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-discrimination Law

All of the services outlined above are to be provided “within available resources,” meaning all services may not be available in all areas of the state though efforts to expand “state-wideness” persist.

One of the difficulties is the fact that the RSNs are required to prioritize the expenditure of their state-only funds in covering the costs of crisis and ITA to all citizens of the state and for inpatient care for publically funded consumers, and residential resources. Once those needs are met, an RSN may use the remaining funds on the other services above. Since inpatient services are some of the most costly to provide for the RSNs, significant effort has been made on the part of DBHR to provide technical assistance to the RSNs on ways to improve their Utilization Management and Review tools and processes.

RSNs also are encouraged to develop alternatives to their use of Institutions for Mental Disease (IMDs) as these may only be paid for through state only funds as well. Unfortunately, for some RSNs, their state-only funds are exhausted before they are able to provide the other services listed above.

The mental health system and the RSNs operate the only behavioral health crisis system in the state, resulting in responsibility by default for conditions not normally considered as mental illness. These crisis services are available to anyone in the state, regardless of income. Crisis services include a 24-hour crisis line and in-person evaluations for individuals requesting or being referred to crisis intervention or for those individuals presenting with mental health crises. These situations are best resolved in

the least restrictive manner and include family members and significant others as appropriate to the situation and as requested by the individual in need.

For consumers already receiving services through the CMHAs, often an Individual Crisis Plan (ICP) is on file. The ICP contains the preferred intervention strategies put forth by the consumer and their families, as defined by the consumer. Many consumers also utilize Advance Directives for psychiatric care describing their desired outcomes should more restrictive measures be required to provide for their own safety or the safety of others.

In addition, RSNs ensure access to other necessary services such as medical services and medication, interpretive services, staff with specialty expertise, and access to involuntary treatment services. Involuntary treatment, as part of crisis services, is available in all of the communities of the state 24-hours per day. These services include a face-to-face evaluation of the need for involuntary psychiatric hospitalization.

A decision for someone to be detained must be made by a Designated Mental Health Professional (DMHP). General criteria for involuntary detention and evaluation include the likelihood of being determined to be either gravely disabled or at risk of harm to self, others, or property as a result of a mental disorder. Neither presenting a risk of harm nor a having a mental disorder alone are sufficient to justify the loss of an individual's right to make decisions about their own care.

While local decisions related to 72-hour involuntary detentions are made by community based DMHPs, state courts determine subsequent fourteen day or ninety day commitment decisions. Individuals needing involuntary care may receive it in community hospitals, in free-standing evaluation and treatment facilities, in one of the three state-operated psychiatric hospitals (two adult, one child) or in one of the three Children's Long Term Inpatient Residential Treatment Facilities for Psychiatrically Impaired Youth.

Under a separate contract, RSNs also operate as prepaid inpatient health plans (PIHPs) and administer a full continuum of community mental health services as defined in the Medicaid State Plan and Amendments (SPA) and as described in the 1915 (b) waiver for managed care.

A few of these services include:

- Comprehensive treatment activities (individual, group, family) designed to help the consumer attain goals as prescribed in the consumer's individual service plan. These services are to be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, employment, or educational environments. These services may include, but are not limited to: developing the consumer's independent self care

skills, monitoring and supervision of the consumer's functioning, health services, counseling, and psychotherapy

- Appropriate prescription and administration of medications including reviews of medications and their side effects and consumer/family education related to these
- Effective hospital diversion services which are a less restrictive alternative to inpatient hospitalization, or are a transitional program after discharge from inpatient services. These services are designed for people with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. These services include a mix of individual, group services, and crisis services

As prepaid inpatient health plans, RSNs authorize and pay for voluntary community inpatient psychiatric care for residents in their service areas. As Medicare and private insurance continue to cut costs by trimming services and rates, community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards.

This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs. Washington State continues to seek creative solutions to providing comprehensive medical services to all of our citizens. For the recipients of the public mental health system, this is usually through the base of community physicians who accept Medicaid for payment. There are also community clinics that provide service on a sliding scale basis for persons with limited resources. Case managers at community mental health agencies (CMHA) level often work with consumers' Primary Care Physicians (PCP) to ensure physical issues are addressed.

While more needs to be done to improve the provision of health services to consumers with serious mental illness (SMI), the state has implemented several strategies to address the over-arching access issue. For example, there are carve-out pilot programs in both Pierce County and King County that were developed to integrate primary care and substance abuse treatment.

DBHR's contracts with Regional Support Networks (RSN's) and Healthy Options Plans require working agreements between these entities at the local level, detailing how they will coordinate care. Effective January 2005, a pilot project was initiated called the Washington Medicaid Integration Project (WMIP). Through this project, DSHS has contracted with Molina Healthcare of Washington, Inc. (Molina) to manage and provide medical and chemical dependency services through Molina's provider network, with an initial requisite enrollment of 6,000 individuals in Snohomish County, though many people opted out of the program.

The focus of this project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early,

help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

Outpatient mental health services are provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

As with all health care, community based outpatient services are preferable when it comes to the diagnosis and treatment of health conditions. However, when acute situations arise or when outpatient services are unable to alleviate the presenting condition, inpatient hospital care often becomes a necessary and critical resource. Dental services are available to adult consumers.

It remains difficult to find dentists who accept medical coupons as payment and those that do, accept very limited numbers of new patients. The need to assess consumer's need for dental care is a requirement of the therapist in developing an individual service plan. Several RSNs contract with Sea Mar a federally qualified health clinic (FQHC) to provide mental health services, a few Sea Mar clinics have dental services available. Two RSNs are using flex funds for dental services for their clients.

Case Management services are required under RCW 71.24 and Washington Administrative Code 388-865-0230.

Co-occurring disorders for adults and youth were specifically addressed by the 2006 legislative session. Chapter 70.96 RCW requires that DSHS develop a plan for co-occurring mental health and substance abuse and by January 1, 2006 adopt a screening and assessment process for these individuals. The integrated process was implemented by all chemical dependency and mental health treatment providers as well as the designated mental health professionals and crisis responders on January 1, 2007.

Several RSNs support education, employment, co-occurring and transition age youth activities through their federal block grant funds.

Washington

36 - Adult – Estimate of Prevalence

Adult- An estimate of the incidence and prevalence in the State of serious mental illness among adults

Washington State has an estimated number of adults with serious mental illness (SMI) of 274,642 in FY2009 using guidelines in the Federal Register, Vol. 64, No. 121[1].

SMI estimates are derived from diagnoses and the Global Assessment of Functioning (GAF) scale. All diagnoses except substance abuse, development disorders, personality disorders, and dementia were used in the calculation. A GAF score of 60 or below was used as the functioning cutoff to determine SMI status. Total adults served as well as the Estimated SMI served were based on data from fiscal year 2009.

Total served in FY2009 included clients served by Pierce region which turned into Fee-For-Service beginning January 2009. However, the estimated SMI in FY2009 did not include Pierce region. This is because clients' functioning scores, a required data element to calculate SMI, were not available to DBHR for Pierce region clients. The estimated SMI served is likely an undercount.

Table 1: FY09 SMI Estimates for Adults (18 years or older)

Estimated SMI (FY2009)	Total Adults Served	Estimated SMI Served	Quantitative Target
274,642[1]	92,251	58,907	59,643

[1] Applies 5.4% prevelance rate to Washington State Populations estimates http://nri-inc.org/projects/SDICC/urs_forms.cfm,2008_SMI_SED.xls

Washington

37 - Adult - Quantitative Targets

Adult- Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

The following tables include the actual number of adults (18+ years) served in FY2009 as well as the projected number served in FY2010. This information is reported for adults with serious mental illness and for the total adult service population. Washington State is not restricted in serving only clients with serious mental illness, although, the majority of the Mental Health Division service population meets the Federal Register criteria for serious mental illness.

In reviewing this table, please remember that these numbers represent Washington's best estimate for quantitative targets. Any data in the Adult Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. The following table provides the number of adults served with Serious Mental Illness and the total number of adults served. Then, by using an estimate of the number of people in Washington State with Serious Mental Illness[1] and the total population, prevalence rates are reported for the State.

Projected service numbers are based on the most recent estimated population change data supplied by Washington State's Office for Financial Management (OFM) which are based on projections created from the most recent US Census.

Projected Service Rates				
Time Period	**FY09 Adults Served**		**FY10 Adults Projected**	
SMI Status	**SMI**	**Total**	**SMI**	**Total**
Adults Served	**58,907**	**92,251**	**59,643** assumes we continue to serve 21.4% of estimated SMI	**93,403** assumes we continue to serve 1.8%
WA Adult Population	**274,642**[2]	**5,085,973**	**278,074**[1]	**5,149,519**
Penetration Rate	**21.4% of adults with SMI are served by the Mental Health Division**	**1.8% of all adults in Washington State are served by the Mental Health Division**		

[2] Applies 5.4% prevelance rate to Washington State Populations estimates
http://nri-inc.org/projects/SDICC/urs_forms.cfm,2008_SMI_SED.xls

Washington

38 - Adult - Outreach to Homeless

Adult -Describe State's outreach to and services for individuals who are homeless

In the last five years, Mental Health Block Grant (MHBG) funds have been used to support several facilitated planning sessions in various parts of the state. In FFY 2008, the former Mental Health Division (MHD) made homelessness a priority for federal block grant funds. Common Ground, a well-established private, non-profit housing specialty agency conducted planning sessions for RSNs designated by the Projects for Assistance in Transition from Homelessness (PATH) state contact. RSNs were asked to invite substance abuse, housing, law enforcement and other allied providers to identify unmet housing needs for mentally ill people in their community and to plan to meet those needs.

Common Ground also was contracted with 2009 MHBG funds to conduct a facilitated planning session in Wahkiakum County, part of Timberlands RSN. Housing is limited, and the county is very small in population, though there is strong commitment to reach and house homeless individuals. The requirement of the RSN staff was to invite allied partners such as substance abuse, corrections, housing and others to participate in a session to identify needs, resources and goals for additional housing. Common Ground facilitated the session and assisted in development of strategies to achieve the goals.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in 2008 and 2009 and again in 2010. Support is intended to assist people from the mental health provider community to gain greater knowledge of housing issues and to have an opportunity to bring their knowledge to the conference. In the last three years, mental health providers and Department of Veterans Affairs (DVA) staff have made presentations about service to mentally ill individuals.

As a recipient of PATH grant funds and with previous SAMHSA technical assistance, Washington has, for the last four years, promoted SSI/SSDI Outreach Access and Recovery (SOAR) through a unique arrangement. The state Department of Veterans Affairs (DVA) has been contracted to conduct SOAR training which incorporates information about access to Veterans' benefits. Training informs participants about means to expedite access to benefits and how to improve the likelihood of approval of an application on first submission.

The Mental Health Transformation Project sent three peer counselors to SOAR training. They will, in turn, provide additional training in their local areas.

RSNs are required through general contractual provisions to provide jail coordination services.

Contract terms include:

- Coordinate with local law enforcement and jail personnel, including maintenance or development and execution of Memoranda of Understanding (MOU) with local, county and city jails in the RSN service area
- MOUs are expected to identify and implement a process for people who are incarcerated and diagnosed with a mental illness or who may be identified as in need of mental health services to be referred to the RSN or designee for service
- Jointly identify and provide transition services to individuals with mental illness intended to expedite and facilitate their return to the community
- Accept referrals for intake of people who are not enrolled in community mental health services but who meet priority population definitions at RCW 71.24
- Conduct mental health intake assessments for this group of people and, when indicated, provide transition services prior to their release from jail
- Develop and implement MOUs with local DSHS Community Service Offices (CSOs)
- Assist individuals in jail who have mental illness in completing and submitting applications for medical assistance (to support costs of mental health treatment) to the local CSO prior to release from jail

RSNs use federal block grant funds to provide homeless outreach, to support housing access and to support transitional housing, including services to young adults.

The Division is assisting in the creation of a new voucher program mandated by the Legislature in 2010 that revises the State's income and health insurance program, formerly General Assistance Unemployable (GAU) now to be called Disability Lifeline. The new housing voucher component will be jointly planned and administered by the Departments of Social and Health Services and Commerce and will be offered in lieu of most of the cash benefit for persons who are homeless and sufficiently disabled to be unable to work but not currently on federal disability benefits.

The belief is that the provision of housing will increase the likelihood clients will recover sufficiently to return to work and/or will stabilize their living situation during the time they are seeking federal disability coverage. Current estimates suggest that at least 40% of the persons who are homeless and on the Disability Lifeline have a mental illness diagnosis.

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Washington

39 - Adult - Rural Area Services

Adult -Describes how community-based services will be provided to individuals in rural areas

While 80% of Washington's population resides in the western half of the state, Washington has many rural areas within that geographic area and many more on the less populated eastern side of the state.

Transportation is one of the larger barriers to accessing services but so, too, is the limited availability of treatment. In addition factors such as a culture of intense privacy, lack of trust for government, and increased isolation pose barriers in rural areas, perhaps more so than in urban areas.

Some of the ways in which DBHR has addressed the need for rural outreach has been by setting travel standards for accessing services, supporting training activities on the specialized needs of consumers in these less populated areas, and participating in the rural mental health conferences. One tool available for increased access to rural consumers is the use of telemedicine sites for the provision of services. Across the rural areas of Washington, there are several sites that are using this technology to access psychiatrists and other specialists for their clients.

While Washington has made significant progress in services to rural consumers, more needs to be done. Specifically, DBHR wants to focus on:

- Increased education and training related to the special needs of this population and effect ways in which to engage them in treatment
- Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security Disability
- Continued participation in the Rural Mental Health Conferences
- Workforce development
- Stigma reduction
- Increased demands for measurable outcomes that demonstrate consistency across population densities and age span

The DBHR will track the implementation of HB 2072 which is intended to improve the coordination of special needs transportation throughout the state and particularly in rural areas. Below is a summary of that legislation.

There are approximately 623 organizations and agencies in Washington that provide some level of service to persons with special transportation needs. "Persons with special transportation needs" defines those individuals, including their personal attendants, who, because of physical or mental disability, income status, or age, are unable to transport themselves or to purchase transportation.

Special needs transportation services are provided by many different providers, including: public transportation systems; state-funded human service programs, most notably the Department of Social and Health Services (DSHS); civic and community-based groups; and private for-profit and non-profit entities. Within the state, there are 28 public transportation systems, of which seven serve urbanized areas, eight serve small cities, and 13 serve rural areas.

Established in 1998 and chaired by the Secretary of Transportation, or her designee, the Agency Council on Coordinated Transportation (ACCT) is a council of state agencies transportation providers, consumer advocates, and legislators, which was created to facilitate a statewide approach to coordinated special needs transportation and to develop community based coordinated transportation systems.

Under HB 2072 the role of the Agency Council on Coordinated Transportation (ACCT) is strengthened, and the ACCT is established as a statewide authority. The ACCT's new duties include:

- proposing statewide policies and objectives to the Legislature;
- establishing performance measures and objectives for evaluating the ACCT's progress in accomplishing its objectives;
- developing common service definitions, and uniform performance and cost-reporting systems;
- designating local coordinating coalitions in two pilot project regions; and
- progressing toward the goal of establishing a single clearinghouse for driver background checks in cooperation with the Department of Social and Health Services (DSHS) and the Washington State Patrol.

The ACCT is directed to appoint a local coordinated coalition (LCC) in two Medicaid brokerage regions, as defined by the DSHS. Membership on the LCCs includes several agency representatives as well as members of any existing local coordinating coalition. The purpose of an LCC is to advance local efforts to coordinate and maximize efficiencies in special needs transportation programs and services.

Transit agencies are directed to work collaboratively with the LCCs for the purpose of advancing the coordination of special needs transportation services. Improved accessibility for persons with special transportation needs is added as criteria for eligible Transportation Benefit District improvement projects. Applicants for special needs grants must include an explanation of how the funding will advance coordination of services. In making final special needs grants award decisions, the WSDOT must seek

input from the ACCT. In awarding other special needs transportation grants, the WSDOT must give priority to projects that result in improved coordination or increased efficiencies.

Frontier Communities Referenced in Budget Proviso Language

The 2010 Legislature included the following language in the state budget that recognizes issues related to service in more rural areas: In implementing the new public mental health managed care payment rates for fiscal year 2011, the department shall to the maximum extent possible within each regional support network's allowable rate range, establish rates so that there is no increase or decrease in the total state and federal funding that the regional support network would receive if it were to continue to be paid at its October 2009 through June 2010 rates. The department shall additionally revise the draft rates issued January 28, 2010, to more accurately reflect the lower practitioner productivity inherent in the delivery of services in extremely rural regions in which a majority of the population reside in frontier counties, as defined and designated by the national center for frontier communities.

Washington

40 - Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Many issues exist with the provision of mental health services to older adults. Public testimony provided to the system transformation group as part of their activities identified the following information:

- Older adults do not seek treatment, and they also often refuse treatment when it is offered.
- Residential services and adult family homes are noted as working well for older adults but there are inadequate resources. The mental health system requires increased partnerships with providers of long-term care services including skilled nursing facilities, adult family homes and boarding homes.
- Intake and outreach procedures are not specific to the needs of older adults.
- There is a need for increased communication between physical health care providers, mental health care providers and other services older adults may be utilizing.
- There is a need for more workforce development in the field of geriatric mental health.

Older adults are another priority identified by the Mental Health Planning and Advisory Committee for FFY11 federal block grant funding.

The Older Adults Treatment and Services subcommittee (OATS) of the Mental Health Planning and Advisory Council (MHPAC) envisions a system that encompasses cross-system coordination and prioritizes the development and implementation of policies, planning and evidence-based and promising practices that support the specialized needs of older adults. OATS sponsored a conference focusing on the mental health needs of older adults in September 2008. It was the first conference of this kind for many years.

In order to continue to address the mental health treatment needs of older adults, members of OATS are beginning a collaboration with Regional Support Networks, Home and Community Services, and the Area Agencies on Aging to develop regional events aimed at improving understanding and communication between the mental health system and residential providers.

Washington State is proud to be the founder of the Gatekeeper Program and continues to support this program. This program trains every day workers such as postal carriers

and meter readers to recognize signs of isolation, depression and other age-related changes in older adults, as well as co-occurring substance abuse issues. Additionally, the PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) are two evidence-based practices also developed within Washington State.

As the DBHR continues its work towards integrated behavioral health and primary care, there will likely be opportunities to encourage the implementation of all three of these programs. DBHR supports other integrated and cross-system partnerships in the RSNs such as Elder Services, Expanded Community Services, Luckett House and Hope Options serving the specialized needs of older adults.

Another innovative program is the Senior Services of Snohomish County. This program provides well-trained volunteers over age 55 to support residents age 60 and over in congregate care facilities or adult family homes. The program provides ongoing follow-up and small support groups around mental health issues.

In FFY 10, the RSNs used MHBG funds for older adults in the following manner:

- Geriatric crisis services providing specialized out-of-facility services to older adults not on Medicaid to assist them to live as independently as possible and thereby promote resiliency;
- Gatekeeper program;
- Increased access to community support service by case finding and referral;
- Depression screening for older adults (60+) using the Geriatric Depressions Scale;
- HOPE Options an in-home intervention and case management service to vulnerable seniors with mental illness whose housing and independent lifestyle has become unstable; and
- Geriatric outreach and mental health screening.

Washington

41 - Adult - Resources for Providers

Adult -Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Each Regional Support Network (RSN) is a county or group of counties with one exception, OptumHealth, a private for profit organization, was chosen to serve as the RSN for Pierce County through competitive procurement. Some counties within the RSNs have specific taxes dedicated to mental health. These are Clallam, Clark, Island, Jefferson, King, Okanogan, San Juan, Skagit, Snohomish, Spokane, Thurston, Wahkiakum and Whatcom. These tax dollars are outside of the scope of the public mental health system administered by the DBHR. They do use these tax dollars for specific mental health projects. Several RSNs contribute local funds as part of their matching dollars for their capitation Medicaid payment. There are currently 152 licensed Community Mental Health Agencies, most of which contract with RSNs. The community mental health providers also have available donation and other funds that they use for Non-Medicaid consumers.

The spreadsheet below displays the funds distributed by the DBHR. Totals are rounded. Funds cannot be separated by age.

RSN Estimated Revenues					
Fiscal Years 2010 and 2011					
	Fiscal Year 2010		**Fiscal Year 2011**		**2010 FBG**
RSN	Medicaid	Non Medicaid	Medicaid	Non Medicaid	
Chelan Douglas	6,529,528	2,539,819	6,264,786	2,539,819	108,865
Clark	23,049,482	8,767,111	25,427,770	8,767,111	423,288
Grays Harbor	5,724,499	1,428,522	6,035,268	1,428,522	70,748
Greater Columbia	41,211,974	12,873,223	42,561,102	12,873,223	669,757
King	100,682,761	40,009,096	103,952,428	40,009,096	1,880,150
North Central	15,983,652	3,735,700	14,950,310	3,735,700	216,633
North Sound	45,798,397	22,995,396	47,765,190	22,995,396	1,098,134
Peninsula	21,556,758	7,144,474	22,373,976	7,144,474	344,059
Pierce	40,649,304	17,696,259	43,773,318	17,696,259	803,669
Southwest	7,138,371	1,886,462	7,740,957	1,886,462	98,787
Spokane	39,493,137	10,967,662	38,987,713	10,967,662	458,013
Thurston Mason	14,847,241	6,912,326	15,477,000	6,912,326	300,952
Timberlands	7,112,510	1,992,807	7,472,983	1,992,807	100,384
Total	369,777,615	138,948,857	382,782,800	138,948,857	6,573,440

Note: Non-Medicaid revenue also includes funding related to Expanding Community Services (ECS), PALS, PACT, and Jail Services. Medicaid funding includes funding for b (3) services and Local Match Option. Medicaid FY11-13 budget is scheduled to be developed in October 2010 following the release of official forecasted eligibility numbers.

The Table above provides estimates of the amount of funding available through the state of Washington to each Regional Support Network (RSN) for State Fiscal Years 2010 and 2011 based upon funding distribution formulas. This table does not include MHBG funding, the distribution table which may be found in Adult–Grant Expenditure Manner. For the 2009–2011 biennium RSN state funds were cut 9% ($11.6 million). RSNs are required to prioritize remaining state funds on non-Medicaid crisis, inpatient, and residential services. It is anticipated that state general funds will again be cut next biennium, starting July 2011.
Many RSNs apply for grants, partnering with counties or other community agencies to increase their resource base. Additionally, the Community Mental Health Agencies with whom they contract may apply for grants, partner with non-profit organizations or conduct other activities in support of enhancing their fiscal resources.

Due to extreme budgetary pressures, funding for non-Medicaid consumers was cut by 9% during this biennium ($11.6 million). Many individuals still need mental health treatment and State-only dollars are now prioritized for non-Medicaid crisis, inpatient and residential services. As a result of this cut in funding, the number of individuals who are not Medicaid eligible receiving non-crisis outpatient services each month dropped by 13% during the latter half of 2009. Economic circumstances locally and nationally do not portend immediate improvement in these circumstances.

Washington State faces a significant shortage of community psychiatric inpatient beds. A recent study published by the Washington State Hospital Association identified there were 637 community psychiatric inpatient beds in the state in October 2008. This comes out to approximately 9.7 beds per 100,000 residents. Data from an American Hospital Association survey from 2006 identified that the national average was 25.2 community psychiatric inpatient beds per 100,000 residents, and at 9.7 beds, Washington's rate is one of the lowest, if not the lowest of any state.

From 2008 to 2010, Washington's unemployment rate doubled, going from 4.5% to 9.9% (Governor's Report). In that same period, 28,000 more people were provided income assistance by Economic Services Administration, a 23% increase. A 2005 study by Washington State Institute of Public Policy on adults served by the state's public mental health system found much lower employment rates for these clients. Clients who do work tend to work substantially fewer hours, have considerably lower total earnings, and work for far lower wages than adults in the general population.

Some counties among the RSNs have specific taxes dedicated to mental health as a result of legislative authorization. As of June 2010, thirteen counties have passed the 1/10th of 1% sales tax option and six additional counties are planning to implement the tax. The total 2009 calendar year distribution of levied tax dollars to participating counties was $67,822,762. Counties with this new tax are: Clallam, Clark, Island, Jefferson, King, Okanogan, San Juan, Skagit, Snohomish, Spokane, Thurston, Wahkiakum and Whatcom. In 2010 the state legislature expanded authority to levy this tax to cities.

The 1/10th of 1% tax dollars are outside of the scope of the public mental health system administered by the Division of Behavioral Health and Recovery (DBHR). RSNs use these tax dollars for specific mental health projects. Several RSNs contribute local funds as part of their matching dollars for their capitation Medicaid payment. The community mental health providers also have available donations and other funds that they use for non-Medicaid consumers.

Implementation of the tax was slower in eastern Washington, possibly owing to more conservative values and more challenging economic environments. However, four of the six counties still considering the tax are in eastern part of the State. The Counties working to pass the tax include Chelan, Douglas, Ferry, Stevens, Grays Harbor, and Lewis.

DBHR requires training at the provider level through its contracts with the RSNs. Additionally, DBHR offers many opportunities for expanding the provider skill base and workforce development. For example, this past year DBHR supported trainings at the provider level on varied topics as displayed below:

Co-Occurring Disorders	MHP training on Access to Care Standards
EBPs (Evidence Based Practices)	Club House Development
Youth 'n Action Model Training & Technical Assistance	Community Connectors (Parent to Parent) Annual Training Retreat
Parent Professional Partnerships & Parent Initiated Wraparound	Semi-annual Children's Long-Term Inpatient Parent Training & Support Weekend
Washington Dads – training for male caregivers, parents in advocacy, & parent to parent support	DBHR training to community hospitals regarding serving DD/MI populations
Fetal Alcohol Effect	Tribal Collaboration
Gay, Lesbian, Transgender & Bisexual	Children in Foster Care – Foster Parent
Safety for CMs and MHPs	Ethnic Minorities
Early Intervention & Prevention	Cross-system Crisis Planning
Crisis Intervention Training for Law Enforcement	WRAP (Wellness Recovery Action Plan)
Evidence Based Supported Employment & Permanent Supportive Housing	PACT training

This training is in addition to other activities described elsewhere in this plan.

Washington

42 - Adult - Emergency Service Provider Training

Adult -Provides for training of providers of emergency health services regarding mental health;

Many of the RSNs provide training to emergency room staff to help specifically identify individuals in need of mental health care and to coordinate care with designated mental health professionals to promote community diversion and avoid hospitalization. RSNs provide training to emergency room (ER) and emergency medical technician (EMT) staff on recognition of mental illnesses.

Through the collaborative effort of the Division of Behavioral Health and Recovery Services and the Division of Developmental Disabilities (DD), yet another example of training provided to emergency and health providers is the Community Hospital Mental Illness/Developmental Disabilities (MI/DD) Training. Together, the Divisions are creating a training targeted to the community hospitals that serve people with a dual diagnosis of mental illness and developmental disability on how to better understand, evaluate, triage, and treat this special population. Training is being provided to both ER staff as well as employees who would be providing inpatient treatment.

DBHR is committed to providing training to the state's emergency and health providers. As first responders, emergency and health providers being well trained and educated about people with mental illness and available services will only help move our state further toward Transformation.

RSNs partner with their local NAMI and law enforcement officials for the provision of the evidence based practice called Crisis Intervention Training (CIT).

As a community partnership between all law enforcement agencies, mental health providers, mental health advocacy groups, and consumers of mental health services and their families, communities which establish CIT programs do so with the following objectives in mind:

- Increase the feeling of safety in the general community
- Increase law enforcement officer safety
- Increase mental health consumer safety
- Better prepare police officers to handle crises involving people with mental illness
- Make the mental health system more understandable and accessible to law enforcement officers
- Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health treatment system
- Improve access to mental health treatment in general and crisis care specifically for people who are encountered by law enforcement
- Collaboratively, make the mental health system responsive to law enforcement to

the greatest extent possible with community resources
- Divert people with a mental illness who are in crisis from the criminal justice system whenever possible and
- Work collaboratively with court systems to reduce the incarceration rate of people with a serious mental illness who are in need of treatment

The CIT course is a weeklong, 40 hour training. The course emphasizes that CIT is a partnership between law enforcement, the mental health system, mental health advocacy groups, and consumers of mental health services and their families. As such, trainers include representatives of all identified stakeholders. The intensive training provides a common base of knowledge about mental illness; a basic foundation from which officers can build. The course is not aimed at making CIT officers mental health professionals; however, it is intended to provide officers with skills to:

- Recognize signs and symptoms of mental illness
- Recognize whether those signs and symptoms represent a crisis situation
- De-escalate mental illness crises
- Know where to take consumers in crisis
- Know appropriate steps in following up these crises such as: contacting case managers, other treatment providers, or providing referral information to mental health treatment agencies or advocacy organizations like the local NAMI chapter to consumers and family members.

The training emphasizes development of communication skills, practical experience and role playing. Also officers are exposed to mental health professionals, consumers and family members both in the classroom and in the field during site visits.

The week long course includes an overview of mental illness from multiple perspectives: Persons with mental illness; Family members of loved ones with mental illness; and Mental health professionals.

These perspectives are provided by individual consumer and family presentations or by panels of several consumers or family members. Substantive amounts of interaction between CIT officers in training and mental health consumers and their families make the core training session very effective as the officers learn the following:

- ✓ Specific signs and symptoms of serious mental disorders.
- ✓ The kinds of disturbed behavior officers may see in people in a mental illness crisis should be emphasized.
- ✓ The common problem of co-occurring disorders including co-occurring substance abuse and mental illness, along with co-occurring developmental disability and homelessness.
- ✓ The influence of culture and ethnicity on the topic of mental health and how it is dealt with inside those cultures and ethnicities specific to the ethnic make-up of

the particular community wherein the training is being provided.

Emergency service training that seems to be forgotten until it is needed is occurring in Washington State is for disaster preparedness. The state Mental Health Authority has the responsibility to respond to the behavioral needs of the citizens in times of a disaster. The DBHR has an appointed Mental Health Disaster Coordinator, and requires in the RSN contracts that they not only designate a coordinator but that they have a plan with their county authorities that outline their roles. These plans are reviewed by the DBHR.

DBHR has developed training materials for disaster mental health counseling based on the SAMHSA model of intervention. Materials include a Power Point presentation and appropriate hand outs. A training session was provided in 2008 to at least 25 individuals in order to test and evaluate the materials. DBHR has completed successfully a regular service program and has a list of trained volunteers to assist should another disaster occur.

Through FBG funds the DBHR coordinated with the Washington Department of Veterans' Affairs to produce a one-day training session for crisis responders and law enforcement personnel encountering crises with returning soldiers from Iraq and Afghanistan. Training participants included mental health workers, police, drug treatment counselors, tribal representatives and other community service personnel.

The workshops were developed in response to the serious challenges that face local communities as soldiers still dealing with war trauma return from the battlefield after prolonged and repeated deployments.

Washington

43 - Adult - Grant Expenditure Manner

In determining which initiatives would be funded this year, DBHR followed the list of federal guideline priorities coupled with priorities recommended by the state Mental Health Planning and Advisory Committee. Funding is distributed according to a method described later in this section. Funding for DBHR administered and RSN administered projects are guided by the following guidelines:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;
2. Work in tandem with the Division's Strategic Plan which has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";
3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family/youth voice;
4. Link well to other resources and Transformation activities;
5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and
6. Align well with other Division initiatives or legislatively mandated expectations.

The 2011 focus for block grant funding is:

- Consumer, advocate, and family voice driven and promoted activities
- Homeless population with mental illness (emphasis on children, youth and their
- families)
- Tribal supports that improve infrastructure and services to tribal communities
- MHPAC resources that ensure consumer participation continues to increase, ensuring state-wide diversity is represented
- Cultural competence is incorporated into RSN plans and activities

Of the roughly 8.4 million dollars awarded to Washington State, 5% or the grant limit is retained by DBHR for administrative costs. Eighty percent of the remaining 95% of funds is distributed to the RSNs for decisions about local use for various projects. Distribution of MHBG funds to RSNs is based on population distribution based on

projections of the most recent state year. The other 20% (approximately 1.4 million) is utilized by DBHR for selected activities.

A total of $6,664,429 will be distributed to RSNs in accordance with the table below, Total Federal Block Grant Distribution. Funding Awards, Based on Population Distribution.

Total Federal Block Grant Distribution		
Total Grant Award		$8,463,723
5% MHD Admin		$423,186
RSN's		$6,664,429
DBHR		$1,376,108

In the 2009-2011 biennium budget, the state legislature required a portion of Federal Block Grant funds to be used by the RSNs to offset State only cuts. Funds are calculated based on budget rounding methodology.

The process by which the RSNs receive funds for specific services through this grant is:

1. RSNs must submit plans that fall within the guiding principles and spending categories.
2. RSNs must submit a statement articulating how its proposed plan supports Transformation, Recovery, or Resiliency.
3. RSNs must submit evidence that their RSN Advisory Board was involved in the development or review of their plan.
4. The state Planning and Advisory Council and state program staff will assess each planned service and make recommendations as to whether it falls within the guiding principles, spending categories, and promotes services geared toward the promotion of Recovery and Resiliency or Transformation.
5. Feedback was provided to RSNs upon review of their proposals. Performance Indicators and Outcome Measures are required and serve as the basis of contract terms. At the end of the process, fully executed contracts that hold a greater focus on Recovery and Resiliency or Transformation will be in place by the start of the Federal Fiscal Year.

Examples of some of the RSN proposed uses for FFY 2011 MHBG funding include, but are not limited to:

- Continuing Education and Employment Services to consumers
- Homeless Outreach
- Outreach to Older Adults
- Consumer advocate positions
- Housing subsidies
- Resource Center for non-Medicaid Consumers
- EBP trainings (e.g.: DBT, Wrap-Around)
- Community based services to consumers in rural areas
- Cultural competency training
- Development of consumer-run programs/ businesses and drop-in centers
- Creation of new residential and hospital diversion resources
- Support to NAMI
- Expansion of co-occurring disorder treatment
- Tribal Youth Suicide prevention
- Stigma reduction
- Development of Clubhouses
- Provision of *Recovery* and *Resiliency* trainings
- Scholarships for consumers to attend workshops and conferences
- Peer support counselor training
- Crisis Intervention Training for law enforcement
- Consumer and family education
- Integrated medical and mental health screenings
- Transition Services re: drug/mental health court, and chemical dependency

Washington

44 - Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Goal 1: Funding will be used for NAMI education, training, community education and outreach. (MHTP funds and block grant funds)

Goal 2: Services will include consumer run activities, clubhouses, parent and youth support, Wraparound flex funds, peer support activities, Wellness Recovery Action Planning training (MHTP funds and block grant funds)

Goal 3 Efforts to address disparities will include activities for older adults, co-occurring disorders and a study of practice and consultation methods to assess what may need to be done further to improve service capacity.

Goal 4: Will provide for continued technical assistance and training support activities related to EBPs and promising practices across the lifespan.

Goal 5 Will continue to advance the use of teleconferencing and telemedicine in providing mental health services to under-served and hard-to-access consumers.

Goal 6 Integration of behavioral health and physical health will be furthered through training and planning activities to develop "person-centered health homes" in collaboration with the Medicaid Purchasing Administration, the Aging and Disability Services Administration, the Division of Developmental Disabilities and the Children's Administration. (MHTP and FBG Funds)

Goal 7 Establish pilot projects for at least three communities to maximize local resources, and develop coalitions to serve returning Veterans and National Guardsmen in their own communities. (MHTP and FBG funds)

Goal 8 Plan and develop a Tribal-Centric mental health delivery system to meet the mental health treatment needs of Washington's 29 tribes.

Table C. MHBG Funding for Transformation Activities

NOTE: The figures in this table are for projects conducted by Regional Support Networks (RSNs) only. The funds managed by Division of Behavioral Health and Recovery (DBHR) amount to $1,376,107. Proposals have been submitted but not yet approved for use. Categorization of projects into Transformation activities is not available at this time.	**Column 1**	**Column 2**	
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY2010.	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	X		$860,562
GOAL 2: Mental Health Care is Consumer and Family Driven	X		$3,039,992
GOAL 3: Disparities in Mental Health Services are Eliminated	X		$1,140,327
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	X		$781,954
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*****	X		$694,582
GOAL 6**:** Technology Is Used to Access Mental Health Care and Information			$0.00
Total MHBG Funds	*N/A*		$6,517,417

*****Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: *Excellent Mental Health Care is Delivered and Research is Accelerated*. CMHS is authorized to conduct evaluations of programs and not research.

Washington

45 - Adult - Goals, Targets and Action Plans

The following pages display goals, targets and action plans follow on the next pages.

#45 - Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	87,537	90,003	92,251	87,000	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

SAS Query of CIS for the period of 7/1/09-3/31/10: 82,748
Last year caseload grew 14.2% from March to June
Estimate 94,498 by year end. Expect will meet goal.

Table Descriptors:

Goal:	#1: Increase Access to Services for Adults with SMI
Target:	Adults served through the public mental health system: 87,000 Basic Tables 2A and 2B in the URS will provide breakout by Age, Gender, and Race/Ethnicity.
Population:	Adults with Serious Mental Illness-Note (criterion below is self populating for 3:Children's Services won't let input Criteria 1: Comprehensive Community–Based Mental Health Plan.)
Criterion:	2:Mental Health System Data Epidemiology 3:Children's Services
Indicator:	RSNs and DBHR will work to increase the number of adults served through the public mental health system, with focus given to special populations
Measure:	Number of persons served through public mental health system (No Numerator of Denominator required.)
Sources of Info	MHD-Consumer Information System (CIS).
Special Issues:	Starting in Calendar Year 2008, Pierce County discontinued operation as the Regional Support Network (RSN). Subsequently the region was converted to a fee for service program for Medicaid mental health services. Direct service provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data has been submitted to MHD in various forms and with variations in reporting requirements. The FY2008 Actual was most likely an over-count as some clients served by Pierce region in FFS setting may have also received services elsewhere in the state. We have no way to identify duplicate clients due to varied reporting requirements between Pierce FFS and the other RSNs.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.
Action Plan:	Support the growth of a culturally competent workforce by training those who serve the following special populations: Older Adults, American Indians, Alaska Natives and their communities, Ethnic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping consumers obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers and families served by multiple agencies.

Transformation Activities: Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds -30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	6.39	6.51	6.01	6.50	N/A
Numerator	643	631	600		
Denominator	10,065	9,697	9,984		

MH PI Query for CY2009: 6.5%
Expect will meet goal

Table Descriptors:

Goal:	#2: Decrease percentage of persons who are readmitted to an inpatient setting within 30 days of discharge
Target:	The percentage of adults readmitted to any inpatient setting within 30 days of discharge is 6.5%
Population:	Adults with Serious Mental Illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) will minimize the percentage of adults who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were then re-admitted to any of the inpatient settings within 30 days.
Measure:	Numerator: Number of persons readmitted to any inpatient setting within 30 days of discharge Denominator: Number of total discharges from any inpatient setting.
Sources of Info	MHD-Consumer Information System (CIS).
Special Issues:	Starting in Calendar Year 2008, Pierce County ceased to operate as the Regional Support Network (RSN). Instead the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce County service encounter data has been submitted to DBHR in various forms and variation in reporting requirements. The Actual percentage for FY2009 did not include Pierce region data due to variation in Pierce data reporting requirements
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4Decreasing returns to hospitals demonstrates increased community tenure which evidences recovery and adequate community supports.
Action Plan:	Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require, through contract, that people discharged from state hospitals are seen within seven days.

Transformation Activities: Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds -180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	22.88	17.93	23	18	N/A
Numerator	2,303	1,799			
Denominator	10,065	10,034			

MH PI Query currently not available

Table Descriptors:	#3: Decrease percentage of persons who are readmitted to an inpatient setting within 180 days of discharge.
Goal:	
Target:	The percentage of adults readmitted to any inpatient setting within 180 days of discharge – 18%
Population:	Adults with Serious Mental Illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) will minimize the percentage of adults who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were then readmitted to any of the inpatient settings within 180 days.
Measure:	Numerator: Number of persons readmitted to any inpatient setting within 180 days of discharge Denominator: Number of total discharges from any inpatient setting.
Sources of Info	MHD-Consumer Information System (CIS).
Special Issues:	Starting in Calendar Year 2008, Pierce County discontinued operations as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services. Direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data has been submitted to DBHR in various forms and variation in reporting requirements. The Actual percentage for FY2009 did not include Pierce region data due to variation in Pierce data reporting requirements.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4. Decreasing readmission to hospitals demonstrates increased ability to maintain community tenure which further evidences adequate community supports and increases the likelihood of recovery. Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days.
Action Plan:	

Name of Performance Indicator: Evidence Based -Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	7	7	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

Table Descriptors:

Goal:	#4: Increase the number of evidence-based practices received by adults.
Target:	The number of evidence-based practices provided to adult consumers are 7.
Population:	Adults
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) and DBHR will work to increase the number of adults receiving EBP treatment throughout the state.
Measure:	Number of EBPs delivered by the adult mental health throughout the state (no numerator or denominator required).
Sources of Info	The data has been acquired through a Provider Survey conducted by Washington Institute of Mental Health Research and Training (WIMHRT)
Special Issues:	There may be other EBPs provided to adult consumers in the State. However, the Provider Survey only focuses on the 7 adult EBPs per NOMs reporting requirements.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPS that are culturally competent. Oversee the implementation of six 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist training.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	2,618	3,419	1,822	2,618 Target 5,361 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	To increase the number of adults who receive supported housing services.
Target:	To increase the number of adults who receive supported housing services to 2,618.
Population:	Adult with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Increase the number of adults (18+) who receive supported housing services.
Measure:	Prior to FY2008: Number of adults (18+) who receive supported housing services. No numerator and denominator were required. FY2008 and forward: Numerator: Number of adults who receive supported housing services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	Provider survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).
Special Issues:	The number of clients reported represents only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.
Significance:	This is a required National Outcome Measure (NOM) under EBP. Goal supports New Freedom Commission (NFC) goals #3 and #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goals #3 and #5.
Action Plan:	Assist projects developed through the 2008 and 2009 Supportive Housing Institutes to become operating housing projects. Devise and implement non-capital supportive housing

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	1,872	1,974	895	1,872 Target 4,123Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal: To increase the number of clients who receive supported employment

Target: To increase the number of adults who receive supported employment to 1,872.

Population: Adult with serious mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of clients who receive supported employment
Prior to FY2008: Number of adults (18+) who receive supported employment services. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of adults who receive supported employment services. Denominator: Number of adults served by DBHR with SMI.

Sources of Info Provider survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: The number of clients reported represent only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.

Significance: This is a required National Outcome Measure (NOM) under EBP. Goal supports New Freedom Commission (NFC) goals #2, #3 and #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goals #2, #3 and #5.

Action Plan: Continue MIG-sponsored willing partner initiative to increase the number and effectiveness of EB supported employment programs and track performance.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	782	830	877	840 Target 2,454 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	#5: Increase the number of EBPs received by adults
Target:	To increase the number of clients who receive Assertive Community Treatment to: 840
Population:	Adults with Serious Mental Illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) and DBHR will work to increase the number of adults receiving EBP Treatment throughout the state. Prior to FY2008: Number of adults (18+) who receive ACT services. No numerator and denominator were required.
Measure:	FY2008 and forward: Numerator: Number of adults who receive ACT services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	This is new data being acquired through a Provider Survey conducted by Washington Institute for Mental Health research and Training (WIMHRT).
Special Issues:	The number of clients reported represent only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Health Goal supports Mental Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six (6) 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental

Health Specialist.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Family Psycho-education (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	5,976	13,410	2,005	2,000 Target 4,147 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	To increase the number of adults who receive Family Psycho-education.
Target:	The number of adults receiving Family Psycho-education is: 2,000.
Population:	Adults with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Increase the number of adults who receive Family Psycho-education
Measure:	Prior to FY2008: Number of adults (18+) who receive Family Psycho-education services. No numerator and denominator were required. FY2008 and forward: Numerator: Number of adults who receive Family Psycho-education services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)
Special Issues:	The FY2008 actual client count was most likely an over-count due to some provider agencies reporting unusually large number of clients. In the 2009 Actual count, we are excluding responses considered unreliable. The number of clients reported represents only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation

of six 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist training.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	3,045	2,704	3,049	3,000 Target 7,457 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	To incase the number of adults who receive co-occurring disorders treatment
Target:	The number of adults who receive co-occurring disorders treatment is: 3,000
Population:	Adults with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Number of adults who receive co-occurring disorders treatment Prior to FY2008: Number of adults (18+) who receive Co-occurring treatment services. No numerator and denominator were required.
Measure:	FY2008 and forward: Numerator: Number of adults who receive Co-occurring treatment services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)
Special Issues:	The number of clients reported represent only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist training.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	1,044	325	4,538	1,050 Target 7,089 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	To increase the number of adults who receive illness self-management services
Target:	The number of adults who receive illness self-management services: 1,050
Population:	Adults with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Increase the number of adults who receive illness self-management services.
Measure:	Prior to FY2008: Number of adults (18+) who receive Illness Self-management services. No numerator and denominator were required. FY2008 and forward: Numerator: Number of adults who receive Illness Self-management services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	Provider survey conducted by Washington Institute for Mental Health Research Training (WIMHRT)
Special Issues:	The 2010 target is set to be below the FY2009 Actual count due to data collection problems in the provider survey as noted in the Supported Housing indicator. The number of clients reported represents only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist training.

Transformation Activities: Name of Performance Indicator: Evidence Based -Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	18,180	16,566	13,818	14,000 Target 8,056 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	To increase number of adults who receive medication management services
Target:	The number of adults receiving medication management services is: 14,000
Population:	Adults with serious mental illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Increase the number of clients who receive medication management services
Measure:	Prior to FY2008: Number of adults (18+) who receive Medication Management services. No numerator and denominator were required. FY2008 and forward: Numerator: Number of adults who receive Medication Management services. Denominator: Number of adults served by DBHR with SMI.
Sources of Info	Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)
Special Issues:	The number of clients reported represents only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the state. Counts of the number of clients who receive supported housing services are provided by provider agency self-report through a survey. There is some question about whether the counts of clients who receive each EBP are over-counts. The client count is highly influenced by the response rate of the Provider survey each year. There is no way to un-duplicate client counts across providers.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist training.

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	57.74	59.81	61.69	63 Target 61.5 Actual	N/A
Numerator	821	769	871	786	
Denominator	1,422	1,287	1,412	1,279	

We will fall slightly short of goal

Table Descriptors:

Goal:	#6: Improve client perception of care.
Target:	To increase the percentage of adults who report achieving positive outcomes on the MHSIP Survey: 63%.
Population:	Adults with Serious Mental Illness
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) will work to improve client perception of care as evidenced by the number of adults surveyed who agree with the items on the MHSIP regarding their perception of positive outcomes.
Measure:	Numerator: Number of persons who responded that they agreed or strongly agreed to the positive outcomes scale on the MHSIP survey. Denominator: Number of total MHSIP respondents.
Sources of Info	The MHSIP survey conducted by Washington Institute for Mental Health research and Training (WIMHRT).
Special Issues:	In the past, WA has measured perception of care using a different scale on the MHSIP. Additionally, WA only conducted the Adult MHSIP every other year, with the off years being used to conduct youth surveys. Beginning with FY2007 application, however, the MHSIP has been conducted on a yearly basis for both populations, per SAMHSA requirements re: yearly reporting on this NOM.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4
Action Plan:	Continue to support training across spectrum of administrators, providers, and consumer/family members related to articulated consumer/family voice. In particular, Recovery, Consumer Driven service system, and culturally competent care initiatives will be emphasized. Ombuds training also will be supported.

Name of Performance Indicator: Adult -Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	11.57	11.73	10.05	11.60	N/A
Numerator	7,393	7,247	5,837		
Denominator	63,921	61,787	58,056		

SAS Query of CIS for the period of 7/1/09-3/31/10: 8.8% employment rate
Last year employment rate through 3/31/09 was 10.13% (comparable to what was reported at year-end)
Expectation that we will fall far short of our goal. Perhaps due to the "jobless economic recovery".

Table Descriptors:	
Goal:	Increase the number of persons who are engaged in employment related activities.
Target:	The percentage of adults who are employed is: 11.6%.
Population:	Adults
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems
Indicator:	Regional Support Networks (RSNs) will increase the percentage of adult outpatient recipients between 18 and 64 years of age who were engaged in employment at any time during the fiscal year.
Measure:	Numerator: Number of adults (18-64) who were employed either part-time or full-time, in supported employment at any time in the fiscal year. Denominator: Number of total adults who received MH services in the FY and whose employment status is available.
Sources of Info	MHD-Consumer Information Systems (CIS).
Special Issues:	WA has lost funding through Division of Vocational Rehabilitation for support of Club Houses; however, DBHR is seeking legislative funding to reinstate support of this pre-vocational program. The FY2009 Actual percentage does not include clients served in Pierce region. Employment data used to calculate this indicator is not available due to variation in Pierce region FFS reporting requirements.
Significance:	This is a recommended National Outcome Measure (NOM), in process of becoming required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4 Continue to support training of certified peer counselors. Support efforts to train administrators and providers on value/ways of employing certified peer counselors. Support programs designed to facilitate return to school and competitive employment for consumers.
Action Plan:	

Transformation Activities: Name of Performance Indicator: Adult -Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	60.75%	72.36%	75.59%	74% Target 73.86% Actual	N/A
Numerator	65	89	96	65	
Denominator	107	123	127	88	

Met Goal

Table Descriptors:

Goal:	Decrease the number of persons who have had criminal justice system involvement including arrest and incarcerations
Target:	To increase the percent of adult consumers arrested in T1 who were not rearrested in T2 to: 72%
Population:	Adults
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	The percentage of adults who have had involvement with criminal justice system in the fiscal year
Measure:	Prior to 2007: Numerator: Number of adults who were arrested, convicted, or adjudicated in the fiscal year. Denominator: Number of total adults served by the DBHR in the FY. For FY2008 and forward: Numerator: From the MHSIP survey the number of adult consumers who reported NOT being arrested in the FY. Denominator: Number of adults who responded to the MHSIP survey not being arrested in previous year.
Sources of Info	Prior to 2007: Merge the DBHR data with the State's arrest and conviction data. FY2007 forward: Adult MHSIP survey conducted by Washington Institute for Mental Health Research and Training
Special Issues:	Prior to 2007: DBHR was not been able to obtain timely data due to system limitations. This is no longer an issue with the MHSIP survey beginning in 2007.
Significance:	This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MH PAC) Goal # 4.
Action Plan:	Continue to support training of Law Enforcement in EBP of Crisis Intervention Training (CIT). Continue to support persons served in Mentally Ill Offender program. Continue to require, through the State Mental Health contract, provision of Jail Transition Services required by 2006 legislative budget proviso, including assistance with applications to Medicaid support. Assess ability to improve more timely data

collection for this NOM. This data will be collected on the MHSIP Survey or on an annual basis using the questions and methodology proposed by SAMHSA.

Name of Performance Indicator: Adult -Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	90.65%	92.54%	92.27%	92.6%	N/A
Numerator	50,305	64,080	61,946		
Denominator	55,491	69,242	67,135		

SAS Query of CIS for the period of 7/1/09-3/31/10: 92.4% housing stability
Last year housing stability rate through 3/31/09 was 93.0% (a little more than what was reported at year-end)
Expect we will come close to meeting our goal.

Table Descriptors:

Goal:	Increase/Maintain family stability as evidenced by adults maintaining housing.
Target:	The percentage of adults (18+) who were homeless/living in shelter in the fiscal year is 7.4%
Population:	Adults
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Percentage of adults (18+) who were homeless or living in shelter in the fiscal year
Measure:	Prior to FY2008: Numerator: number of adults who maintained housing in the FY. Denominator: Number of total adults receiving outpatient services and who had more than one living situation recorded in the fiscal year. Starting in FY2008: Numerator: Number of adults (18+) who were homeless/living in shelter in the fiscal year Denominator: Number of total adults receiving outpatient services and whose living situation status was available in the fiscal year
Sources of Info	MHD's Consumer Information System (CIS)
Special Issues:	Stable housing continues to be a real and serious challenge for WA; however, DBHR remains committed to encouraging growth of appropriate residential resources and supports through the RSNs. FY2009 Actual percentage did not include Pierce region data. Pierce region living situation data is not available due to variation in reporting requirements. See notes about Pierce County in "Increase Access to Services" indicator
Significance:	Goal supports New Freedom Commission (NFC) goal #3. Continue to support
Action Plan:	development residential resources and encourage the development of safe, affordable housing. Continue to support mental illness education, stigma reduction, recovery,

resiliency, employment and other factors that lead to stable housing. Continue to require and further encourage development of cross-system collaboration efforts for families served by multiple agencies within DSHS and the community.

Transformation Activities: Name of Performance Indicator: Adult -Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	62.2%	63.1%	64.1%	64% Target 65.4% Actual	N/A
Numerator	889	842	944	871	
Denominator	1,429	1,334	1,473	1,332	

Will exceed goal

Table Descriptors:

Goal: Increase the number of social and natural supports reported by consumers.

Target: The percentage of adult consumers who report they are socially connected is 64%.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: RSNs will work to assist adult consumers in increasing their social and natural supports.

Measure: Numerator: Number of adults who responded Agree and Strongly Agree to the MHSIP Social Connectedness scale in the FY.
Denominator: Number of total adults who responded to the MHSIP survey in a fiscal year.

Sources of Info Beginning in 2007, DBHR is using the MHSIP survey for this indicator.

Special Issues: N/A

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) Goals #1 and #5. Goal supports Mental Health Planning and Advisory (MH PAC) Goals 3! And #5. Having a meaningful relationship is a necessary part of increasing the likelihood of recovery.

Action Plan: Continue to support drop-in centers, consumer and family advocacy/self-help, social activities, pre-vocational skill building, and development of ICCD Club Houses through trainings across the spectrum of administrator, providers, consumers and family members. Continue to require, through contract, that consumers are informed of their right to have and are encouraged to have family and friends involved in their Recovery and treatment. Continue to support Tribal activities that enhance that community's whole-wellness. Support mental illness education and stigma reduction activities.

Name of Performance Indicator: Adult -Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	61.68	65.0	64.5	65 Target 64.6 Actual	N/A
Numerator	874	858	943	855	
Denominator	1,417	1,320	1,462	1,323	

Will meet goal

Table Descriptors:

Goal: : Improve level of functioning.

Target: The percentage of adult consumers who report positively on the functioning scale of the MHSIP survey is 65%.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase the number of adults and older adults who report improved level of functioning over a fiscal year.

Measure: Numerator: Number of adults who responded Agree and Strongly Agree with the MHSIP Functioning scale. Denominator: Number of total adults who responded to the MHSIP survey in a fiscal year.

Sources of Info Adult MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT). The functioning scale consists of 6 items

Special Issues: N/A

Significance: This is a recommended National Outcome Measure (NOM) expected to become a required.
Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health
Planning and Advisory (MHPAC) Goal #5. Being involved in meaningful activities is a necessary part of increasing potential for recovery.

Action Plan: Continue to support quality improvement as it relates to services for adult consumers since symptom reduction and involvement in meaningful activities are conversely related. Support consumer participation in activities that enhance creativity, spirituality, education, employment and social inter-action.

Washington

46 - Child - Establishment of System of Care

Child – Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness

This is a joint response. Please see Adult – Establishment of System of Care

It is important to note increased attention to children's mental health and the passage of the Children's Mental Health Act. Provisions of that act provide for pilot Wraparound projects and emphasize the implementation of Evidence Based and Promising Practices that will lead to an enhanced service package for children, youth and their families.

In the last two years, the former Mental Health Division has undergone dramatic organizational change. Much of this involved some attrition and staff reduction in force, resulting in fewer staff to maintain service and quality levels. Last year consolidation of mental health and substance abuse divisions under the Health and Recovery Services administration (HRSA) capitalized on shared staffing and increasingly, mental health staffing, particularly RSN contracts and oversight was moved to the health care services division of HRSA.

This year Medicaid functions of HRSA have combined with Health Care Authority and formed a Medicaid Purchasing Administration. Mental health and substance abuse division functions, which were combined last year, have been transferred to the Aging and Disability Services Administration (ADSA). Despite general effects of change, staff have maintained their commitment to service standards and quality contract management.

Annual meetings with children's mental health stakeholders and quarterly meetings with RSN Children's Care Coordinators with their family representatives have been fruitful towards improved communication and discussion of systems of care as upheld in each community. Washington has been the grateful recipient of 5 System of Care (SOC) grants and has been studying the prospect of applying for a statewide SOC grant. In the meantime, a shared commitment to integration is achieving traction, particularly in some areas that have a strong role to play in the regional mental health system.

RSN contract language has been strengthened related to Early Periodic Screening Diagnosis and Treatment (EPSDT) and coordination of care. Increasing numbers of staff and families have been supported to attend the Georgetown System of Care Training Institutes.

Leadership has gained an appreciation of system of care practices as they relate to the implementation of “person-centered health comes” which has a primary care foundation, but for which chemical dependency and mental health liaison activities are recommended. Similarly, collaboration around foster children with mental health needs is facilitated by the new “Fostering Well Being” program.

Washington

47 - Child - Available Services

Child -Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Among the services available in Washington are:

- Health, mental health, and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Medical and dental services;
- Support services;
- Services provided by local school systems under the Individuals with Disabilities Education Act;
- Case management services;
- Services for people with co-occurring (substance abuse/mental health) disorders;
- Other activities leading to reduction of hospitalization.

For all services covered by the Washington State Plan, see:

http://maa.dshs.wa.gov/medicaidsp/Table%20of%20Contents.html

Mental Health services available to children and youth consumers include the full scope of Medicaid Rehabilitative services as described in the State Plan services which include:

Brief Intervention Treatment; Crisis services; Day Support; Family treatment; Freestanding Evaluation and Treatment; Group services; High Intensity Treatment; Individual Treatment Services; Intake evaluation;	Medication Management; Medication Monitoring; MH Svcs. provided in Residential settings; Peer Support; Psychological Assessment; Rehabilitation Case Management; Special population evaluation; Stabilization Services; and, Therapeutic psycho-education.

The following EBPs are available in various communities across the state and offer

support, social supports, and diversion from hospital or Division of Behavioral Health and Recover (Mental Health) Children's Administration (CA), Juvenile Rehabilitation Administration (JRA) and others.

- Multidimensional Treatment Foster Care (MTFC)
- Trauma Focused Cognitive Behavioral Therapy (TFCBT) –
- Multi-systemic Treatment (MST) 4 supported sites
- Family Integrated Transitions (FIT)
- Functional Family Therapy (FFT)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT)
- Aggression Replacement Therapy (ART))
- Multi-Family Group Family Psycho-education (MFG)
- Incredible Years.
- Triple P.
- Nurse Family Partnerships
- Promoting First Relationships
- Homebuilders
- Structured Behavioral Therapy

The Mental Health Division was a division of the Health and Recovery Services Administration (HRSA) between 2005 and May 2010. For the last year it has been operating as one division with Chemical Dependency and Substance Abuse, as the Division of Behavioral Health and Recovery. A recent realignment of DSHS has put DBHR under the umbrella of another DSHS Administration, Aging and Disability Services Administration.

Children and youth who are Medicaid enrollees are eligible under federal guidelines for mental health services upon referral from their primary care physician. Children and youth who first come to the attention of the community mental health system are referred for a health care screening if they have not had one recently. This promotes a coordinated system of care among primary health care, mental health, substance abuse, dental, hearing, and vision services. Through contract language and contract oversight DBHR upholds the requirements of Diagnosis and Treatment (EPSDT).

State law RCW 70.96 requires co-occurring services for youth, as described in the Adult portion of this plan. The law requires screening and assessment (GAIN SS) to identify the most common types of co-occurring disorders. All direct service social workers in child serving systems of DSHS are required to conduct screening as part of intake and, in preparation for that, have been trained in techniques adapted for application with youth.

Children and youth have the comparable services available to them as are available to adults and older adults, for example crisis, involuntary treatment, case management, community outpatient and inpatient services. In addition, RSNs provide many

coordinate services to support resiliency and transformation through use of federal block grant allocated to them. Among the uses are:

- Tribal youth suicide prevention
- Peer support
- NAMI family to family training
- Suicide prevention training
- Wrap-around services training
- Parent Partner activities
- Psychiatric evaluation and medication management for SED youth not covered by Medicaid
- Children's crisis outreach and diversion services
- Mental Health specialist consultation
- Parent and caregiver education
- Under-insured school age children counseling services
- Child mental health specialist training
- Day support programs in schools
- Statewide non-profit parent run organizations
- Non-affiliated parent support organizations, including one for fathers (WADADS)
- Specialized EBP implementation for a tribal community

Community partnerships among law enforcement agencies, mental health providers, mental health advocacy groups and consumers of mental health services and their families have provided for the existence of crisis intervention training, which has the following objectives:

- Better prepare law enforcement officers to handle crisis involving people who have a mental illness
- Increase the feeling of safety in the general community
- Increase mental health consumer safety
- Increase law enforcement officer safety
- Make the mental health system more understandable and accessible to law enforcement officers
- Supply officers with the resources to refer properly people in need of care to mental health services
- Improve responsiveness of mental health system personnel to law enforcement officers
- Divert people who have a mental illness who are in crisis from the criminal justice system and into the mental health system

This week long course includes an overview of mental illness from multiple perspectives, including those of people who have mental illness, family members, and mental health professionals. A number of parents of youth in treatment and in transition

have become involved with crisis intervention training and have had a positive effect in educating others and helping them understand the needs of youth who are seriously emotionally disturbed.

RSNs offer various federal block grant programs (not-statewide)
Regional Support Networks submitted their proposals for block grant funding which will be directed in part to children's programs.

The following programs are examples:

- ~ Workshop course taught by family members of adolescents with mental illness to other like family members
- ~ Single Parent Support Group
- ~ Teen Talk – a youth suicide telephone prevention program
- ~ Tribal youth suicide and dropout prevention and school based curriculum on early intervention
- ~ Manuals for children and youth in mental health services "Navigating Life"
- ~ Trainings for law enforcement agencies on Crisis Intervention with Mentally Ill Children,
- ~ Crisis services expansion, stabilization, follow up expansion and Wraparound
- ~ In-school and in-home outreach
- ~ Support for clinicians to obtain "Child Mental Health Specialist" (Washington distinction)
- ~ Increase in evidence-based practices for foster children, (e.g. Parent Child Interactive Therapy).
- ~ Evidence-based practice training
- ~ Support of existing parent support services.
- ~ Parent partner trainings.
- ~ Juvenile justice support and transitions
- ~ Support of new parenting network providing advocacy resources and support for families

Other regional (RSN) projects include:

- ~ Wellness Project – for families' and children who don't have insurance a free clinic which screens for mental health, and developmental disabilities issues and provides referrals to local social service providers
- ~ RSN contracted provider " Adolescents for Change" group has tripled in size evidencing successful youth/family partnering
- ~ Local "shared resources meetings" that partners with Child Welfare, Schools, Juvenile Justice, Parent Advocacy, Developmental disabilities , etc. to address children and youth involved in multiple systems and referrals for children's long term inpatient program requests; and shared trainings;
- ~ Implementation of new support models for children and caregivers.

- Expansion of Wraparound,
- Increased availability of EBPs,
- Financing of new family support organizations
- Wellness Recovery Action Plan training for transition aged youth.
- Drafting of proposed legislation to support parent empowerment re IEPs
- New programs for infant mental health and training initiatives
- Navigating Systems training for families and collaborative problem solving class
- New Youth Inpatient Evaluation and Treatment Center for 12-18 for voluntary and involuntary youth
- Redesigned Children's Hospitalization Alternative Program
- SAMHSA System of Care Grant
- WA Dads expansion,
- Innovative use of new Tax money
- Information sharing Guide for child serving systems
- School-based Wraparound initiated

Washington

48 - Child - Estimate of Prevalence

Child -An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

The Division of Behavioral Health and Recovery (DBHR) used guidelines in the in the Federal Register, Vol. 64, No. 121[3] and recommendations from a 2003 report to Washington State Legislature[4] to estimate the number of children in our service populations who have SED diagnoses. A CGAS score of 60 or below was used as the functioning cutoff to determine SED status.

Total children served as well as the Estimated SED served were based on data from fiscal year 2009. Please note that total served in FY2009 included clients served by Pierce region which turned into Fee-For-Service beginning January 2009. However, the estimated SED in FY2009 did not include Pierce region. This is because clients' functioning scores, a required data element to calculate SED, for Pierce region clients were not available to DBHR due to variation in Pierce FFS reporting requirements. The estimated SED served is likely an undercount.

Table 2: SED Estimates for Children (0 to 17 years of age)

Estimated SED (FY2009)	Total Children Served	Estimated SED Served	Quantitative Target
110,755-158,222	**36,367**	**24,319**	**36,436**

[3] As operationalize by the National Association of State Mental Health Directors Research Institute (NASMHDRI) (http://nri-inc.org/projects/SDICC/urs_forms.cfm.). NASMHDRI established 10% as a point estimate of children aged 9-17 in Washington State with SED (CGAS<=60). No estimate is provided for children 0-8 years of age.

[4] http://www.spokanecounty.org/MentalHealth/Data/Gain-Adult/Additional%20Resources/2003Prevalence.pdf) suggested the use of a 7% prevalence rate for children 0-17 yrs.

Washington

49 - Child - Quantitative Targets

Child—Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The following tables include the actual number of children and youth ages 0-17 served in FY 2009 as well as the projected number served in FY 2010. This information is reported for children and youth with serious emotional disorders (SED) and for the total child-youth service population. Washington State is not restricted to serving only clients with serious mental illness, although the majority of the Mental Health Division service population meets Federal Register criteria for serious emotional disturbance.

Estimates of the total number of children in Washington State with SED were derived from guidelines set forth in the Federal Register, Vol. 64, No. 121[5] and recommendations from a 2003 report to Washington State Legislature[6].

Please note that the total served in FY 2009 and projected clients served in FY 2010 did not include clients served in Pierce County, which operated as a Fee for Service (FFS) area beginning January 2008 through June 2009. Note also that SED estimates in both fiscal years did not include Pierce County clients. This is because functioning scores, a required data element to calculate SED were not available to DBHR for Pierce County, due to FFS payment mechanisms.

The following table provides the number of children served with SED and the total number of children served. Then, by using an estimate of the number of people in Washington with SED and the total population, prevalence rates are reported for the state. In reviewing this table, it should be remembered that these numbers represent Washington's best estimate of quantitative targets. Any data in the Child plan represents our best estimates, based on available data and reflects the limitations of our reporting and information systems.

[5] As operationalized by the National Association of State Mental Health Directors Research Institute (NASMHDRI) (http://nri-inc.org/projects/SDICC/urs_forms.cfm.). NASMHDRI established 10% as a point estimate of children aged 9-17 in Washington State with SED (CGAS<=60). No estimate is provided for children 0-8 years of age.

[6] http://www.spokanecounty.org/MentalHealth/Data/Gain-Adult/Additional%20Resources/2003Prevalence.pdf) suggested the use of a 7% prevalence rate for children 0-17 yrs.

Projected Penetration Rates				
Time Period	**FY09 Served**		**FY10 Projected**	
SMI Status	**SED**	**Total**	**SED**	**Total**
Children Served	**24,319**	**36,367**	**24,365** Assumes 67% of youth served have SED	**36,436** assumes we continue to serve 2.3% of youth population
WA Child/Youth Population	**110,755-158,222**	**1,582,227**	**110,965-158,522**	**1,585,226**
Penetration Rate	**15.4%-22%**	**2.3% of all children/youth in Washington State are served by the DBHR**	**15.4%-22%**	

Washington

50 - Child - Systems of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services.

Public mental health services are provided to children and youth under the same Regional Support Network (RSN) managed care system as the adults. Each RSN is required to hold Memorandum of Understanding with the allied systems of care related to children and youth in their regions. Emphasis is given to the expectation that services for children will be well coordinated on every level.

Managed behavioral health services for children and youth are integrated throughout the mental health system and allied systems of care plans. Providers are required to include care coordination through allied system treatment system planning for children and youth served by multiple systems such as: such as substance abuse, developmental disabilities, juvenile corrections, child welfare, Medicaid-funded healthcare, and the schools. The RSNs and their providers utilize child and family teams to coordinate care individual service plans. These teams are also utilized to provide discharge planning for children who are in inpatient settings and juvenile detention centers.

A growing number of children and youth and their families are receiving Wrap-Around services. Family engagement is facilitated by growing numbers of parent peer partners, some of whom are certified by that state as peer counselors.

The needs of all children and families are complex and ever changing. Over the years, many specialized systems including juvenile justice, child welfare, substance abuse, special education and mental health have evolved in an effort to respond to complex behavioral health needs by implementing corresponding evidence-based practices.

The DBHR with its partners are increasingly involved in efforts to coordinate special programs, fiscal efficiencies and case management structures that focus on cross-system coordination and streamlined service access. The healthcare providers (primary care provider) is seen as central in a system that addresses comprehensive needs and coordinates referrals. The primary health integration program (Fostering Well Being) is a recent program bringing all health care for foster children under the management of the Medicaid Authority.

Housing and residential needs persist across all ages and all ethnicities. While it is preferable to serve children in their homes within the structure of their natural supports, children at times require the specialized care of inpatient services at the State Hospital's Child Study and Treatment Center (CSTC) or one of the other Children's Long-term

Inpatient Program's (CLIP) residential facilities. Screening and referral protocols are in place for these services to improve access.

In addition to the services funded by DBHR and other state agencies for the provision of system-wide services to children, the DBHR funds mental health parent programs such as the Community Connector project which provides an essential link for parent support in the continuum of care that is often overlooked by formal systems. Parents have developed ways to survive the day to day stresses of caring for special needs child/youth. The Community Connectors and its parent network assist other parents who find themselves in a similar situation.

Many efforts have been made to improve the continuum of services to children across all social and health service. Implementation continues to focus on workforce development. By supporting specialized training and certification for clinicians, significant workforce enhancement can be achieved without disruption to usual funding levels and service priorities.

The DBHR and the Mental Health Transformation worked with the Office of the Superintendent of Schools (OSPI) to develop and conduct statewide train- the- trainer sessions focusing on public education and publicly funded community mental health service coordination. Individual service plans (WAC 388-865-0435) for children and youth require coordination with a child's IEP whenever it is possible and feasible. For children under three there is a requirement to that the plan must be integrated with the individual family service plan, if it exists.

The individual service plan is required to address all life domains and plan accordingly. Life domains include:

- Housing;
- Food;
- Income;
- Health and dental;
- Transportation;
- Work, school or other daily activities;
- Social life; and,
- Referral services as appropriate to treatment such as substance abuse.

RSNs provide training to emergency room staff to help specifically identify mental health issues and to coordinate care with designated mental health professionals for community diversion for all ages. They employ children mental health specialists as part of their crisis teams and also as part of their training staff when working with emergency rooms and emergency medical technicians.

A specific training for Children's Mental Health Specialists with an improved curriculum was provided in September, 2009 by the Washington Institute for Mental Health Research and Training (WIMHRT) and co-facilitated by mental health employees.

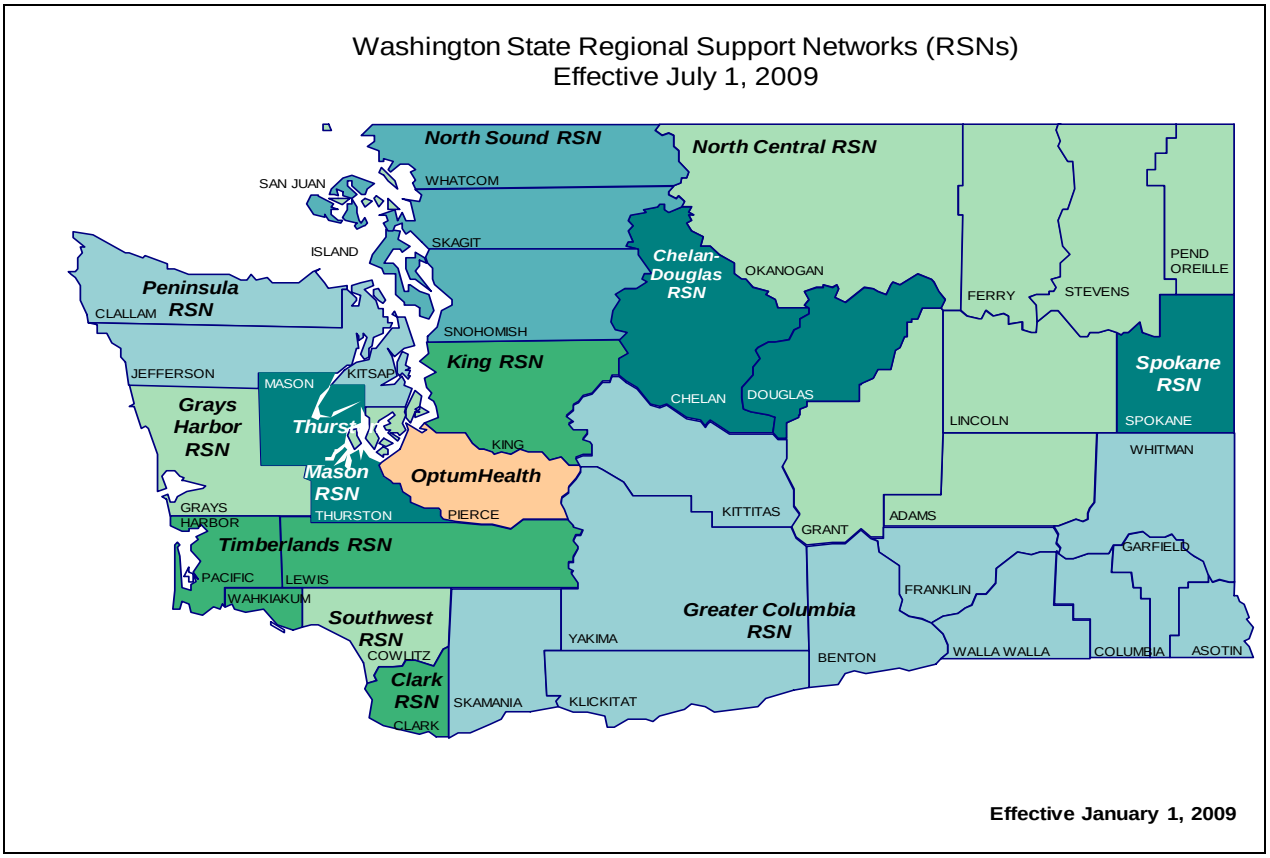
DBHR is supportive of System of Care approaches and is sending 3 staff and 8 parents and youth to the Georgetown Training Institutes this summer. These individuals will be required to provide in-service demonstrating lessons learned and ideas for application within Washington State.

Washington

51 - Child - Geographic Area Definition

Child -Establishes defined geographic area for the provision of the services of such system.

Services are provided to children through the same Regional Support Network (RSN) structure as that for adults. The map below reflects the current catchment areas for each RSN.



RSN boundaries remain the same. Due to a change in contractual arrangements, as of July 2009, OptumHealth functions as the Regional Support Network (RSN) - Prepaid Inpatient Health Plan (PIHP) in Pierce County.

Washington

52 - Child - Outreach to Homeless

Child -Describe State's outreach to and services for individuals who are homeless

As this plan is mainly a combined plan for adults and children, the description provided in the adult section of this plan also addresses Homeless issues for children, youth and their families. DBHR did, however, note a small number of homeless youth and their families being served by the mental health system and made this a priority for federal block grant for 2010 This brought attention to the need for RSNs to consider this population when planning use for their funds. As such, some RSNs are targeting funds to children, youth and their families with the intent of increasing the number served. Peninsula RSN, for example, is funding a transitional supported living program for youth and young adults.

Transition age youth with mental and emotional health needs face additional barriers in finding a place to rent. Beginning in June of this year a consumer group of youth and adults has been contracted through DBHR to provide 2 “train the trainer trainings” for transition age youth to become trainers in an adapted “Ready to Rent” model. These youth and their adult mentors will be part of existing youth serving agencies in eastern and western Washington (one each). Through this contract the mentors and the youth trainers will be provided consultation and support to provide ongoing trainings to transition age youth on renter preparedness.

In Spokane, a youth engagement center (clubhouse) is in the first year of providing services to homeless youth 14 to 21.Youth may attend daily Monday through Friday. Breakfast and lunch are available. In Clark County there are two projects that have components that address youth housing issues: The Wellness Project which serves people with no funding and a housing case manager is provided and Teen Talk a warm line for teens.

Many counties have developed outreach and engagement programs for homeless or disenfranchised youth, using HUD, county strategic planning money, federal grants and in-kind contributions from community collaborators, but not necessarily including mental health funding. Youth may attend wellness and recovery groups, Alcoholics Anonymous, Narcotics Anonymous, and Overeaters Anonymous groups and other self-help groups. The center will help youth in transition re-integrate into the community by having ready-made peer to peer connections.

Washington

53 - Child - Rural Area Services

Child-Describes how community based services will be provided to individuals in rural areas.

As this is mainly a combined plan, the description in the adult plan also addresses the issues for children, youth and their families in rural areas.

As stated, DBHR's contracts with the RSNs has set travel standards for accessing services and the DBHR has supported training activities on the specialized needs of consumers in these less populated areas, and participating in the rural mental health conferences.

The use of telemedicine sites for the provision of services has increased access to child psychiatrists and other child mental health specialists for the rural areas. Child psychiatrists in rural eastern Washington are few and far between, this technology provides access to services at the University of Washington, Children's Hospital, and other areas across western Washington.

DBHR has contracted, commissioned or provided parent/professional training with an emphasis on urban and rural areas. The support of parent partnerships has grown due to a number of factors:

- strengthening of curriculum for parents of youth and children as Certified Peer Counselors (due to certified peer parent contributors)
- State supported Wraparound pilots of Washington.
- Broader parent involvement in Regional Support Network / DBHR children's planning meetings
- Growing commitment of RSNs and community mental health providers to fund parent partnership, advocate, support positions
- Increasing organization of the "Community Connectors'" network and annual training, held in central Washington with outreach and support for parents across the state to attend
- Emerging emphasis on parent-initiated Wraparound

Washington

54 - Child - Resources for Providers

Child -Describes financial resources, staffing and training for mental health services providers necessary for the plan

Please see the adult plan for financial and staffing resources.

Children's mental health specialists are required to oversee treatment of children. Children's specialists are defined in state regulation as mental health professionals with a minimum of 100 hours actual hours of special training in child development and the treatment of children and youth with serious emotional disturbance (SED) and their families. Additionally they must have one-year of full-time experience in treatment of children with SED under the supervision of a child mental health specialist.

The DBHR Contract with the Washington Institute for Mental Health Research and Training conducts special populations training such as Minority Specialists, Aging, and children/adults/families. DBHR staff participates annually in the contract management for and the actual presentation of the theme.

State legislative bill 2SBHB1088 provided sufficiently for one and one-quarter of nationally respected training and a separate evaluation process. Training dollars were cut; however, DBHR increased the University of Washington (UW) Evidence Based Practice Institute (EBPI) funding to conduct maintenance training and technical assistance on the basis of an ongoing needs assessment.

DBHR and the UW EBPI are bringing a nationally known expert to Seattle to assist in supervisor training for the pilot projects and cross-system discussion of how DSHS might begin to discuss a statewide model of training and certification. We are anticipating support for developing this model, or at least a strategic plan to develop access when the child/youth is ready.

As a result of being a Model for Change (MacArthur Grant) recipient, several Washington counties are address training plans as part of youth early detention.

The DBHR continues to sponsor the popular statewide Trauma-Focused Cognitive behavioral therapy. About to go into its 5th year, for the last 4 years having a cohort of approximately 800 therapists trained and receiving a minimum of 18 hours of direct supervision/consultation. The highlights of the Trauma Focused Cognitive Behavioral Therapy (TFCBT) program development include:

- Core learning collaborative of approximately 100 individuals attending in teams of three
- Follow up supervision/consultation in team telephone conferences 2x per month for 6 months
- Corps of advanced supervisors/consultants
- A few admirable “champion” agencies
- Adaptation of the model focusing on CBT modules to include one for TF
- Adaptation of the model focusing on TFCBT/CBT with abusing parent or parent who did not protect
- Annual Advanced seminars (Focusing on Family; Latino application; Severely acting out youth, Tribal emphasis)
- Supervisor Seminars.

DBHR is embarking on a “WRAP” training program which will incorporate the child/youth and family liaison as a trainer.

DBHR is exploring other EBPs for implementation in the coming FFY: Triple P phases I through IV and for transitional youth.

Washington

55 - Child - Emergency Service Provider Training

Child -Provides for training of providers of emergency health services regarding mental health

Please see also the Adult Emergency Service Provider section of this plan.

It is important to note in this section that through WADADS a relationship has been developed between several law enforcement agencies and the parent organizations. Parents are providing “in-service training” to police officers and other first responders on how to effectively respond to their children. At the recent 2-day training session dads brought with them members of their local police force who just wanted to “learn” from the fathers.

King County RSN has a crisis team of children's specialist, parents and youth trained to assist in the field. Many of the RSNs require that their crisis teams include at least one Child Mental Health Specialist, and that when children in crisis are seen, if the crisis provider was not a Child Mental Health Specialist, the practitioner consults with a Child Mental Health Specialist.

Washington

56 - Child - Grant Expenditure Manner

Child -Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Please see the adult section and other sections of the plan about expenditures.

Washington does not separate funding by age group but on a population distribution formula. DBHR historically has spent between fifteen and twenty percent of their block grant funds on parent and youth activities.

Washington

57 - Child - Goals, Targets and Action Plans

Tables that display goals, targets and action plans follow on the next pages.

57 Performance Indicators: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	35,673	36,579	36,367	36,579	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

SAS Query of CIS for the period of 7/1/09-3/31/10: 32,015
Last year caseload grew 17.8% from March to June
Therefore, estimate 37,713 by year end (more if March data is not fully entered yet).
Expect we will meet our goal

Table Descriptors:

Goal:	#1: Increase Access to Services for Children and Youth with SED
Target:	Number of children and youth served through the public mental health system: 36,579
Population:	Children and Youth with SED
Criterion:	2:Mental Health System Data Epidemiology 3:Children's Services
Indicator:	RSNs and DBHR will work to increase the number of children and youth served through the public mental health system, with focus given to special populations.
Measure:	Number of children/youth (ages 0-17) served in community outpatient setting. (No Numerator or Denominator required.)
Sources of Info	MHD-Consumer Information System (CIS).
Special Issues:	Beginning in CY2008, Pierce County discontinued operations as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services. Direct service provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce region data has been submitted to DBHR in different forms and with variation in reporting requirements. The FY2008 Actual may be an over-count as some clients served by Pierce region in FFS may have also received services elsewhere in the State. We have no way of identifying setting these duplicate clients
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.
Action Plan:	Support the growth of a culturally competent workforce by training those who serve children and youth within the following special populations: American Indians, Alaska Natives and their communities, Ethic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping children and youth obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers/families served by multiple agencies. Encourage early prevention and

intervention activities through collaboration with schools, foster care system, and juvenile justice

Transformation Activities: Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds -30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	5.64	6.65	6.83	6.80	N/A
Numerator	55	71	70		
Denominator	975	1,068	1,025		

MH PI Query for CY2009: 6.9%
Expect we will be very close to our goal

Table Descriptors:

Goal: #2: Decrease percentage of children and youth who are readmitted to an inpatient setting within 30 days of discharge.

Target: The percentage of children and youth readmitted to any inpatient setting within 30 days of discharge – 6.8%

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services

Indicator: Regional Support Networks (RSNs) will minimize the percentage of children and youth who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and then readmitted to any of the inpatient settings within 30 days.

Measure: Numerator: Number of children and youth (ages 0-17) readmitted to any inpatient setting within 30 days of discharge in the fiscal year Denominator: Number of total children and youth discharges from any inpatient setting in the Fiscal year.

Sources of Info MHD-Consumer Information System (CIS).

Special Issues: Beginning in CY2008, Pierce County discontinued operations as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and directs provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data has been submitted to DBHR via different forms and with variation in reporting requirements.
FY2009 Actual percentage does not include clients served by Pierce region due to the FFS data limitations.

Significance: This is a required National Outcome Measure (NOM). The Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4 Decreasing returns to hospitals demonstrates increased community tenure which evidences recovery and adequate community supports. Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days. Continue to expect RSNs to maintain percentage of outpatient children and youth who are NOT hospitalized as a rate >95%. Encourage development of community resources for kids as alternatives to hospitalization. Evaluate function of Children's Long-term Inpatient Program (CLIP) and support coordination efforts.

Action Plan:

Transformation Activities: Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds -180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	20.82	19.13	16	15.70	N/A
Numerator	203	212			
Denominator	975	1,108			

PI query for this indicator is currently unavailable. Curtis is working on getting it back up and running. Based on 30-day rates, it is likely that we will meet our goal.

Table Descriptors:

Goal:	#3: Decrease percentage of children and youth who are readmitted to an inpatient setting within 180 days of discharge
Target:	The percentage of children and youth readmitted to any inpatient setting within 180 days of discharge – 15.7%
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) will minimize the percentage of children and youth who were discharged from a state hospital, community hospital or freestanding evaluation and treatment facility and who then were re-admitted to any of the inpatient settings within 180 days.
Measure:	Numerator: Number of children and youth (age 0-17) readmitted to any inpatient setting within 180 days of discharge. Denominator: Number of total children and youth discharged from any inpatient setting.
Sources of Info	MHD-Consumer Information System (CIS).
Special Issues:	Starting in Calendar Year 2008, Pierce County discontinued operations as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services. Direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data has been submitted to DBHR in various forms and variation in reporting requirements. The FY2009 Actual percentage does not include clients served by Pierce region due to the FFS data limitations.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4. Decreasing readmission to hospitals demonstrates increased ability to maintain community tenure, which further provides evidence of the presence of adequate community supports and improved resiliency.
Action Plan:	Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days. Continue to expect RSNs to maintain percentage of outpatient children and youth who are NOT hospitalized as a rate >95%. Encourage development of community resources for kids as alternatives to

hospitalization. Evaluate function of Children's Long-term Inpatient Program (CLIP) and support coordination efforts.

Name of Performance Indicator: Evidence Based -Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	3	3	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

Table Descriptors:

Goal:	#5: Increase the number of evidence-based practices provided to children and youth.
Target:	Number of evidence-based practices provided to children (0-17) is 3.
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) and DBHR will work to increase the number of EBPs provided throughout the state to children and youth.
Measure:	Number of EBPs provided to children and youth throughout the state. (No Numerator or Denominator required)
Sources of Info	This is new data being acquired through a Provider Survey conducted by Washington Institute of Mental Illness research and Training (WIMIRT) which is only partially completed.
Special Issues:	There may be other EBPs provided to children/youth in the State. However, the Provider Survey only focuses on the 3 children's EBPs per NOMs reporting requirements.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4
Action Plan:	Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs for children and youth as well as implementation of EBPs that are culturally competent related to these age groups. Oversee the implementation of 2006 legislatively proviso's EBP start-ups. Disseminate EBP Resource Guides. Support Mental Health Specialist trainings

Transformation Activities: Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	520	475	493	495 Target 202 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal:	#5: Increase the number of EBPs received by children and youth
Target:	The number of children and youth receiving Therapeutic Foster Care services is 495:
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) and DBHR will work to increase the number of children and youth receiving EBP treatment throughout the state.
Measure:	Prior to FY2008: Number of children and youth who receive Therapeutic Foster Care services. No numerator and denominator were required. FY2008 and forward: Numerator: Number of children and youth who receive Therapeutic Foster Care services. Denominator: Number of children and youth served by DBHR with SED.
Sources of Info	A Provider Survey conducted by Washington Institute of Mental Health research and Training (WIMHRT).
Special Issues:	Counts of the number of clients who receive therapeutic foster care services are provided by provider agency self-report on a survey. There is some question about the counts of clients who receive each EBP are over-counts. Client count is highly influenced by the response rate of the survey. Also there is no way to unduplicate client counts across provider agencies. Therapeutic Foster Care is provided under the Behavioral Rehabilitation portion of the State Plan managed by the Children's Administration of DSHS and conducted by providers who are contracted with DSHS Children's Administration, licensed by DBHR for community (mental health) support services and contracted with the RSNs. The state funds several pilots of Multidimensional Treatment foster care – an EBP unto itself. DBHR contracts with a provider for the MH managed site.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.
Action Plan:	As funds allow, DBHR will continue to support training for foster parents with federal block grant funding and sustain community programs in partnership with children's administration. MH will continue to seek funding to sustain MTFC and expand as possible by implementing additional pilot sites.

Transformation Activities: Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	1,314	610	153	610 Target 1,688 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are not reliable. Revised data gathering is planned for the coming year.

Table Descriptors:

Goal: To increase the number of children/youth who receive multi-systemic therapy.

Target: The number of children/youth who receive multi-systemic therapy is: 610

Population: Children/Youth with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and youth who receive multi-systemic therapy.

Measure: Prior to FY2008: Number of children and youth who receive Multi Systemic Therapy services. No numerator and denominator were required.
FY2008 and forward: Numerator: Number of children and youth who receive Multi Systemic Therapy. Denominator: Number of children and youth served by DBHR with SED.

Sources of Info Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: Counts of the number of clients who receive multi-systemic therapy are provided by provider agency self-report on a survey. There is some question about whether the counts of clients who receive each of the EBPs are over-counts. Client count is highly influenced by the response rate of the survey. Also there is no way to un-duplicate client counts across provider agencies.

Significance: This is a required NOMs outcome measure. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health
Planning and Advisory (MHPAC) Goal #4 MST is a successful intervention with multi-system involved youth, particularly in the juvenile justice system. WA State supports MST as reported in RSN encounter data as a Medicaid covered modality. WA State funds and oversees a two-county pilot that is also being evaluated by Washington State

Action Plan: Institute for Public Policy (WSIPP) with consultation by MST Inc.

Continue to monitor outcomes and support ongoing funding of state covered pilot. Identify as possible funding opportunities for expanded implementation of fidelity MST.

Transformation Activities: Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	1,335	974	419	500 Target 320 Actual	N/A
Numerator	N/A				
Denominator	N/A				

EBP estimates from WIMHRT are unreliable – often varying wildly from year-to-year so comparisons to our "goal" are somewhat meaningless.

Table Descriptors:

Goal:	To increase the number of children and youth who receive family functional therapy
Target:	The number of children and youth who receive family functional therapy is:500
Population:	Children with serious emotional disturbance
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Number of children and youth who receive family functional therapy
Measure:	Prior to FY2008: Number of children and youth who receive family functional therapy. No numerator and denominator were required. FY2008 and forward: Numerator: Number of children and youth who receive family functional therapy. Denominator: Number of children and youth served by DBHR with SED.
Sources of Info	Provider survey conducted by Washington Institute for Mental Health Research and Training
Special Issues:	Counts of the number of clients who receive Family Functional Therapy are provided by provider agency self-report on a survey. There is some question about whether the counts of clients who receive each of the EBPs are overcounts. Client count is highly influenced by the response rate of the survey from year to year. Also there is no way to un-duplicate client counts across provider agencies. In WA FFT has been provided by licensed community mental health providers under contract with the Juvenile Rehabilitation Administration.
Significance:	This is a required NOMs outcome measure. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4. Functional Family Therapy (FFT) is a very effective evidence based practice, particularly with multi-system involved children where juvenile justice has been involved.
Action Plan:	Training and fidelity requirements are not covered under the state plan modality, therefore fidelity implementations of this evidence-based practice are limited to special pilot funding.

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	65.30	64.26	66.13	65 Target 66.9 Actual	N/A
Numerator	574	543	574	582	
Denominator	879	845	868	870	

Exceed goal

Table Descriptors:

Goal:	#6: Improve client perception of care-children and youth.
Target:	To increase the percentage of children and youth who report achieving positive outcomes on the MHSIP Survey to 65%
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Regional Support Networks (RSNs) will work to improve children and youth client perception of care as evidenced by the number of adults surveyed who agree with the items on the MHSIP regarding their perception of positive outcomes.
Measure:	Numerator: Number of children and youth (age 0-17), parents, and caregivers of children under 13 years of age who agreed or strongly agreed with the MHSIP Outcomes Scale. Denominator: Number of children and youth (age 0-17), parents, and caregivers of children under 13 years of age who took the survey.
Sources of Info	This is new data being acquired through the MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).
Special Issues:	WA has only conducted the Child/Youth MHSIP every other year, with the off years being used to conduct Adult surveys. Beginning in 2007, however, the MHSIP will be conducted on a yearly basis for both populations, per SAMHSA requirements re: yearly reporting on this NOM.
Significance:	This is a required National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory Council Goal 4
Action Plan:	Continue to support and train members related to articulated child/youth/family voice. In particular, Recovery, Consumer across spectrum of administrators, providers, and consumer/family Driven service system, and culturally competent care initiatives will be emphasized. OMBUDS to be encouraged for children/youth/families. Parent support and empowerment will raining will also be supported. Individual choice, satisfaction, and safety will continue to be supported

Name of Performance Indicator: Child -Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	25	28.89	31.1	29 Target 30.5 Actual	N/A
Numerator	220	234	259	259	
Denominator	880	810	835	850	

Exceed Goal

Table Descriptors:

Goal:	#7: Decrease the number of children/youth suspended or expelled from school
Target:	The percentage of youth or caregivers who reported improvement in school attendance in the FY is 29%.
Population:	Children with significant emotional disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	Number of children/youth (0-17) or caregivers who reported improvement in school attendance in the FY.
Measure:	Prior to FY2008: Numerator: Number of children/youth were expelled or suspended from school during the last 12 months. Denominator: Number of respondents (caregiver/youth) to the YSS-F survey. For FY2008 and forward: Numerator: Number of youth/caregivers who reported improvement in school attendance. Denominator: Number of respondents (caregiver/youth) to the YSS-F survey.
Sources of Info	YSS-F survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)
Special Issues:	WA has YSS-F survey and adult MHSIP survey were conducted on alternating years, but measured other activities such as school performance in the past. Prior to 2007, both surveys are conducted every year as per SAMHSA requirements re: yearly NOM reporting related to this indicator
Significance:	This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC Goal #4.
Action Plan:	Encourage development of youth certified peer counselors. Support training on effective early intervention strategies, services provided under the Individuals with Disabilities Education Act. Continue to support cross-system collaboration to assist children and youth with serious emotional disturbances to achieve in school and employment. Youth participation in Children's Sub-committee of MH PAC will continue to be encouraged.

Transformation Activities: Name of Performance Indicator: Child -Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	47.50	48.98	55.4	TARGET: 52 Actual: 61.5%	N/A
Numerator	19	24	31	40	
Denominator	40	49	56	65	

Exceeded goal.

Table Descriptors:

Goal:	#8: Decrease the percentage of children and youth consumers who have had involvement with the juvenile justice system
Target:	Increase the percentage of youth consumers who were NOT arrested in Time 2 to 52%:
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	RSNs and DBHR will work to decrease the number of youth consumers who were involved with the criminal justice system.
Measure:	Prior to 2007: Numerator: Number of children/youth who were arrested convicted or adjudicated in the fiscal year. Denominator: Number of total children/youth (0-17) served by the Division of Behavioral Health & Recovery in the fiscal year. For FY2008 and forward: Numerator: Number of children/youth who reported not being arrested in the fiscal year. Denominator: Number of children/youth who responded to MHSIP survey and who reported being arrested in the previous year.
Sources of Info	Prior to 2007: Merging the DBHR data with state arrest and conviction data. FY2007 and forward: MHSIP survey conducted by Washington Institute for Mental Health Research and Training
Special Issues:	Prior to 2007:Merging the DBHR data with state arrest and conviction data Information: FY2007 and forward: The YSS-F survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).
Significance:	This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory Council (MHPAC) Goal #4.
Action Plan:	Continue youth released from juvenile justice facilities. Support cross-system collaboration within to require RSNs to ensure community mental health agencies provide services to DSHS as well as schools, providers and community. Continue to support training of Law Enforcement officers in EBP of Crisis Intervention Training.

Name of Performance Indicator: Child -Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	98.35%	98.67%	98.53%	98.7	N/A
Numerator	23,160	27,010	27,548		
Denominator	98.35%	98.67%	98.53%		

SAS Query of CIS for the period of 7/1/09-3/31/10: 98.66% housing stability
Last year housing stability rate through 3/31/09 was 98.58% (a little more than what was reported at year-end)
Expect we will come close to meeting our goal.

Table Descriptors:

Goal: #10: Increase family stability as evidence by children and youth maintaining housing

Target: The percentage of children and youth who were homeless or living in shelter in the FY is 1.3%

Population: Children and youth with serious mental disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services

Indicator: Percentage of children and youth who were homeless or living in shelter in the fiscal year

Measure: Prior to FY2008: Numerator: Number of children and youth (0-17) with 2 or more living situations recorded who did not become homeless in a fiscal year. Denominator: Number of total children and youth (0-17) served in community outpatient services in the fiscal year. FY2008 and forward: Numerator: Number of children served by DBHR who were homeless or living in shelter in the FY Denominator: Total number of children served by DBHR and whose living situation status was available in the FY.

Sources of Info MHD-Client information system (CIS)

Special Issues: Stable housing continues to be a real and serious challenge for WA; however DBHR remains committed to encouraging growth of appropriate residential resources and supports for children, youth, and families through the RSNs.

Beginning in CY2008, Pierce County discontinued operating as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services. Direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data has been submitted to DBHR via different forms and with variation in reporting requirements.

The FY2009 Actual percentage does not include Pierce region clients due to data limitations.

Significance: Goal supports New Freedom Commission (NFC) goal #3. Goal supports Mental Health Planning and Advisory Council (MHPAC) Goal #3

Action Plan: Continue to support development residential resources and encourage the development of safe, affordable housing. Continue to support mental illness education, stigma reduction, recovery, resiliency, employment and other factors that lead to stable housing. Continue to require and further encourage development of cross-system collaboration efforts for families served by multiple agencies within DSHS and the community.

Transformation Activities: Name of Performance Indicator: Child -Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	85.92	85.82	86.11	86 Target 88.0 Actual	N/A
Numerator	763	726	744	770	
Denominator	888	846	864	872	

Exceed Goal

Table Descriptors:

Goal:	#8: Increase the sense of social connectedness experienced by children and youth
Target:	The percentage of children and youth reporting positively to social connectedness scale on the YSS-F survey is: 86%
Population:	Children with Significant Emotional Disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
Indicator:	RSNs will work to assist children and youth consumers in increasing their social and natural supports.
Measure:	Numerator: Number of children and youth responded that they agree or strongly agree to the 4 items that make up the social connectedness scale on the YSS-F survey. Denominator: Number of total children and youth who responded to the YSS-F survey
Sources of Info	YSS-F survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)
Special Issues:	
Significance:	This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #3. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3. Having meaningful relationships is a necessary part of increasing the likelihood of resiliency.
Action Plan:	Continue to encourage development of after school and social activities that enhance resiliency. Encourage self-empowerment, voice, and safety. Continue to collaborate within DSHS and communities to develop self-help, suicide prevention, and stigma reduction activities, including: trainings and conferences for all stakeholders, professional and personal. Continue to support Tribal activities that enhance that community's whole-wellness. Support mental illness education and stigma reduction activities.

Name of Performance Indicator: Child -Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Actual	FY 2010 Target	FY 2011 Target
Performance Indicator	65.4	68.9	70.6	67 Target 70.6 Actual	N/A
Numerator	575	578	610	611	
Denominator	879	839	864	865	

Exceed Goal

Table Descriptors:

Goal:	#9: Improve level of functioning for children and youth
Target:	The percentage of children and youth agree or strongly agree to the functioning question on the YSS-F survey:67%
Population:	Children with significant emotional disturbance (SED)
Criterion:	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services 4:Targeted Services to Rural and Homeless Populations
Indicator:	RSNs will work to increase the number of children and youth who report improved level of functioning over a fiscal year.
Measure:	Numerator: Number of children and youth respond agree or strongly agree to the functioning question on the YSS-F survey. Denominator: Number of total children and youth who responded to YSS-F survey in the fiscal year.
Sources of Info	YSS-F survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).
Special Issues:	
Significance:	This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #3, #4, #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3, #4, #5
Action Plan:	Continue to require RSNs to collaborate with community and state agency stakeholders for the provision of mental health and COD services for children and youth. Continue to support training across full spectrum of administration, providers, consumers, families, schools, juvenile justice. Continue to support quality improvement as it relates to services for children and youth consumers as symptom reduction and involvement in meaningful activities are conversely related. Support child/youth/family participation in activities that enhance involvement in meaningful activities creativity, spirituality, education, employment, and social interaction.