SECTION P. PUBLIC COMMENT ON THE STATE PLAN

Stakeholders

The Division of Behavioral Health and Recovery (DBHR) is working collaboratively with its stakeholders (mental health consumers; chemical dependency consumers; Counties; Regional Support Networks (RSNs); the Community Mental Health Council; Chemical Dependency organizations; provider associations, and the public) to ensure all voices are heard in the development of the application. DBHR is utilizing a variety of forums including face-to-face meetings, video/phone conferences, and an active website so our partners and the public can review and respond to each section as it is developed. DBHR leadership has met with RSNs (monthly), the Association of Counties (full association meetings and liaison meetings), and state agency partners (provider associations) to present information on the Unified Block Grant application process and to collect input/ feedback on the proposed narrative and plan.

Tribes

DBHR leadership engaged in the government-to-government formal consultation process with leadership from Washington's 29 federally recognized Tribes. Over the summer, per protocol, there were three roundtable meetings regarding the block grant and a formal consultation. We took notes during these meetings and also received written comments. From this consultation process, we have included the Tribes' perspectives in this application.

Consumers

DBHR conducted a statewide video-conference (with nine locations) and additional face-to-face meetings to ensure we included consumer feedback. Consumer voices are an important part of the application and the plan for ongoing federal funding. As we continue clarifying plan steps and objectives across the next 21 months, the public will continue to be offered similar avenues to have input in all aspects of the work that we do.

Compilation

Compilation of feedback received from these different partner populations has been integrated to ensure that the application and plan is reflective of those we serve. The feedback process has been invaluable in generating this narrative and will assist us in ensuring our plan becomes a living document for our division and for the State behavioral health system of care.

Some specific questions were posed to consumers, stakeholders, and tribes as we conducted this process. The edited responses are collected below and are presented in the spirit of open communication. Decisions will be made jointly over the next year.

Who should we invite as Potential Partners?

We asked consumers, stakeholders, and tribes to generate a list of other partners to consider for inclusion. A list of potential partners was generated and is included here (alphabetically):
• Adult Protective Service • American Sign Language communities • Community Advisory Councils for Development Disabilities • Chemical Dependency and Mental Health providers •Child welfare • Children's Long-term Inpatient Program facilities • Community Action Programs • Community supports (disability resources) • Consumer-run organizations •Consumers with Co-occurring disorders • County and city governments • Court-appointed special advocates (CASA) • Courts • Child Protective Services • Criminal Justice • Crisis Residential Center • Developmental Disabilities Division • Dentists • Department of Commerce

• Department of Corrections • Domestic violence centers • Department of Vocational Rehabilitation • Emergency Departments • Educational programs such as Head Start •Employment programs • Employment specialists • Educational School Districts • English as a Second Language (ESL) and Limited English Proficiency (LEP) communities • Ethnic groups • Faith-based organizations • Families • Family resource centers • Foster parents • GLBTQ community • Health centers • Homeless advocacy groups • Hospitals • Housing authority •Jails • Juvenile Rehabilitation Administration • Juvenile detention • Kinship care programs •Law enforcement • Local health jurisdictions • Medical professionals (emergency department representatives) • Military families • NAMI • National Guard • Older adults • Peer centers •Peer counselors • Peer-to-peer programs • PFLAG (Parents, Families and Friends of Lesbians and Gays) • Probation officers • Public health clinics • Regional advisory boards •RSNs • Schools • Senior centers •Shelters • Traumatic Brain Injury • Tribes • TriCare • VA Hospitals • Veterans services • Work Source • Youth clubs • Youth in transition

How do we identify representatives?
A variety of suggestions were made about how to best identify and include a variety of participants to get a broad perspective on problems and solutions. The specific methods will have to be worked out in the next few months, but some ideas are:

- Snowball sampling – have each person identify 5 others; they each identify 5 more
- Invite who you know and then identify who is missing.
- Include individuals who are invested in the community, and are credible with bi-directional communication
- Support the people who are committed to the process
- Identify someone who is a level above the provider group so that they can give a birds'-eye view (local coalition chairs, or county/local government)
- Contact the agencies and have them select /identify a representative
- Board members of local agencies/ coalitions
- Self-nominate or agency nominate
- Use an application process

Who calls the regional meetings?
The BHAC is responsible for calling the meetings in partnership with DBHR. We plan to have 3-5 regional meetings with a broad local/regional membership; the co-chairs of BHAC will attend the regional meetings. The BHAC will need to include regional representatives to also communicate back-and-forth.

How can we engage partners?

- The full BHAC ongoing; smaller workgroups could be ad hoc (perhaps similar to Transformation Workgroup)
- Regional meetings
- Take advantage of conferences – perhaps add a track or an additional day
- Meet with key individuals as needed (key informant interviews)
- Use the Office of Consumer Partnership
- We need both a BHAC and regional meetings to have sufficient input
- Create local groups
- Use a variety of methods to get feedback: Web, phone conference, in-person trainings, community cafes, town hall meetings, a think tank

Do you have any other suggestions/ or thoughts?

- An Advisory Council should be about 8-10 persons, or 12-15 with state representatives.
- Find ways to bring in youth and youth voices
- Put together a calendar/timeline for key decision time points and key periods for comment. Ideally, have annual and bi-annual comment periods
- People will be supportive rather than suspicious if it's on a public calendar.
- Any discussion and decisions will be shared widely
- The group needs to develop a "charter"
- Define a "partner". We need the "right" person attending. Someone who:
    - Contributes
    - Reports back to the community
    - Does not just attend a meeting, but participates
    - Is willing to speak
    - Is affiliated/ interested in publicly funded services
    - Is willing to adapt with changes
    - Understands behavioral health systems/issues
    - Is open-minded, not stuck with "we've always done it this way"
    - Cooperates
    - Problem-solves
- Use a structure that parallels the tribal consultation approach. Smaller workgroups leading up to the large group meeting
- Give the group real authority to influence allocations
- Perhaps the BHAC should have monthly meetings with OCP and quarterly meetings with the Secretary
- Could we include a meeting of stakeholders at the state conferences
- Be aware that not everyone can use/access computers or the internet: need multiple modalities; reasonable accommodation
- Invite university participation for background in behavioral health and research
- Be sure to include consumer-run organizations
- Concern that the CD community didn't have as much of a consumer voice present
- Have "listening sessions" to really get at the community/consumer voice