

Washington

Uniform Application

FY 2010 – State Plan

Community Mental Health Services

Block Grant

Center for Mental Health Services

Division of State and Community Systems Development

September 1, 2009

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

XX FY2010 FY 2010-2011

STATE NAME: Washington

DUNS #: 12-734-7115

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Social and Health Service

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia

STATE: WA

ZIP: 98504

TELEPHONE: 360-902-0843

FAX: 360-902-0809

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: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia

STATE: WA

ZIP CODE: 98504

III. STATE FISCAL YEAR

FROM: 07/01/2009

TO: 06/30/2010

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: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia

STATE: WA

ZIP: 98504-5320

TELEPHONE: 360-902-0820

FAX: 360-902-7691

EMAIL: baldech@dshs.wa.gov

Washington

2 Executive Summary

The Mental Health Division (MHD) 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 2010. 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:

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.

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.

MHD 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 MHD 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 is facing a budget shortfall 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.

Section I

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 State¹ 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 States Code. [Audit Provision]

(c) The State will:

- (1) 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

September 1, 2009

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, Ineligibility, 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 under-

signed, 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 and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary, WA State Department of Social & Health Services	
APPLICANT ORGANIZATION WA State Mental Health Division		DATE SUBMITTED September 1, 2009

Disclosure of Lobbying Activities

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: <input checked="" type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input checked="" type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime _____ Subawardee _____ Tier _____, if known: Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: 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 <i>(if individual, last name, first name, MI):</i> No Lobbying will be conducted	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
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: _____ Print Name: <u>Susan N. Dreyfus</u> Title: <u>Secretary, WA State Dept of Social & Health Services</u> Telephone No.: <u>(360) 902-7800</u> Date: <u>September 1, 2009</u>	
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)	

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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 Coastal 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 WA State Mental Health Division		DATE SUBMITTED September 1, 2009

II. 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 2008	Estimate/Actual FY 2009
\$17,688,942	\$37,757,566	\$32,167,828

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.

III. 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 2006	Actual FY 2007	Actual/Estimate FY 2008
\$237,930,763	\$236,727,429	\$274,739,059

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.

Section IV. State Mental Health Planning Council Requirements

9 Table 1. Council Membership List

	NAME/ADDRESS	REPRESENTATION	APPOINTMENT DATE	APPOINTMENT EXPIRE
	Traci Adair DSHS/ADSA/HCS	State Employees	October 2006	Required Department appointed
	Thressa Alston	Other (not state employee or provider)	March 2005	March 2011
	Rebecca Bates	Family Members of Children with SED	May 2004	May 2010
	Chuck Benjamin North Sound RSN	RSN Representative	January 2008	January 2011 (first term)
	Kathryn Carlton	Family Members of adults with SMI	January 2009	January 2012 (first term)
	Dan Clement	Other (not state employee or provider)	March 2007	March 2010 (first term)
	Brien Critchlow	Consumers/Survivors/ Ex-patients	July 2007	July 2010 (first term)
	Andy Toulon Mental Health Division	State Employees	June 2009	Required Department appointed
	Annie Conant Housing Division, CTED	State Employee	November 2005	Required Department appointed
	Rick Crozier, Vice Chair Older Adult Pgm.. Manager	Provider	January 2004	January 2010
	Cheri Dolezal	Other (not state employee or provider)	April 2008	March 2011 (first term)
	Judie Ebbert- Rich	Family Members of Children with SED	January 2009	January 2011 (first term)
	Danny Eng DSHS/DVR	State Employees	October 2003	Required Department appointed
	Diane Eschenbacher	Consumers/Survivors/ Ex-patients	January 2009	January 2012 (first term)
	John Furze	Other (not state employee or provider)	August 2007	August 2010 (first term)
	Shirley Havenga	Provider	November 2008	November 2011 (first term)
	Tamara Johnson	Consumers/Survivors/ Ex-patients	September 2008	September 2011 (first term)

	NAME/ADDRESS	REPRESENTATION	APPOINTMENT DATE	APPOINTMENT EXPIRE
	Vanessa Lewis	Family Members of Children with SED	January 2007	January 2010 (first term)
	Dwight McClain	Consumers/Survivors/Ex-patients	July 2007	July 2010 (first term)
	Cathii Nash, Chair	Consumers/Survivors/Ex-patients	February 2004	February 2010
	Don Nichols	Consumers/Survivors/Ex-patients	November 2007	November 2011 (first term)
	Helen Nilon	Consumers/Survivors/Ex-patients	August 2007	August 2010 (first term)
	VACANT WA Office of Superintendent of Public Instruction	State Employees		Required Department appointed
	Eleanor Owen	Family Members of adults with SMI	February 2004	February 2010
	Michael Paulson DSHS/HRSA	State Employees	January 2007	Required Department appointed
	VACANT DSHS/CA	State Employees	September 2008	Required Department appointed
	Tom Saltrup Director of Behavioral Health, Dept of Corrections	State Employees	November 2007	Required Department appointed
	Dorothy Trueblood	Family Members of Children with SED	January 2008	January 2011 (first term)
	Bill Waters Val Ogden Center	Other (not state employee or provider)	June 2007	June 2010 (first term)
	JoEllen Woodrow	Consumers/Survivors/Ex-patients	October 2005	October 2011
	Vacant	Tribal Representative		
	Bianca Stoner Transformation Grant	MH Transformation Grant, Non-voting Member	Not Applicable	Not Applicable
	Christina Carter	Mental Health Division Staff to MHPAC	Not applicable	Not Applicable
	Aaron Wolfman	Mental Health Division Staff to MHPAC	Not Applicable	Not Applicable

10 TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	32	
Consumers/Survivors/Ex-patients(C/S/X)	8	
Family Members of Children with SED	4	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers) Tribal Liaison	5	
TOTAL C/S/X, Family Members and Others	19	59.4%
State Employees	8	
Providers	3	
Vacancies	2	
TOTAL State Employees and Providers	13	40.6%

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. 4) Totals and Percentages do not include vacancies.

11 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

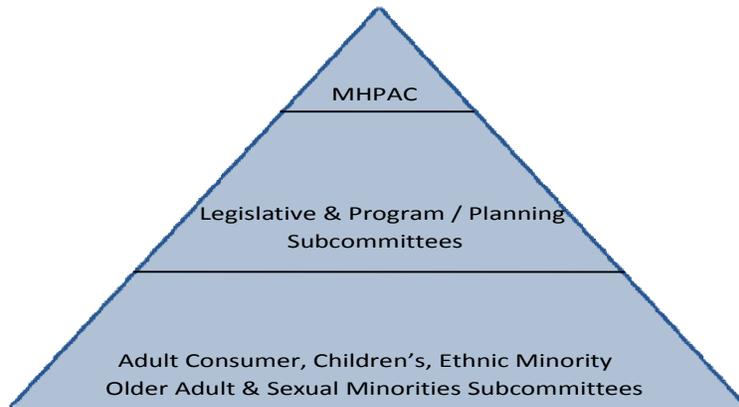
Other Goals:

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.

As a result of Planning Council trainings and attendance to national conferences, the Planning Council has organized its structure to establish the following standing subcommittees to carry-out its mission and to meet its goals:

- Adult Consumer Subcommittee,
- Legislative/Administrative Subcommittee,
- Program/Planning Subcommittee,
- Children’s Treatment and Services Subcommittee,
- Sexual Minority Treatment and Services Subcommittee,
- Older Adult Treatment and Services Subcommittee, and
- Ethnic/ Multi-cultural Treatment and Services Subcommittee.

For communication purposes, the Planning Council is at the apex of a triangle. The Legislative and Program/ Planning Subcommittees are the next step down. The five remaining Subcommittees form the base of the triangle.



Children’s, Older Adults’, Ethic Minorities’, Adult Consumer & Sexual Minorities’ Subcommittees

A representative of each Standing Subcommittee is designated in the Bylaws as a member of the Planning Council. Each Standing Subcommittee is charged by the Planning Council to focus their attention on the implementation of the Goals and Purpose of the Planning Council. Therefore, on the Planning Council Meeting Agenda, Subcommittee reports reflect the Planning Council Goal being discussed or implemented.

This increased expertise has been the MHPAC’s focus on increasing consumer and family involvement at the onset of MHD policy, planning, and implementation endeavors. This supports the culture at the Division which supports the common goal of improving the quality of life for adults with severe mental illness and children with serious emotional disturbances.

11 A FBG WA PAC Comments and Recommendations

July 10, 2009

Report from the Chair, Cathii Nash, of the Mental Health Planning and Advisory Council:

The years 2008-2009 were a time of opportunity and growth in the State of Washington. The Mental Health Planning and Advisory Council (the Council) was advised of the Governor's request to reduce its budget, initially first 15% in August, and then an additional 10% in November, 2008. This was based on the budgetary shortfalls of state income and was asked of all agencies and councils.

Working closely with then Director Richard Kellogg, the Council reduced its meetings to eight per year and voted in February an emergency amendment to its bylaws to further reduce its meetings to seven per year for the 2009. The Council feels this is the barest minimum of meetings it needs to fulfill its mandates of recommending the State Plan, being active in the distribution of the Federal Block Grant and advocating for persons with SMI or SED. Mr. Kellogg and previous DSHS Secretary Robin Arnold-Williams both agreed that any money saved would be spent on direct consumer services and education.

As 80% of the Federal Block Grant funds are allocated to the Regional Support Networks (RSNs), the Council devoted a full meeting to the training of the administrators. All RSN administrators were invited to the Council's January meeting so that the Council could work with them on the Council's goals and criteria for the upcoming Federal Block Grant. The Council's decision matrix and guidelines were shared with the administrators and a greater understanding of the process was gained. The Council Chair was also invited to speak at three of the RSN Advisory Board meetings on the same topic. The RSN proposals were presented to the Division on May 1 and the Council held a two day review and 'grading' of the proposals on May 19 and 20.

Based on a numerical score of zero to five, the RSNs were rated thusly: North Sound – 3.779, Clark County – 3.574, King County – 3.0185, Pierce County – 2.55, Gray's Harbor – 2.528, Spokane County – 2.4625, Thurston Mason – 2.533, Peninsula – 2.098, Chelan-Douglas – 2.045, Southwest – 1.9425, North Central – 1.874, Timberlands – 1.8579 and Greater Columbia which scored both a 1.5825 and 0. The scores were based on the Federal Block Grant proposals *only* and may not accurately define the overall treatment of mental health in their area. The scoring did not take into account Medicaid and State-only programs.

One of the major steps forward taken by the Division and the Council is that a Cultural Competency clause will be written into the contract work orders for the Federal Block Grant. The Council is giving serious consideration to recommending a "carve-out" of the Federal Block Grant specifically for children's programs in 2010-2011.

From the remaining 20% of the Federal Block Grant not used by administration, conversations were held with Acting Director MaryAnne Lindeblad who promised in March, 2009 that the Council would have more input into the use of those funds in the future.

Ms. Lindeblad and Mr. Kellogg were instrumental in getting the Legislature to release the Federal Block Grant from its funding of the King County MIO-CTP program. Monies that had been used for that program will once again be divided up by all the RSNs and used for consumer services.

Legislatively, all seven subcommittees were extremely busy in this year of economic downturn and agency upheaval. Medicare, Medicaid and social service programs were reduced and many consumers and non-Medicaid consumers will be impacted. Two proposals were raised in the Legislature to recreate the structure of the Department of Social and Health Services (DSHS) and although neither bill passed, we have already seen the Mental Health Division and Substance Abuse be formed into one Division, with one director, David Dickinson. We look forward to working with Mr. Dickinson in the future.

In its last year of funding, the Transformation Grant has been working toward the creation of a system of fully integrated mental and physical health care in the state. The Council will be very active in assuming a role in this movement and working with the new Secretary of DSHS, Susan Dreyfus. During the past year, the Council and its Subcommittees have been involved in various Departmental and Transformation workgroups.

The Council has helped to re-write the Washington Administrative Code for brief intake procedures, it helped to write HB2654 (setting the parameters for Consumer-run services), and it has been a part of the Housing Consortium workgroup. The Council also continued its representation on the Performance Indicators Workgroup (which is our DIG Grant workgroup) and continues to fine-tune and analyze the data collected from the RSNs. These projects and many others help carry consumer voice and reduce stigma throughout the state.

In the state of Washington, we are blessed to have a new Block Grant Writer (Hank Balderrama), a new MHD representative to the Council (Andy Toulan), a new Director (David Dickinson), a new Secretary (Susan Dreyfus) and a new SAMHSA representative (Holly Berrilla). The Council is looking forward to the opportunity to prove to them our dedication and partnering ability. Together we will create the best state in the nation for mental health care. We have come far. We have further to go.

PART C. State Plan

Section I. Description of State Service System

Washington

12 Adult - Overview of State's Mental Health System

As the public mental health authority for the 6,488,000 (OFM estimate of 2007) residents of Washington State, the Mental Health Division (MHD) 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.

The public system operates the mental health crisis and involuntary treatment act for the citizens of the State. The Mental Health Division 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. 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 1915b 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.

Pierce County officials made a decision (effective January 2008) not to participate in the mental health managed care system. Therefore the MHD quickly established a fee-for service Medicaid system in this county. MHD contracted with all existing Community

Initially the MHD contracted FBG funds directly with agencies that previously contracted with the previous RSN in order not to disrupt services to consumers. For 2009, however, the Community Mental Health Agencies were treated as an RSN and had to plan for service delivery accordingly. These agencies, large and small, Tribal, corporate run and consumer run, came together and developed individual plans that met the

needs of the consumers of the county, stayed within their budget and gained approval of the Pierce County Citizen's Advisory Board.

During calendar year 2008, the MHD conducted a competitive procurement process to identify and contract with an organization to provide Regional Support Network/Prepaid Inpatient Health Plan (RSN/PIHP) administrative services. OptumHealth was the successful bidder and began operations under contract with MHD July 1, 2009. As of that date, FBG and other contracts previously contracted directly to provider agencies have begun to be contracted through OptumHealth, which is a for profit organization.

All FBG funds contracted to any RSN do not provide for administrative costs to be accrued to the RSN. That requirement also will apply to FBG contracts with OptumHealth.

MHD 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.

This year the MHD has 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 will involve 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 will be held with PAC sub-committees, and a work group will be 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 \$539,686 will be spent on homeless related projects including some transitional housing, housing assistance, utility

assistance. An additional \$679,500 will be spent on older adult projects including Gatekeeper project, outreach and screening, Alzheimer support groups, and older adult case management; A total of \$452,458 will be dedicated to Tribal projects which range from an elder outreach project, flex funds for youth and children, non-traditional services, outreach, education and training; and, \$1,230,511 will be used for consumer and family activities such as Clubhouse, a Consumer Council, parent operated organizations, consumer run organizations, WRAP training by certified WRAP facilitators, supported education and NAMI training programs and support activities.

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 2009 Plan as areas needing attention:

Housing: Lack of safe and affordable housing.

Benefits: Too many individuals need mental health 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, Uniform Reporting System and Developmental Tables, RSN reporting, hospital reports and jail reports. The subjective input of MHD 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. Part of the focus will be on the recent merger of mental health and substance abuse divisions into a combined division and the accompanying emphasis on integrated health services.

The MHD 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 MHD of a number of regional forums focused on increased coordination between mental health agency programs and local DVR offices. MHD 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.

MHD works closely with the Department of Community Trade and Economic Development (DCTED, which recently changed its name to Department of Commerce), the state organization that administers Housing and Urban Development (HUD) funding, to promote the development of supported housing models. This includes co-sponsorship with the Washington Families Fund of eight local teams to participate in a Supported Housing Institute, where each team developed proposals for the development of local, permanent supported housing projects. MHD also sponsored a statewide study of housing needs and updated a housing directory intended to connect policy makers and implementers to promote coordination of efforts.

MHD 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, MHD 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 MHD, Health and Recovery Services Administration (HRSA), Regional Support Networks (RSNs) and community hospitals meet regularly to improve community psychiatric hospital resource management.

MHD also works closely with the Department of Corrections (DOC) in statewide efforts to coordinate services for individuals with mental illness being released from prisons.

14 Adult - New Developments

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

Through use of Medicaid Infrastructure funds the Mental Health 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 40% 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. A collaborative aspect of the work included the joint financial support from the Mental Health Division and Mental Health Transformation Grant Project for a five-session track and keynote address on employment at the 2009 Behavioral Health Conference, the premier mental health conference in the State.

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. By September 2009 – 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 2008 Institute was jointly funded by the Department of Community Trade and Economic Development (CTED), DSHS/Mental Health Division and Washington Families Fund a unique partnership among the State of Washington, in collaboration with King, Snohomish, and Pierce Counties, the cities of Seattle, Everett, and Tacoma and several philanthropic and corporate partners, led by the Bill and Melinda Gates Foundation as well as the United Way of King County, Boeing, Microsoft, the Campion, the Ben .B. Cheney and the Greater Tacoma Community Foundations.

Additionally each team was required to contribute to offset the on-site technical assistance. The 2009 Institute added Impact Capital among the financial supporters. Sixteen capital permanent supportive housing projects will have been designed and will be 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. Every project developed during the Institutes will have a “leg-up” to receive state Housing Trust Fund grants managed by CTED.

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 MHD 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 MHD 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 Community Trade and Economic Development the primary state funding agency for low income housing and homeless projects, representatives from every Regional Support Network, from the MHD 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.

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) Mental Health Division (MHD) 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.

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 were 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 MHD’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.

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-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 Mental Health 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. 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 session of the Washington State Legislature

HB1349: 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 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 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 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 dramatically impacted the public mental health system in Washington State and to which much of the Mental Health's Division's strategic plan responds and upon which it is built.

In 2006, the WA 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 MHD 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.

The dissolution of the Pierce County RSN on January 1, 2008 has led to the creation of a fee-for-service (FFS) system in that County. In order to provide the Department with greater ability to select qualified RSN management, SSB 6404 in 2008 established a process to replace a RSN and PIHP functions should an RSN again determine not to serve in that capacity.

The 2008 Legislature provided funding for a comprehensive plan for reducing the Spokane RSN use of Eastern State Hospital (Spokane Acute Care Diversions). The Legislature also provided funding for increasing non-Medicaid services to other RSNs.

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 RSN is a county or group of counties. 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 MHD. 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. 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 MHD. Totals are rounded.
Funds cannot be separated by age.

RSN Estimated Revenues					
Fiscal Years 2010 and 2011					
RSN	Fiscal Year 2010		Fiscal Year 2011		2010 FBG
	Medicaid	Non Medicaid	Medicaid	Non Medicaid	
Chelan Douglas	6,102,027	2,545,342	6,394,693	2,545,342	108,865
Clark	17,590,219	8,788,583	18,424,436	8,788,583	423,288
Grays Harbor	5,572,054	1,432,110	5,835,814	1,432,110	70,748
Greater Columbia	39,633,142	12,907,198	41,528,532	12,907,198	669,757
King	87,865,401	40,104,469	92,024,429	40,104,469	1,880,150
North Central	15,484,644	3,746,689	16,227,674	3,746,689	216,633
North Sound	42,138,473	23,051,100	44,138,837	23,051,100	1,098,134
Peninsula	18,226,270	7,161,927	19,087,287	7,161,927	344,059
Pierce	38,325,582	16,791,402	40,146,106	16,791,402	803,669
Southwest	6,727,145	1,891,473	7,046,352	1,891,473	98,787
Spokane	31,931,138	10,920,073	33,442,079	10,920,073	458,013
Thurston Mason	14,185,552	6,927,592	14,859,427	6,927,592	300,952
Timberlands	6,806,543	1,997,899	7,129,410	1,997,899	100,384
Total	330,588,189	138,265,857	346,285,078	138,265,857	6,573,440

Note: Non-Medicaid revenue also includes funding related to Expanding Community Services (ECS), PALS, PACT, and Jail Services

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

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 Mental Health Division (MHD) 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 (DSHS) is appointed by the Governor to this Cabinet Level position and oversees all administrations within DSHS, which include Health and Recovery Services Administration (HRSA), Aging and Disability Services Administration (ADSA), Children's Administration (CA), Economic Services Administration (ESA) and Juvenile Rehabilitation Administration (JRA).

HRSA encompasses mental health, substance abuse and physical health care divisions. HRSA also is the Medicaid agency for Washington. Mental health and substance abuse have been incorporated into one division as of June 1, 2009, and HRSA is moving to an integrated care model.

Mental Health Reorganization to Increase Integration

Building on the realignment that began in 2005, when medical assistance, mental health and chemical dependency divisions began a new relationship under the Health and Recovery Administration (HRSA), on June 1, 2009 components of three divisions were re-organized to create two divisions. Most components of the former Mental Health Division headquarters were merged with the former Division of Alcohol and Substance Abuse under a single director, David Dickinson. MHD Regional Support Network contracts and other RSN quality-monitoring components were integrated with the managed care Healthy Options staff in the Division of Healthcare Services. The combined mental health and substance abuse division will coordinate closely with Healthcare Services Division, directed by MaryAnne Lindeblad, in an integrated care model.

Other divisions within HRSA include the:

- Division of Finance and Rate Development which provide fiscal and budget services for the administration;
- Division of Eligibility and Service Delivery, which provides Medicaid hotlines for clients and providers, including authorization lines, eligibility policy issues, community service office (CSO) intake worker training, and provider enrollment;
- Division of Healthcare Services which includes care management, quality oversight, family services, benefits management (fee for service and managed care) and coordinated care pilots: Medicaid Integration Partnership, and Chronic Care Program.

- Division of Systems and Monitoring: high technology services, audits and data sifting, provision of services and technical expertise to the entire HRSA and which encompasses:
 - Claims Processing
 - Veterans’ Project
 - Medicaid Eligibility
 - Quality Control
 - Consolidated Information Technology services
 - Legal Services—rule writing, Administrative Hearings, Human Resources, public disclosure, contracts and workforce advancement and Division of Disability Determination Services

The Mental Health Division (MHD) 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 MHD 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

MHD 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.

- ✓ Medicaid funding (and required State Match) is allocated to RSNs based on a formula that includes the number of disabled and non-disabled adults and children eligible for Medicaid in the region.
- ✓ State-Only funding is allocated to RSNs based on the region’s proportion of total population – except when legislatively authorized funding is directed for a specific purpose, for example PACT – among the main uses of State-Only funding is operating the crisis and involuntary treatment systems.
- ✓ Federal Block Grant of which 5% is reserved for administrative costs. Of the remaining 95%,
 - 80% is allocated to RSNs through a population based distribution formula
 - 20% is allocated at the discretion of MHD headquarters, and will have guidance from the Planning and Advisory Council

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 MHD 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 2008:

- A total of 118,074 people, approximately 92,000 of whom were covered by Medicaid, utilized mental health services in community outpatient settings.
- More than 8,100 people received services in community hospitals.
- Almost 2,300 people received inpatient services in state hospitals.
- Medicaid eligible people received about 88 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, 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.

In January of 2008 DSHS assumed the duties of the former Pierce County Regional Support Network which terminated their contract. Services in Pierce County were delivered through fee for service contracts between the state and local mental health providers through calendar year 2008. This arrangement ended on July 1, 2009 when the managed care corporation OptumHealth assumed the role of Regional Support Network for Pierce County. OptumHealth was selected through a competitive procurement process that was developed in response to legislation passed in 2008 that allowed for the state to contract with entities other than county-based entities in the event a county was not willing or qualified to serve as an RSN.

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
- Program of Assertive Community Treatment (PACT) teams implemented in nine counties
- Services to individuals in and transitioning from jails implemented statewide
- 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

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 be 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.

For children and youth acute inpatient services are provided either in community psychiatric hospitals or in special units set aside for children and youths. Children's Long-Term Inpatient facilities (CLIP) provide inpatient care for those children and youth who need extended inpatient services. CLIP facilities include Child Study Treatment Center, a 47 bed state run facility on the grounds of Western State Hospital. MHD also holds contracts for the operation of three CLIP programs. These facilities provide capacity for an additional 44 children statewide. Standing agreements between CLIP and each RSN detail the responsibility for the resource management of these 91 beds. There are two involuntary treatment facilities for youth, one in Kitsap County, one in Yakima County.

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 1200 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

Although the Division holds its leadership role as extremely important, in terms of conveying and overseeing the implementation the Governor's and State Legislature's intentions and initiatives, MHD holds strong beliefs in the need for collaboration with the Mental Health Planning and Advisory Council (MHPAC), allied systems, other state agencies, the Transformation Work Group (TWG), RSNs, the other formal providers of services to children and families, providers, and consumers/families/advocates at large. In addition to oversight of the mental health system, MHD is responsible for resolution of consumer grievances and Fair Hearings that require State level intervention as well as the coordination of emergency preparedness and response to such incidents as natural disasters and acts of terrorism.

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.

The planning system and infrastructure for the delivery of children's mental health services is much the same as that for adults. RSNs, including the new Pierce County RSN, OptumHealth, must provide a complete array of services to children and youth through sub-contracts with local community health agencies for provision of direct care services to individuals in this vulnerable population who have serious emotional disturbances (SED) and who meet medical necessity criteria.

Between nine and thirteen percent of children and youth ages 9 to 17 years old have serious SED that affect their functioning in family, school or community activities. There are an additional number of children and youth identified by school systems as having a serious behavioral disability. These children and youth are served not only by mental health and school systems, but often also by the Department of Social and Health Services (DSHS) Children's Administration, DSHS Juvenile Rehabilitation Administration, and DSHS Division of Alcohol and Substance Abuse, now a combined division with Mental Health Division. Youth also receive services through the state Department of Health and physical health care providers.

Over the course of many biennia, training and technical assistance on the use of innovative methods of cross-system partnerships to deliver coordinated care have been provided. In addition, numerous local and national reports on coordinated care and best practices have been written. It is, however, funding directives and the high level of commitment in allied systems of care that supports the growth and cohesion of children's services and which is the major force behind the coordination of care.

Youth may have multiple needs to be addressed, including mental illness, substance abuse, trauma experiences, and patterns of property destruction, assaultive behavior, sexually offending behavior, fire setting and cognitive impairments, among others.

Children and adolescents with the most severe disorders usually have needs that require services from at least two child serving systems, along with medical care and other support. These children may have histories of being bounced from one service system to another, among them child welfare, mental health, juvenile justice, substance abuse, developmental disabilities and special education.

Too often children are not identified as having mental health problems and instead do not receive timely and effective services and end up in juvenile justice settings. At least three RSNs and one Pierce County provider fund diversion programs through Federal Block Grant funds or co-fund evidence based practices to assist children and their families to stay in their homes.

It is important that care coordination exists for these children and their families. Families should not have the additional burden of coordinating with multiple systems that assist them. Those systems should assume the responsibility to work together to serve children or youth and their families.

Neither should it be necessary for parents to relinquish custody and care of their children to get services they need. Such has been the case in the past wherein a parent who could not meet the state eligibility criteria to obtain care for their child was forced to make the difficult choice to relinquish custody, thereby making the child a ward of the state in order for the child to become eligible for services.

MHD has a successful three-year pilot project that uses Multi-dimensional Treatment Foster Care (MTFC) in the Peninsula RSN. The pilot maintains fidelity standards, but parents are not required to place their children in foster care to meet eligibility requirements.

With the passage of HB 1088 last year, three pilot sites for fidelity Wrap-Around have begun. These sites are in the North Sound RSN (Skagit County), Grays Harbor County and the Southwest RSN (Cowlitz County). The MHD has contracted with Vroon Vanden-Berg to provide readiness assessments and to develop fidelity based programs. The first children and families were served in July 2008.

Another portion of HB 1088 is the review of the MHD's Access to Care Standards (ACS). These Standards were set as a Term and Condition of the MHD 1915(b) Medicaid waiver. The Centers for Medicare and Medicaid Services (CMS) required the MHD to establish statewide diagnosis and function levels into the assessment of individuals entering the public mental health system. Along with medical necessity, this composes major entry requirements for service. One of the allied systems' outcries is that the ACS prevents children and youth from entering the system.

While this is an unconfirmed concern, the state legislature responded to it by creating three new legislative provisions:

1. the number of mental health visits offered under the physical health care managed system increased from 12 visits to 20;
2. the types of practitioners who could provide up to 20 visits expanded;
3. a review of Access to Care Standards was provided to the Legislature in January 2009.

The Mental Health Division operates one children's psychiatric hospital, Child Study and Treatment Center. MHD also contracts with three children's long term residential care programs, located in Seattle, Tacoma and Spokane. These facilities provide services to children with SED who need extended stay treatment. The total bed capacity for the state is 91 children at a time. This currently is causing some children to have long wait times for needed care. The MHD has, in its internal strategic plan, identified the need to reduce the number of children waiting more than 30 days for admission.

Another identified issue is the lack of step down placement, or less intensive care services, for children leaving extended care facilities. The use of EBPs and coordination with the DSHS Children's Administration may create viable alternatives.

The Statewide Action for Family Empowerment of Washington (SAFE-WA), a parent organization supported by the Mental Health Division through MHBG funds and the Mental Health Transformation Grant, is in its fifth year of 501(c) (3) status. SAFE-WA is comprised of family driven organizations and a youth organization from across the state. SAFE-WA meets every other month and develops monthly reports to bring a united voice to the Mental Health Division's management on prominent children's issues.

SAFE-WA is recognized by allied systems of the mental health system as a meaningful mechanism to facilitate discussions about utilization of parents, friends and neighbors to support children with SED.

The mental health system has received requests for technical assistance about best ways to incorporate family and friends into planning and support processes to help children with SED or behavioral needs to live normalized lives in their communities. Although this network of parents has become more accepted by providers as the organization's influence expands, they are, unfortunately, not yet seen universally as a resource. This group, however, has a strong belief in and commitment to their role as a system partner and plans to remain involved as coordination and recognition of their contributions continue to grow.

For several years, the MHD parent network had one or two actively involved fathers. Mental Health Division staff met with fathers alone at trainings to get their input on what they thought the fathers might need to come together and support each other. Staff listened and tried to meet the need. A new organization subsequently formed known as Washington Dads WADADS. To date, they have supported each other with the development of child specific IEPs and have mentored each other in the CLIP application process. WADADS have established a website <https://www.wadads.org> where they post information, training events and have a chat room. In 2009, they are planning more regional meetings with one or possibly two larger meetings.

Youth 'N Action provide a voice to at-risk young people, ages 14-24, in Washington State. Their mission is to empower youth with the resources and tools required to:

- Advocate successfully to meet their needs in education, treatment, mental wellness, and overall health and happiness
- Understand their rights and responsibilities in government
- Participate in fun activities
- Support and encourage one another through peer support

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 2008 MHBG Plan:

By Formal Systems Use:

- Continued utilization of inpatient care and
- Involvement with the juvenile justice system is too high

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 developing programs for diversion and workforce development and increased family involvement.

In addition, expedited medical eligibility was established by 2SHB1088 for youth leaving Juvenile Rehabilitation Administration (JRA) facilities. A special workgroup has been established for a collaborative arrangement between Juvenile Rehabilitation Administration, the Division of Substance Abuse and Mental Health, to address enhanced parole.

By Natural Supports: Too few families feel empowered or involved in the care of their loved ones. More training and support are needed to enhance optimal use of this valuable natural resource

Too few families feel empowered or involved in the care of their loved ones. More training and support are needed to enhance optimal use of this valuable natural resource, families. The Children's Mental Health Reform bill, 2SHB1088, firmly establishes the involvement of families in the treatment of their child. Parent advisory committees are established for children in long-term psychiatric treatment.

Several parent focused training sessions occurred in the last year, including a parent "Connectors' Retreat" with workshops on advocacy, Wrap-Around, partnering and a full day of training on legal aspects of Individual Education Plans (IEPs). This conference included "Leadership Training II" for parents who participated as co-facilitators and individual support peers. This annual 3-day retreat is supported by federal block grant dollars.

Triple-P, an evidence-based practice that includes parent training is firmly established in one RSN and serves as a model for others. Additionally, the REACH Institute along with Washington's Children's Mental Health Evidence-Based Practice Institute (also established by 2SHB1088) conducted a six week course for parents who are interested

in becoming coaches for other parents in parent-professional partnerships. This is called the “Parent Empowerment Program”. A Children’s Mental Health Forum and Survey conducted in 2008 sought input on many variables relevant to improvements in the mental health system for children and will continue to inform our system transformation efforts.

Increased community education on early intervention and preventions as well as Recovery and Resiliency are needed to infuse the system and child and youth consumers with hope;

By Understanding of Recovery and Resiliency: Increased community education on early intervention and preventions as well as Recovery and Resiliency are needed to infuse the system and child and youth consumers with hope

Early intervention is a value and a goal in WA. Efforts such as trauma-informed care in MHD’s relationships with schools introduced by WA Mental Health Transformation Grant and the University of Washington’s specialty training and promotion in infant mental health are two drivers. King County has taken leadership in a partnership with an RSN contracted provider which will certainly encourage innovation in other RSNs.

The Department of Social and Health Services (DSHS) Division of Substance Abuse (now incorporated with Mental Health) has long supported prevention efforts in the schools as recipient of federal grants. Evidence-based practices, such as TFCBT which often rely on federal block grant money and Triple-P, and Incredible Years, for which there is early dissemination in WA offer both early intervention, and certainly have a prevention motive. These programs are in pilot stages, however and expansion and sustainability will depend on legislative advocacy, commitment and funding.

By Educational/Vocational Activities: More support in education, jobs, and meaningful activities is needed to help children and youth become productive members of society.

Too few programs exist for this age group; trauma informed care expansion in schools promotes this goal. Multi-dimensional Treatment Foster Care emphasizes skills development, school outcomes, reduction in recidivism and independent living skills. Washington has an active youth empowerment organization (Youth ‘n Action or YNA) operating under the umbrellas of our statewide parent organization. YNA has demonstrated creativity, engagement and effectiveness and has become a model for such organizations across the country. Youth participate in community development and are on state and university advisory boards. Tamara Johnson is a youth representative to the MHD Planning and Advisory Council.

By Evidence Based Practice: Increased utilization of available evidence based practices

Several mentions have been made of current EBPs, their effectiveness, support and our commitment to expansion. The limitations for funding streams to include sustainable training and consultation and fidelity-requirements (such as bundled services) sometimes defy the ability to support with federal Medicaid dollars. Washington has shown great advances in particular in the educations of families and providers resulting

in the reduction of some of the early resistance to EBPs.

By 2012 DSHS is required to emphasize: early identification, intervention and prevention and to eliminate duplicative care plans and case management.

Among the systemic changes that are recommended are the greater use of evidence-based practices statewide, focus on resiliency and recovery, integration of educational support services and the achievement of specific performance based outcomes.

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 has had a dedication to SOC principles for many years. The legislation mentioned several times in this update (2SBH1088) funded three high fidelity Wrap-Around sites that are moving into their second year of operation. WA contracted with a nationally known trainer to conduct fidelity training and certification. The University of Washington under the leadership of Dr. Eric Bruns is conducting the evaluation. In the first year of operation, 57 families were engaged in Wrap-Around. Early evaluation among other positive outcomes is showing fidelity rates that rival and exceed national standards, and high stability of home residence.

Washington is examining and enhancing our reporting requirements to include specific performance indicators legislated by 2SHB1088.

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

June 30, 2009 marked the completion of the first year of operation of the 3 Wrap-Around pilot sites established under 2SHB 1088 (North Sound, Grays Harbor and Southwest. RSN accomplishments:)

- 57 families have been served by high fidelity Wrap-Around
- The training contract with Vroon Vanden-Berg completed 56 site-specific and group trainings along with ongoing coaching, credentialed site-based coaches, team facilitators and local teams.
- Parent outreach and partnerships were established in all three sites
- 2-day training for approximately 50 parents was held.
- The statewide family organization has and continues to provide support.
- The University of Washington Children's Mental Health Evidence-Based Practice Institute completed the first stage of its evaluation for which early evaluation shows measurable and meaningful results in fidelity adherence and maintenance of youth in the community.
- Ongoing implementation of Children's Mental Health EBPs such as state supported pilots for: "Partnerships for Success" model implementation of Multi-systemic Therapy, Triple P, Tribal implementation of TFCBT, and a parent empowerment program; two core trainings, 15 6 month consultation groups and advanced and supervisor training with national speakers, adding another 200 to over 300 clinicians trained in the state. Additional foster parents trained, creating increased capacity for Multi-Dimensional Treatment Foster Care now with 16 successful graduates avoiding out of community placement, hospitalization or adjudication and successful return to schooling, work or independent living.
- Two SAMHSA SOC grantee communities (Yakima County and Lummi Tribe) completing the first year of their implementations.
"The completion of the CSAT Strategic Plan for Adolescents with substance abuse and co-occurring disorders.
- Actuarial Study completed identifying prospective expense of lowering the "Access to Care Standards" thresholds for medical necessity to access services in the 1915 (b) waiver for public mental health service (based on diagnosis and CGAS determinations).
- Creation of a fee for service network of licensed clinicians now over 500 strong across the state, available for children who do not meet the access standards for severely emotionally disturbed priority population.

- Ongoing work between the Mental Health Division and the Transformation Grant regarding trauma-informed care, parent involvement, employment and youth in transition.
- Completion of SAMSHA grant to bring Youth In Transition(YIT) programs to two Regional Support Networks in rural western Washington
- Partnership with Dept. of Vocational Rehabilitation for a “Trial Work” program at the mental health division, working in the Office Of Consumer Partnerships
- 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 the 1915 (b) managed care waiver. This has expanded the available number of DSHS providers of Medicaid covered children’s mental health services by over 600 licensed mental health professionals.
- The MHD Children’s Unit hired additional staff to oversee Fidelity Wrap-Around Implementation in three counties. Intensive training leading to certification was conducted and UW initial evaluation results are showing stabilization (no out of home placements) and high fidelity scores.
- The RSN Children’s Administrators and Family Representatives workgroup was chartered to conduct quarterly meeting to organize and make recommendations for statewide improvement efforts in children’s mental health, learn from regional programs and support implementation of legislative and department priorities under the RSN Contract.
- The Partnership Access Line “PALS” a collaborative pilot funded under 2SHB1088 has funded consultations to primary care physicians in two regions of the state covering 22 out of 35 Washington State counties. Consultation services target children and youth presenting to PCPs with emotional, behavioral and/or mental health problems for which Child Psychiatrists provide education and consultation regarding diagnosis, medication management, treatment options and referral information. This program coordinates with County and Regional Support Network and Community Mental Health Agencies to support the success and sustainability of this project. It has been funded to continue in the coming biennium.
- Pharmacy program to follow up on children under 5 who are being prescribed psychotropic medications.
- Second opinion on prescriptive practices pilot.
- 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 in its second year of operation. Technical assistance in a two-county RSN addressed ongoing quality improvements for MST services, sustainability initiative, Implementation of 3 new EBPs: Triple P, training for the Parent Empowerment Program, and training for the Skokomish Tribe and enrollment of youth in TF-CBT, attended an advanced training on cultural adaptations of the model, started using the quality assurance database and had several staff trained in Motivational Interviewing. Other projects partially funded by private organizations include this major effort on behalf of foster children:
- Project Focus, funded by the Paul G. Allen Foundation, is being implemented in partnership with the Children’s Administration of the Washington State Department of Social and Health Services. The project seeks to improve outcomes for this population by targeting child welfare caseworkers’ knowledge and utilization of evidence-based practices (EBP) by providing training and consultation to both groups and by increasing the coordination of care. Through in-person training and

phone consultations targeted to identification and appropriate referrals of children/youth in foster care with mental health problems and education in evidence-based health and mental health practices. This consultation is also extended to community clinicians who serve youth in foster care who also receive specific training in use of an EBP tool (MATCH-ADC to treat the three most common mental health problems among foster children. The University of Washington is currently evaluating Project Focus.

Parent and Youth Support

Federal Block Grant funded the Statewide Parent Organization, the expansion of WADADS and a number of other activities including Wrap-Around Training, children's mental health planning participation, attendance at national conferences and other events. Following is a summary of accomplishments:

SAFE-WA

- Outreach to develop new network organizations
- Provided Technical Assistance to emerging youth and family organizations for the implementation of fidelity Wrap-Around training
- Attendance at Building on Family Strengths Conference (Portland, Oregon)
- Updated Parent Resource Guide
- Planned, organized and facilitated Connector's Training
- Development of Connector work plans
- 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
- Facilitation of two parent trainings for youth on the wait-list for the Children's Long-term Inpatient Program
- Technical assistance and consultation to an agency to develop a youth specialist role in the supported housing program.
- Partnership with Youth N Action to develop an artistic expression screen play
- Development of an Organizational Sustainability Planning timeline reflecting youth summit activities

WADADS

- 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

Cross system initiatives

MHD continues involvement in a number of study and workgroups including:

- Children of Incarcerated Parents
- Settlement compliance plans and activities for foster children
- Juvenile Offenders Re-Entry from Rehabilitation facilities
- MacArthur Grant Mental Health and Juvenile Justice
- Project Launch promoting wellness of young children birth to eight
- Medical Home and
- Integrated programs for most vulnerable children

Recently the State of Washington also joined a national research project sponsored by the National Research Institute as one of three states relevant to YSS-F survey data. Washington was asked to join this effort due to level of participation we have achieved.

Washington

21 Child - Legislative Initiatives

Child -Legislative initiatives and changes, if any.

HB 1270: Joint agency request legislation by HRSA and the Health Care Authority that supports applicants' ability to fully complete online applications for state-subsidized health care coverage and helps speed application processing times by DSHS and HCA staff.

SHB 2128: The 2007 Legislature enacted 2SSB 5093, to achieve the Governor's goal that all children have access to affordable health coverage by 2010. DSHS was directed by this legislation to offer children's health coverage to families with incomes above 300% of FPL on a full-cost, non-subsidized basis. The legislation mandated that the benefit design for this higher income population be the same as the Medicaid Categorically Needy (CN) subsidized coverage defined in RCW 74.08.520 and begin on January 1, 2009.

House Bill 2128 changes the implementation date to 2010 and gives HRSA flexibility to structure the benefit in a way that potentially avoids adverse selection and is affordable. HRSA will need the delayed implementation date to modify the benefit design and work with stakeholders to accommodate legislative intent of a budget-neutral program, actuarial realities, and advocates' commitment to affordable health care coverage for higher-income families. The new legislation gives HRSA latitude to establish copayments, pre-existing condition requirements and waiting periods.

2SHB 1373: Eliminates the 7/1/2010 sunset date for increasing the annual number of office visits (from 12 to 20) available to children needing outpatient mental health therapy in managed care programs and on a fee-for-service basis. Permits outpatient mental health therapy in managed care and fee-for-service programs to be delivered by mental health professionals under the direct supervision of 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.

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 EBP pilots was reduced this past legislature but the contractors should be able to provide the same level of core services as they did in the last state fiscal year.

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 UW Evidence Based Practice Institute (EBPI). The evaluation will continue under EBPI funding.

The "Partnerships for Success" EBP pilot projects in Thurston and Mason Counties received reduced funding directed to the ongoing implementation and fidelity monitoring of Multi-systemic Therapy (MST). The contract with MST Inc. through the EBPI was also funded.

Multidimensional Treatment Foster Care funding cut was based on utilization in the previous year from a capacity of 10 foster homes to 5. The program struggles in recruitment of licensed foster homes that will take just one child, but services will continue, at a level commensurate with numbers served in the last state fiscal year and will continue to include aftercare.

Regional Support Networks submitted their proposals for block grant funding which will be directed in part to children's programs. In most counties projects are related to youth activities, parent support, psychiatric services, school support, outreach and engagement of non-Medicaid children, and collaboration with Native American Tribes.

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

MHD provides leadership to the RSNs including the newly contracted Pierce County RSN, OptumHealth, 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 the additional focus on children's mental health issues, DSHS added over 600 licensed clinicians to provide children's mental health services on a fee-for-service basis to children who do not meet access standards for managed care under the State Waiver.

MHD is working in a collaborative fashion with the Children's Administration, Juvenile Rehabilitation Administration and the Office of Superintendent of Public Instruction. Additionally, MHD is working closely with physical health care and substance abuse, chemical dependency divisions to integrate programs for all service populations.

Parents and MHD staff completed the consumer and family operated services report due to the legislature in January 2009.

Allied service system plans required of all of the RSNs are being reviewed, updated and standardized as a project of the RSN Children's Care Coordinator and Family Representatives Workgroup.

Washington's Peer Support Certification program has reached out to parents of children and youth and to adults to participate in training.

MHD has contracted with the Washington Institute of Mental Health Research and Training to revise the Children's Mental Health Specialist training.

This year the structure of the Health and Recovery Services Administration under DSHS umbrella was changed structurally to integrate the Mental Health Division and the Division of Alcohol and Substance Abuse. Planning and collaboration efforts are underway to enhance program policy and planning where our work units can achieve efficiencies and our programs benefit from enhancements (such as treatment for co-occurring mental health and substance abuse).

The parent liaison role within the MHD 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.

The MHD Children's Mental Health Services staff have participated in numerous cross system planning activities for the benefit of children, youth and families.

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

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 Department of Social and Health Services (DSHS) Indian Policy Service and Support (IPSS) unit and with Indian Tribes, supported through monthly meetings and workgroups, including work towards development of the 2010-2012 Medicaid waiver renewal
- + Continued operation of ten PACT teams statewide, which includes training and fidelity measures
- + 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.

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.

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 MHD staff, the MHPAC, consumers, family members, advocates, providers, multiple other community organizations and allied providers.

Housing: There is insufficient safe and affordable housing available.

Benefits: Many individuals need mental health treatment, yet are not eligible for them. State-only dollars are insufficient to meet the need for services from this group of people, and economic circumstances locally and nationally do not portend immediate improvement in these circumstances.

Inpatient Capacity: Secondary to the first two issues, rates of need for hospitalization are increasing but capacity has not increased.

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

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 an unprecedented focus on the mental health system. The merger of the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) mental health and substance abuse divisions, coupled with a move toward integrated health care, promise to bring additional attention in the coming legislative session.

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. Mental Health Parity legislation remains a commitment of the state legislature.

The MHD 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:

- Statewide implementation of Program of Assertive Community Treatment (PACT) teams
- 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

Housing: MHD 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 Housing Action Plan promotes recovery and addresses the increasing demand for hospitalization at Eastern and Western State Hospitals. A goal of the Plan is to create or secure an additional 500 housing units by providing technical assistance to Regional Support Networks (RSNs), providers and consumers to build capacity locally to develop housing, design and implement housing programs and to establish partnerships with landlords.

The focus of the Housing Action plan is on community based housing models that have demonstrated success at increasing stability, reducing episodes and lengths of stay in hospitals and jails and promoting recovery. 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: MHD 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. MHD is in the process of determining specifics of implementation, which will be affected by legislative directive in the coming year.

Utilization Review: The Utilization Review (UR) Project will produce recommendations for statewide criteria and processes for external utilization review of state and community hospitalizations within the state. The goal will be to ensure adequate levels of state and community psychiatric inpatient services that support the recovery of individuals with severe and persistent mental illness. Features of the UR Project will establish acuity levels and criteria for individuals to be supported in community psychiatric inpatient settings and for individuals to be supported in community outpatient programs, based on current access to care standards, involuntary treatment statutes and other and industry standards.

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 is being 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.

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. MHD 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 MHD to certify clubhouses. The Medicaid waiver provides for clubhouse services to be an approved service, which has increased the number of clubhouses across the state. As a result of legislative provisions, state regulations were amended to include certification provisions for clubhouses. Federal Block Grant funds were used by MHD to support technical assistance to clubhouses in preparation for certification review. The state certification process began in September 2008 and will continue.

MHD 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 2010 conference.

The Mental Health Transformation Project and the Office of Consumer Partnerships collaborate 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.

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 history of dangerousness or potential dangerousness on the client they are visiting, if available.

Enhanced opportunity for system and community collaboration

The Mental Health Division (MHD) continues to actively work 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)

MHD 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 system transformation, to legislative initiatives, to state regulation or Washington Administrative Code changes.

CLIP Agreement Signed Between DSHS and Suquamish Tribe

On August 25, 2008 the Mental Health Division and the Suquamish Tribe signed a long anticipated agreement allowing the Tribe direct access to the Children’s Long Term Inpatient Program. CLIP provides treatment for children in need a long term inpatient voluntary residential treatment. The Suquamish Tribe will no longer be required to go through the Regional Support Network and will have direct access to the CLIP review panel for access to services for their children requiring inpatient treatment. The Tribe has been working with MHD for nearly two years in effort to complete this memorandum of agreement. This agreement is a significant step towards establishing and maintaining a respectful government to government relationship between the Department of Social and Health Services and the Suquamish Tribe.

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 Mental Health 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 40% 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. A collaborative aspect of the work included the joint support from the Mental Health Division and Mental Health Transformation Grant Project for a five-session track and keynote address on employment at the 2009 Behavioral Health Conference, the premier mental health conference in the State.

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.

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. By September 2009 – 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 2008 Institute was jointly funded by the Department of Community Trade and Economic Development (CTED, now Department of Commerce), DSHS/Mental Health Division and Washington Families Fund a unique partnership among the State of Washington, in collaboration with King, Snohomish, and Pierce Counties, the cities of Seattle, Everett, and Tacoma and several philanthropic and corporate partners, led by the Bill and Melinda Gates Foundation as well as the United Way of King County, Boeing, Microsoft, the Campion Foundation, the Greater Tacoma Community Foundation, and the Ben .B. Cheney Foundation. Additionally each team was required to contribute to offset the on-site technical assistance. 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, among the financial supporters. Sixteen capital permanent supportive housing projects will have been designed and will be 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. Every project developed during the Institutes will have a “leg-up” to receive state Housing Trust Fund grants managed by CTED.

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 MHD 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 MHD 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 Community Trade and Economic Development the primary state funding agency for low income housing and 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. Block grant funding is used to support technical assistance provided by Common Ground.

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) Mental Health Division (MHD) 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, and other mental health stakeholders to develop the report in cooperation with MHD.

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 MHD’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.

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-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 Mental Health 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 DSHS 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 1, 2009, there are 589 trained Peer Counselors, of which 250 are certified. Another 163 have passed the certification examination and are awaiting license from the Department of Health. There are two more training sessions scheduled for 2009 which will train 50 individuals.

In 2009, training was sponsored by both the MHD and by the RSNs. In collaboration with the Mental Health Transformation Project, an expanded survey of peer counselors will be conducted by WIMHRT utilizing consumers as interviewers. The intent of the expanded survey is to gather more information about current and past employment by peer counselors, factors that impact ongoing employment, knowledge of the state's Medicaid Buy-In alternative and interest/willingness to be part of a job seeker data base. The expanded survey also gathered information about how well the state mandated

curriculum prepared individuals for work as a certified peer counselor and whether further training might be helpful.

Increase Resources For People With Co-Occurring Disorders

MHD and the Division of Alcohol and Substance Abuse staff 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 MHD 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/MHD 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. MHD will continue to actively enhance the outreach capacity and specialized services needed by this traditionally underserved population.

Increased focus on MHBG funds

MHD 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 MHD 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 Mental Health Division (MHD) 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.

The MHD 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

Health and Recovery Services Administration

The Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) was created in 2005 to foster greater integration of the state's medical assistance, mental health, and chemical dependency programs. These programs previously were split in two separate administrations. The creation of HRSA was intended to eliminate administrative barriers to integrated service delivery in order to effectively carry out a vision to promote a healthier Washington. The recent combining of mental health and substance abuse divisions is another step in the movement towards an integrated care model.

The increased collaboration amongst the program areas resulting from joining these programs within the same administration is leading to a transformed vision amongst all programs reflective of the comprehensive needs of consumers. This is a vision in which Washington's system of care 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.

Vision for the State Mental Health System:

The vision for the Washington state mental health system is one in which:

- 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, MHD 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 recently was appointed to the role of Secretary. Susan Dreyfus has already been lauded as a champion for all children with a commitment to improving foster care and mental health services statewide. She is a proponent of system of care principles and hails from Wisconsin and has direct experience in the Wrap-Around Milwaukee. She has already voiced her support for Wrap-Around and identifying the barriers to bringing Wrap-Around to scale in Washington.
- + A diverse and inclusive community support system
- + Counties that have passed and implemented the 1/10th of 1% sales tax to support mental health service expansion and outreach
- + A cross system, legislatively driven, resource for implementing Wrap-Around pilot sites
- + 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.
- + University support and vision including a strong involvement of parents and youth in planning efforts
- + Legislation requiring more rapid implementation of mental health parity
- + Legislators with a strong tie to children's mental health and parent stakeholders
- + A steady increase in Peer Counselors, including parents
- + 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 reinstated 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
- + Active statewide family organization/network of 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 in not just in the Mental Health Division, but Juvenile Rehabilitation Administration, Children's Administration, Developmental Disabilities and Substance Abuse of the importance of parent and youth voice in policy and the opportunities to reach out and support families
- + An exceptional and growing network of dad's (WA Dads) that have brought new light to the need for support for dad raising children with serious emotional disturbance.
- + 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
- + Co-occurring services for youth
- + Mental health education in schools
- + Juvenile drug and family dependency interventions
- + Interventions in juvenile rehabilitation facilities to prevent incarceration of youth who have serious emotional disturbances

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 large areas require more work to be done in facilitation and coordination of care across Washington's multi-service delivery system for children and will take more than one year to accomplish. Therefore the items below continue as unmet needs.

Formal Systems Use

Continued utilization of inpatient care and involvement with the juvenile justice system are needed.

Natural Supports

Too few families feel empowered or involved in the care of their loved ones. More training and support are needed to enhance optimal use of this valuable natural resource.

Understanding of Recovery and Resiliency

Education for children, youth and their families on Recovery and Resiliency is needed as well as for the system to hear from youth and families to ensure the meaning of the language the same.

Early Intervention and Prevention

Increased community education on early intervention and prevention are needed.

Educational and Vocational Activities

More support in education, jobs, and meaningful activities is needed to help children and youth become productive members of society. Too few programs exist for this age group.

Evidence Based Practice

Increased utilization of available evidence based and emerging practice is needed across the entire children's system.

Transition age youth

There is a need for services that may begin prior to a youth in transition from children's to adult services to receive coordinate support from both youth and adult systems one as the transition from one to the other takes place.

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 MHD is to ensure that children with 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: As a follow-up to last year's workgroups to assess the Children's Long Term Inpatient Program (CLIP) and the community acute care resources available to children and youth, there are four separate groups working to improve parent partnerships, access, standard terms and definitions and other related activities. Greater collaboration is occurring with JRA and there is a requirement in SSHB1088 to explore Medicaid eligibility for youth when they are in detention to ensure coordinated after care. Collaboration with Children's Administration, DASA and physical health are active at the state and RSN level.

Natural Supports: MHD 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. That commitment is partially accomplished through contracts with Statewide Action for Family Empowerment of Washington (SAFE-WA) and by continuing to support the growing WA Dads Network. Support is also afforded to parents to attend training and conferences and support from Parent Community Connectors. Parents who have children in long term residential programs often feel isolated and alone. MHD has provided two training sessions specific to their needs and will continue to support these parents while their children are in residence. MHD anticipates this training will continue in 2010.

Understanding of Recovery and Resiliency: The need for a comprehensive Recovery and Resiliency training and the relationship to children and youth is well understood. MHD 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. MHD will continue to work to ensure that language is consistently used. Though MHBG funds MHD will provide funding to assist parents in visiting their child both to participate in treatment activities but, to also allow them some time as a family unit.

Educational/Vocational Activities: MHD 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.

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.

Other concerted efforts have been described throughout this year's plan submission and have strong foundations in partnerships with all levels of stakeholders and demonstrated interest in improving the funding picture as the economy improves. Cross-system partnerships are steadily improving with focus on specific projects as well as shared goals.

MHD has direction and priorities that have resulted from stakeholder input and studies. In addition to what has been mentioned, MHD devoted funding to a "High-Intensity Children's Mental Health Services" workgroup, employee consultant (Tri-West) leadership and resulting in priority setting and funding scenarios to support expanded intensive community based treatment models, crisis services and transition services to improve continuity of care.

MHD'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.

The Evidence Based Practice Institute has developed a Parent and Youth Advisory group which will continue to enhance program development with valuable perspective.

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 57 new families receiving Wrap-Around services in the first year of the project and positive, early outcomes on the UW evaluation conducted by Dr. Eric Bruns
- Children's Long-Term Inpatient Program (CLIP) Agreement signed between DSHS and the Suquamish Tribe: On August 25, 2008 the Mental Health Division and the Suquamish Tribe signed a long anticipated agreement allowing the Tribe direct access to the Children's Long Term Inpatient Program CLIP provides treatment for children in need of long term inpatient voluntary residential treatment. The Suquamish Tribe will no longer be required to go through the Regional Support Network and will have direct access to the CLIP review panel for access to services for their children requiring inpatient treatment. The Tribe has been working with MHD for nearly two years in effort to complete this memorandum of agreement. This agreement is a significant step towards establishing and maintaining a respectful government to government relationship between the Department of Social and Health Services and the Suquamish Tribe.
- Expanded operation of the Children's Mental Health Evidence-Based practice Institute including widespread training.
- Allocation of state funding for EBP pilot projects in a year of cutbacks
- Expansion of FBG funded TFCBT training and consultation to a total of 600 participants, and growth in the number and sophistication of our WA Consultants with increased support from Administrators and community mental health agency leadership
- 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
- Creation of a fee for service network of licensed clinicians now over 500 strong across the state, available for children who do not meet the access standards for severely emotionally disturbed priority population

- Partnership with Department of Vocational Rehabilitation for a “Trial Work” program at the mental health division, working in the Office of Consumer Partnerships
- Official chartering by the RSN Administrators of a collaborative group including RSN children’s care coordinators and family representatives to undertake statewide improvement efforts in children’s mental health, to learn from regional programs and support implementation of legislative and department priorities under the RSN Contract
- A Tribal implementation of Trauma Focused Cognitive Behavior Therapy (TFCBT) through collaborative effort of the EBP Institute, the Regional Support Network under the leadership of the Skokomish Tribe
- The extraordinary “blossoming” of WA DADS now in latter stages of application for 501 (C) (3) tax status, gaining additional funding for special projects from the Transformation Grant for next year, gaining notice at two national conferences and expanding to communities without special support groups for fathers of children with mental health and developmental issues. WA DADS currently has seven invitations from other states and territories to provide technical assistance and training.
- Successful application of two Washington communities, Yakima County and the Lummi Tribe for System of Care Grants and their completion of a robust first year of implementation

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. MHD is moving forward with the requirements to have in place by 2012 a "new" children's mental health system.

**Section III. Performance Goals and Action Plans to Improve
The Service System**

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 Mental Health Division is a division of the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services of the state of Washington. The Assistant Secretary of HRSA and the Mental Health Division Director (now the director of the newly combined division 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 MHD 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, 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 MHD conducted a 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 2009 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 state 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 provider 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 Health and Recovery Services Administration (HRSA) merged mental health and substance abuse divisions into one division. It also has begun a move towards an integrated care model, combined with the HRSA Division of Healthcare Services (DHS).

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 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 MHD 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.

MHD'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 new 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.

MHD staff participates on a co-occurring disorders advisory committee.

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

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated number of adults with serious mental illness (SMI) of 264,239 in FY2007. SMI prevalence for 2008 is not available at the time this plan is being prepared. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of clients in our service population who have SMI.

The MHD made operational the guidelines using diagnoses and the Global Assessment of Functioning (GAF). 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 2008.

Please note that

- (1) Estimated SMI for 2008 was not available at the time the plan was developed so the 2007 data was used.
- (2) Total served in FY2008 included clients served by Pierce region which turned into Fee-For-Service beginning January 2008. However, the estimated SMI in FY2008 did not include Pierce region. This is because clients' functioning scores, a required data element to calculate SMI, were not available to MHD for Pierce region clients. The estimated SMI served is likely an undercount.

Table 1: FY08 SMI Estimates for Adults (18 years or older)

Estimated SMI (2007)	Total Adults Served	Estimated SMI Served	Quantitative Target
264,239	90,000	62,806	63,000

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 FY2007 as well as the projected number served in FY2008. 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 and the total population, prevalence rates are reported for the State.

Fiscal Year 2008 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. In 2007, the estimated adult population was 4,921,600 and the projected population for 2008 is not yet released.

Projected Service Rates				
Time Period	FY07 Adults Served		FY08 Adults Projected	
SMI Status	SMI	Total	SMI	Total
Adults Served	64,216	84,642	60,938	86,561
WA Adult Population	264,239	4,921,600	Data not available	Data not available
Penetration Rate	24.3% of adults with SMI are served by the Mental Health Division	1.7% of all adults in Washington State are served by the Mental Health Division		

This table shows that the Mental Health Division serves 24.3% of the adults in Washington State who are estimated to have a Serious Mental Illness and 1.7% of the general adult population. Adults with mental illness may be receiving services from private providers or through other systems, such as the VA system.

Washington

38 Adult -Outreach to Homeless

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

In the last five years, MHBG funds have been used to support several facilitated planning sessions in various parts of the state. In FFY 2008, 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.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in 2008 and 2009 and are intended to support the conference 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.

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 MHD 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, MHD 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 MHD 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.

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 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 were another priority identified by the MHD for FFY09 federal block grant funding.

The Older Adults and Family and Treatment subcommittee (OATS) of the Planning and Advisory Council (PAC) 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 Older Adult issues in September 2008. The conference was titled "Promoting Resiliency with Older Adults." It was the first conference of this kind for many years. Additionally, OATS will be the featured subcommittee at the PAC all stakeholder meeting in September 2009.

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. MHD, with assistance from OATS, will work to reinvigorate this model across the state, currently there are only two active programs.

There are many other integrated and cross-system partnerships in the RSNs such as Elder Services, Expanded Community Services, Lockett House and Hope Options. The evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative

Treatment) for late life depression exist in a few CMHAs. MHD will support workforce development through training on these to collaborative care models.

Through the work of the System Transformation Initiative (STI) benefit design, Involuntary Treatment Act (ITA) review and housing plan the needs of older adults will be addressed by:

- Increased education and training related to the special needs of this population and ways in which to engage them in treatment
- Increased efforts to train providers on how to better assist these individuals to access services for which they are eligible, such as Medicaid and Social Security
- Continued workforce development
- Reducing stigma
- Increased understanding of designated mental health professionals and crisis workers on the needs of older adults.

Besides the Gatekeeper program, 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 09, 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 RSN is a single county or group of counties. Some counties within the RSNs have specific taxes dedicated to mental health as a result of legislative authorization. As of December 2008, thirteen counties passed the sales tax option and six additional counties were planning to implement the tax. Counties with the new tax include: 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 MHD. 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 now considering the tax are in eastern part of the State. The Counties working to pass the tax now include Chelan, Douglas, Ferry, Stevens, Grays Harbor, and Lewis”.

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

Co-Occurring Disorders	MHP training on Access to Care
EBPs	Club House Development
Fetal Alcohol Effect	Cross-system Crisis Planning
Gay, Lesbian, Transgender & Bisexual	Tribal Collaboration
Safety for CMs and MHPs	Children in Foster Care
Early Intervention & Prevention	Ethnic Minorities
Crisis Intervention Training for Law	DD/MHD training to community
PACT training	WRAP

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 MHD with the Division of Developmental Disabilities (DDD), yet another example of training provided to emergency and health providers is the Community Hospital 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.

MHD 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 MHD 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 MHD.

MHD 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. MHD has completed successfully a regular service program and has a list of trained volunteers to assist should another disaster occur.

Through FBG funds the MHD 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, MHD followed the list of guiding principles developed in 2007 against which all proposals would be measured. To be funded as part of the 20%, activities must:

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 2010 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 estimated 8.3 million dollars awarded to Washington State, 5%, the grant limit is retained by MHD for administrative costs. From the *remaining* 95%, legislation historically has required that 80% be distributed to the RSNs. The other 20% (approximately 1.5 million) is utilized by MHD for selected activities.

In addition, the legislature previously directed that \$500,000 per year be dedicated for a Mentally Ill Offender Community Transition Program. This year the legislature has re-dedicated federal block grant funds in light of economic shortfalls in the state budget.

A portion of funds remaining after administration costs are deducted is dedicated to replace state only funding not currently available due to economic circumstances. Those funds are distributed to RSNs in addition to 80% of remaining funds. A total of \$6,573.440 will be distributed to RSNs in accordance with the table titled RSN Funding Awards, Based on Population Distribution.

**Total Federal Block Grant
Distribution**

Total Grant Award	\$8,344,000
5% MHD Admin	\$417,200
20% of Total-Admin minus fund shift to RSN	\$1,353,360
Legislative Fund Shift	\$683,000
Total to RSN's	\$5,890,440

In the 2009-2011 biennial 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.

**RSN Funding Awards
Based on Population Distribution**

Chelan-Douglas	\$108,865
Clark	\$423,288
Grays Harbor	\$70,748
Greater Columbia	\$669,757
King	\$1,880,150
North Central	\$216,633
North Sound	\$1,098,134
Peninsula	\$344,059
Pierce (OptumHealth)	\$803,669
Southwest	\$98,787
Spokane	\$458,013
Thurston-Mason	\$300,952
Timberlands	\$100,384
Total	\$6,573,440

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 to ensure it falls within the guiding principles, spending categories, and promotes services geared toward the promotion of Recovery and Resiliency or Transformation.
5. Feedback will be provided to RSNs and, 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 2009 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 Adult - Description of Transformation Activities

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 consumer/family education, training, community education and outreach. |
| Goal 2 | Will include consumer run activities, clubhouses, parent and youth support, Wrap-Around flex funds for service, peer support activities |
| Goal 3 | Support activities for Tribal entities, older adults, co-occurring disorders |
| Goal 4 | Will promote activities related to EBPs and promising practices across the lifespan |
| Goal 6 | Funding will be used for teleconferencing and telemedicine. |

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	84,642	90,003	86,561	87,000	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

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 MHD 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 Information:	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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	6.39	6.51	7.40	6.50	N/A
Numerator	643	631			
Denominator	10,065	9,697			

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 Information:	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 MHD in various forms and variation in reporting requirements. The projected 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 Projected	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			

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 Information:

MHD-Consumer Information System (CIS).

Special Issues:

Starting in Calendar Year 2008, Pierce County discontinued to operate 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 MHD in various forms and variation in reporting requirements.

The projected percentage for FY2009 did not include Pierce region data due to variation in Pierce data reporting requirements.

Significance:

Action Plan:

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.

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 Projected	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 MHD 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 Information:	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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	2,618	5.48	1,822	2,618	N/A
Numerator	N/A	3,419			
Denominator	N/A	62,367			

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

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

Sources of Information: 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 #3 and #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goals #3 and #5.
Assist projects developed through the 2008 and 2009 Supportive Housing Institutes to become operating housing projects. Devise and implement non-capital supportive housing

Action Plan:

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,872	3.17	895	1,872	N/A
Numerator	N/A	1,974			
Denominator	N/A	62,367			

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 MHD with SMI.

Sources of Information: 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	782	1.33	782	840	N/A
Numerator	N/A	830			
Denominator	N/A	62,367			

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 MHD 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 MHD with SMI.
Sources of Information:	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 Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	5,976	21.50	2,000	2,000	N/A
Numerator	N/A	13,410			
Denominator	N/A	62,367			

Table Descriptors:

Goal: To increase the number of adults who receive Family Psychoeducation.

Target: The number of adults receiving Family Psychoeducation 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 Psychoeducation
Prior to FY2008: Number of adults (18+) who receive Family Psychoeducation services. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of adults who receive Family Psychoeducation services. Denominator: Number of adults served by MHD with SMI.

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: The FY2008 actual client count was most likely an overcount due to some provider agencies reporting unusually large number of clients. In the 2009 projected count, we are excluding responses considered unreliable.

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 Integrated Treatment of Co-Occurring Disorders(MISA)
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3,045	4.34	3,000	3,000	N/A
Numerator	N/A	2,704			
Denominator	N/A	62,367			

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 MHD with SMI.
- Sources of Information:** 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,044	.52	4,000	1,050	N/A
Numerator	N/A	325			
Denominator	N/A	62,367			

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.
Prior to FY2008: Number of adults (18+) who receive Illness Self-management services. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of adults who receive Illness Self-management services. Denominator: Number of adults served by MHD with SMI.

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research Training (WIMHRT)

Special Issues: The 2010 target is set to be below the FY2009 projected count due to data collection problems in the provider survey as noted in the Supported Housing indicator.
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 Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	18,180	26.56	13,500	14,000	N/A
Numerator	N/A	16,566			
Denominator	N/A	62,367			

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

Prior to FY2008: Number of adults (18+) who receive Medication Management services. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of adults who receive Medication Management services. Denominator: Number of adults served by MHD with SMI.

Sources of Information: 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.

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	55.18	59.81	62	63	N/A
Numerator	772	765			
Denominator	1,399	1,279			

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. 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.
Measure:	
Sources of Information:	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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	11.57	11.73	10.50	11.60	N/A
Numerator	7,393	7,247			
Denominator	63,921	61,787			

Table

Descriptors: Increase the number of persons who are engaged in employment related activities.

Goal:

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 Information: MHD-Consumer Information Systems (CIS).

Special Issues: WA has lost funding through Division of Vocational Rehabilitation for support of Club Houses; however, MHD is seeking legislative funding to reinstate support of this pre-vocational program.

The FY2009 projected 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	39.25	72.36	73	74	N/A
Numerator	42	89			
Denominator	107	123			

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 MHD 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 Information: Prior to 2007: Merge the MHD 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: MHD 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	90.65	7.46	7.50	7.40	N/A
Numerator	50,305	5,162			
Denominator	55,491	69,242			

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 Information: MHD's Consumer Information System (CIS)
Special Issues: Stable housing continues to be a real and serious challenge for WA; however, MHD remains committed to encouraging growth of appropriate residential resources and supports through the RSNs.

Significance: Goal supports New Freedom Commission (NFC) goal #3. 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.
Action Plan:

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	62.21	63.25	64	64	N/A
Numerator	889	838			
Denominator	1,429	1,325			

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 Information: Beginning in 2007, MHD is using the MHSIP survey for this indicator.

Special Issues:

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	61.68	64.99	65	65	N/A
Numerator	874	852			
Denominator	1,417	1,311			

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 Information: Adult MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT). The functioning scale consists of 6 items.

Special Issues:

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

However, 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 projects for Evidence Based and Promising Practices that will lead to an enhanced service package for children, youth and their families.

Last year, the MHD employed approximately 60 staff at headquarters and approximately 240 staff at Child Study and Treatment Center (CSTC). These numbers do not count the fiscal, Information Technology and contract person who are part of “shared-services” in HRSA. Our fiscal, contract and IS staff have all been allocated as shared services.

The MHD headquarters staff is responsible for program and planning, licensing and certification of Community Mental Health Agencies (there is one children's mental health specialist on the licensing team), contract monitoring and federal program development. Within the specialty programs are employees as children's mental health (3 FTEs and 1 parent liaison), an ethnic minority specialist (also covering children and youth issues).

Staff in headquarters also oversee the crisis programs, co-occurring illnesses with developmental disabilities and substance abuse, the jail programs and sit on a variety of cross-system or interagency committees relating to children, youth and their families.

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:

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 persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

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 treatment services;
High Intensity Treatment;
Individual Treatment Services;
Intake evaluation;
Medication Management;
Medication Monitoring;
Mental Health Services provided in Residential settings;
Peer Support;
Psychological Assessment;
Rehabilitation Case Management;
Special population evaluation;
Stabilization Services; and,
Therapeutic psycho-education.
Children's Long-term Inpatient Programs (4)

The following EBPs are available in various communities across the state and offer support, social supports, and diversion from hospital or out of home placement. Services are provided by Mental Health Division (MHD), Children's Administration (CA), Juvenile Rehabilitation Administration (JRA) and others.

- Multidimensional Treatment Foster Care (MTFC) 5 sites (MHD, CA and JRA)
- Trauma Focused Cognitive Behavioral Therapy (TFCBT) – 82 sites covering all RSNs
- Multi-systemic Treatment (MST) 4 sites (MHD, JRA)
- Family Integrated Transitions (FIT) 2 Sites (JRA) 18 sites (CA)
- Functional Family Therapy (FFT) 2 Sites (JRA) 2 Sites (CA)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT) (MHD, JRA)
- Aggression Replacement Therapy (ART) (JRA)
- Multi-Family Group Family Psycho-education (MFG) (MHD CSTC)
- Incredible Years. (CA)
- Triple P. (MHD) (CA) 3 sites
- Nurse Family Partnerships (CA)(7 sites)
- Promoting First Relationships(CA)
- Homebuilders (CA, all 6 regions)

MHD employs approximately 60 people at headquarters and nearly 1,700 at one child and two adult state psychiatric hospitals. Approximately 240 of the hospital staff are employed at Child Study and Treatment Center (CSTC). These numbers do not include fiscal, information technology and contract processing staff who are part of shared services personnel at Health and Recovery Services Administration (HRSA).

The Mental Health Division is part of the Health and Recovery Services Administration (HRSA), and recently was combined with the former Division of Substance Abuse. The Division of Healthcare Services also is part of HRSA, which is moving to an integrated health care model.

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. HRSA hosts an Early Periodic Screen, Diagnosis and Treatment (EPSDT) improvement team quarterly to promote utilization of EPSDT.

An innovative program is the Access to Baby and Child dentistry. This initiative promotes access to dental services for Medicaid eligible toddlers and pre-school children.

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 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 cit training and have had a positive effect in educating others and helping them understand the needs of youth who are seriously emotionally disturbed.

Clark County Options serves youth 14-25 and has a full time job developer on staff. Additionally, the program oversees the Educational Service District (ESD) 112 part time employment specialist.

Youth served by Clark County Options must have been receiving mental health treatment to be in the program while those served through the ESD must be at risk of homelessness and may or may not have a mental illness.

Through both programs, youth receive assistance with resume writing, job readiness and supported employment service. Both programs utilize the EBP supported employment model.

Clark County Options program has served approximately 200 youth since their beginning 5-years ago and an estimated 80% of the youth have been served by the employment program. It is important to note that within this number there are duplicated counts since many children seek more than one job in their development. Additional employment programs for youth exist through Youth Build a program operated within the Goodwill. Youth Source in King County is also providing some employment services to youth

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

Child -An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121

Washington State has an estimated number of children with serious emotional disorders (SED) between **70,619 and 86,312** in 2007. Prevalence estimate of SED for 2008 is not available at the time the plan is being prepared. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of children in our service populations who have SED. The MHD operationalized the guidelines using diagnoses and the Children's Global Assessment Scale (CGAS). All diagnoses except substance abuse and development disorders were used in the calculation. 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 2008. Please note that total served in FY2008 included clients served by Pierce region which turned into Fee-For-Service beginning January 2008. However, the estimated SED in FY2008 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 MHD 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	Total Children Served	Estimated SED Served	Quantitative Target
70,619 - 86,312 – 92,911	35,109	29,000	27,000

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 50 16 served in FY 2008 as well as the projected number served in FY 2009. This information is reported for children and youth with serious emotional disorders 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.

Please note that the total served in FY 2008 and projected clients served in FY 2009 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 MHD 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.

Projected Penetration Rates				
Time Period	FY08 Served		FY09 Projected	
SMI Status	SED	Total	SED	Total
Children Served	25,095	36,936	23,932	32,265
WA Child/Youth Population	NA	1,577,661	Not available	1,588,474
Penetration Rate	NA	2.3% of all children/youth in Washington State are served by the MHD	NA	About 2.0% of all children/youth in Washington State are served by MHD

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 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. As per SAMHSA requirement, MHBG funds are not expended to provide any services other than comprehensive community mental health services.

Services for children and youth are integrated throughout the mental health system and allied system of care and available statewide. The RSNs are responsible for the coordination of care for children and youth served by multiple systems such as substance abuse, developmental disabilities, juvenile corrections, child welfare, Medicaid-funded healthcare, and the schools. The RSNs and their providers utilize multidisciplinary teams to coordinate care. A growing percentage of children and youth are receiving Wrap-Around like services. These teams are also utilized to provide discharge planning for children who are in inpatient settings and juvenile detention centers.

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 those needs. The services developed by these various systems are pre-designed to meet the needs of a typical child when, in fact, they are increasingly serving children and families with unique needs.

The Mental Health Division continues to encourage other child-serving agencies within DSHS to recognize children as “our state’s children” and will continue to discuss and strategize ways to eliminate the barriers to sharing information and data.

The Mental Health Division continues to encourage other state agencies such as schools and health departments to eliminate all barriers and share data whenever possible in order to better serve the needs of children and their families. For physical health care services, children have access through community providers who accept Medicaid and public assistance. Washington State also has a Basic Health Care Program to provide insurance coverage to families when there is none from the employer.

Children in Basic Health have the same coverage as Medicaid eligible children. Additionally, there is several community clinics that provide service on a sliding scale basis for children of families with limited resources and two RSNs have in their service area free mental health clinics.

Governor Christine Gregoire has embarked on a note-worthy effort to ensure every child in Washington State has healthcare coverage by 2010. This is consistently bolstered by several other initiatives and carve-outs within the state aimed at increasing access to quality medical and dental care.

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 MHD and other state agencies for the provision of system-wide services to children, the Mental Health Division funds mental health parent programs such as the Community Connector project and SAFE-WA which provides an essential link 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 SAFE-WA and its parent network assist other parents who find themselves in a similar situation. These parents must have children, grandchildren or foster children with complex needs and be willing to network within their community.

Of special note is the forming network of fathers and male caregivers who provide support for one another. For several years, the MHD parent network had one or two actively involved fathers. Mental Health Division staff met with fathers alone at trainings to get their input on what they thought the fathers might need to come together and support each other. Staff listened and tried to meet the need. A new organization subsequently formed known as Washington Dads WADADS. To date, they have supported each other with the development of child specific IEPs and have mentored each other in the CLIP application process. WADADS have established a website <https://www.wadads.org> where they post information, training events and have a chat room. In 2009, they are planning more regional meetings with one or possibly two larger meetings.

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.

Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The MHD and the Mental Health Transformation project are working together 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. The report of this training effort is due in Fall of 2009. 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 ERs and EMTs.

Through the collaborative effort of MHD with the Division of Developmental Disabilities (DDD) another example of training provided to emergency and health providers is the Community Hospital MI/DD Training. The two divisions are creating a training targeted to the community hospitals that serve persons 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 Emergency Room staff as well as employees who would be providing inpatient treatment.

MHD is committed to providing training to the State's emergency and health providers. As the first responders, emergency and health providers are being trained to recognize and respond to people with mental illnesses, The availability of this service is an asset in helping move our state toward Transformation.

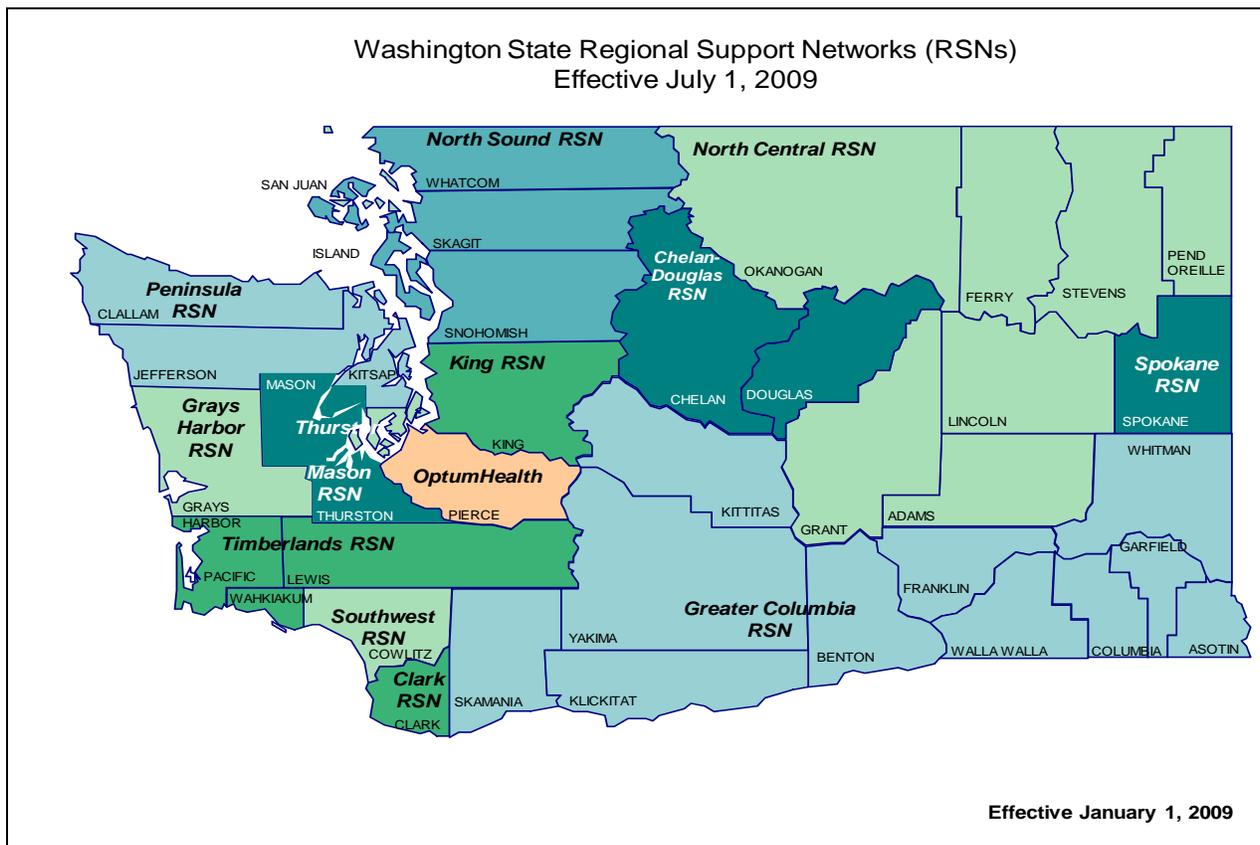
A specific training for Children's Mental Health Specialists will again be held in September of 2009.

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, 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. MHD 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 2009. 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.

Another development is the addition of people who have mental illness being included in the Transitional Housing, Operating and Rent Program (THOR) for families.

Background

In 1999 the Washington State Legislature created a budget proviso of \$5,000,000 to fund the Transitional Housing Operating and Rent (THOR) program and several other initiatives to help homeless families with children. The program operated within the Department of Community Trade and Economic Development (CTED) and provided funding to non-profit organizations, local government and housing authorities to provide housing and services exclusively to homeless families with children. Since then, funding has remained approximately the same.

Until recently, approximately \$2,200,000 was awarded each year for rent assistance, operating subsidies for transitional housing facilities, case management and administrative costs. Local lead agencies in 31 of 39 Washington counties operate THOR programs. THOR funds are awarded to local lead agencies based on a modified version of the Department of Housing and Urban Development's (HUD) allocation formula for funding homeless shelters. In turn, the lead agency may either directly provide or contract for the provision of THOR services. Contractors include local government, local housing authorities, a Regional Support Network, a non-profit community or neighborhood based organization, a federally recognized Indian tribe or a statewide non-profit housing assistance organization.

Recent Changes

In 2008 THOR program was expanded to assist homeless individuals, in addition to families, to secure and retain safe, decent and affordable housing. An additional \$2.5 million was allocated in the 2009 Supplemental Legislative budget.

THOR services and support grantee organizations may use the funds to provide between 91 days and two years of:

- Rental assistance, including security deposits and moving expenses
- Case management services designed to help the client move toward self-sufficiency

- Operating expense subsidies for transitional housing facilities exclusively for homeless families with children

Homelessness Eligibility

Families must be homeless or at imminent risk of homelessness. Homeless means,

“Persons, including families, who on one particular day or night do not have a decent and safe shelter or sufficient funds to purchase a place to stay or are living in places not intended for human habitation.”

Imminent risk is defined as

“Persons, including families, who can provide proof of imminent housing loss or are currently residing in homeless shelters, temporarily living with family or friends, about to be released from prison or jail, or leaving a mental health or chemical dependency treatment facility and have no identified housing option.”

Eligible households include

- Families with children
- Families with children who are receiving services under chapter 13.34 RCW, parent-child dependency juvenile court proceedings,
- Individuals or families without children (only with expansion funds)
- Individuals or families who have a household with an adult member who has a mental health or chemical dependency disorders (individuals and families without children are eligible only with expansion funds)
- Individuals or families who have a household with an adult member who is an offender released from jail or person within the past 18 months (expansion funds only)

Income Eligibility

Families with children must not have an income that exceeds 50% of area median income, as published by HUD. Individuals or families without children must not have an income that exceeds 30% of the area median income, as published annually by HUD.

Additional Services

The MHD Children’s Team believes that there are barriers to serving homeless youth and have contracted with a provider to develop a plan. The provider has a children’s expert on homelessness and, in the past, operated a homeless youth outreach program, Youth N Action (YNA) in western Washington. MHD has applied for a SAMHSA Youth In Transition grant for two rural western Washington RSNs.

In Spokane, a youth engagement center (clubhouse) is being developed. Homeless youth 14 to 21 may attend daily Monday through Friday. Breakfast and lunch are available.

The intent is for Clubhouse personnel to assist youth to use computers for work search, resume writing, and to write a proper cover letter. 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 move from detention to 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, MHD's contracts with the RSNs has set travel standards for accessing services and the MHD 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.

In its contract with SAFE-WA, the statewide parent network, the MHD has required that they provide training for parents and parent/professional training twice a year in rural eastern Washington. The Parent Coordinator for SAFE-WA has been working in rural southeastern Washington to develop a parent support organization. She has been more successful than past tries in "convincing" the providers that this peer support is a value to both the system and the parents.

Both the Grays Harbor and Southwest RSN Wrap-Around Pilot projects are in rural parts of Washington. The Thurston Mason EBP pilot site is also in the most rural part of Thurston County.

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 mental health specialists are 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 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.

In the Wrap-Around pilots, all service providers will receive training.

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 both SAFE-WA and 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.

SAFE-WA also has a network member who works closely with their local juvenile court and police. King County RSN has a crisis team of children's specialist, parents and youth trained to assist in the field.

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. However, we estimate if the RSNs fully implement their plans that \$1.9 million will be spent on children and youth related activities. MHD historically spends 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	35,673	36,579	33,000	36,579	N/A
Numerator	N/A	N/A			
Denominator	N/A	N/A			

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 MHD 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 Information:	MHD-Consumer Information System (CIS).
Special Issues:	Beginning in CY2008, Pierce County discontinued 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 (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 MHD 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, Ethnic 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	5.64	6.65	6.80	6.80	N/A
Numerator	55	71			
Denominator	975	1,068			

Table

Descriptors:

#2: Decrease percentage of children and youth who are readmitted to an inpatient setting within 30 days of discharge.

Goal:

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 Information:

MHD-Consumer Information System (CIS).

Special Issues:

Beginning in CY2008, Pierce County discontinued 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 service encounter data has been submitted to MHD via different forms and with variation in reporting requirements. FY2009 projected percentage does not include clients served by Pierce region due to the FFS data limitations.

Significance:

Action Plan:

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 #4Decreasing 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.

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	20.82	19.13	16	15.70	N/A
Numerator	203	212			
Denominator	975	1,108			

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 Information: MHD-Consumer Information System (CIS).

Special Issues: Starting in Calendar Year 2008, Pierce County discontinued to operate 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 MHD in various forms and variation in reporting requirements.
The FY2009 projected 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 Projected	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 MHD 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 Information:	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'sEBP 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	520	1.91	490	495	N/A
Numerator	N/A	475			
Denominator	N/A	24,910			

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 MHD 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 MHD with SED.
Sources of Information:	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 overcounts. 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 MHD 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. MHD 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, MHD 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,314	2.45	150	610	N/A
Numerator	N/A	610			
Denominator	N/A	24,910			

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.
Prior to FY2008: Number of children and youth who receive Multi Systemic Therapy services. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of children and youth who receive Multi Systemic Therapy. Denominator: Number of children and youth served by MHD with SED.

Sources of Information: 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 Institute for Public Policy (WSIPP) with consultation by MST Inc.

Action Plan: 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,335	3.91	400	500	N/A
Numerator	N/A	974			
Denominator	N/A	24,910			

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
Prior to FY2008: Number of children and youth who receive family functional therapy. No numerator and denominator were required.

Measure: FY2008 and forward: Numerator: Number of children and youth who receive family functional therapy. Denominator: Number of children and youth served by MHD with SED.

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	65.30	64.26	64	65	N/A
Numerator	574	543			
Denominator	879	845			

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 Information:	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 t 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	25	28.75	29	29	N/A
Numerator	220	234			
Denominator	880	814			

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 Information:	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, the beginning in FY2007, 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	47.50	48.98	51	52	N/A
Numerator	19	24			
Denominator	40	49			

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 MHD 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 mental health division 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 Information:	Prior to 2007: Merging the MHD data with state arrest and conviction data. FY2007 and forward: MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).
Special Issues:	Prior to 2007:Merging the MHD 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	98.35	1.33	1.40	1.30	N/A
Numerator	23,160	365			
Denominator	23,549	27,375			

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 MHD who were homeless or living in shelter in the FY Denominator: Total number of children served by MHD and whose living situation status was available in the FY.

Sources of Information: MHD-Client information system (CIS)

Special Issues: Stable housing continues to be a real and serious challenge for WA; however MHD 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 MHD via different forms and with variation in reporting requirements.

The FY2009 projected 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 Continue to support development residential resources and encourage the development of safe, affordable housing.
Action Plan: 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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	85.92	85.82	86	86	N/A
Numerator	763	726			
Denominator	888	846			

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 Information:	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 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	65.42	66.39	67	67	N/A
Numerator	575	561			
Denominator	879	845			

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 Information:	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.