Washington

UNIFORM APPLICATION
FY 2007

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

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Washington

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_FY2007 ___FY 2006-2007 ___FY 2005-2007

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: 98504-0809

TELEPHONE: 360-902-0843 FAX: 360-902-0809

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

NAME: Richard E. Kellogg 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: 98504-5320

TELEPHONE: 360-902-0790 FAX: 360-902-0809

III. STATE FISCAL YEAR

FROM: 07/01/2006 TO: 06/30/2007

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Amy Besel 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: 360-902-0843 FAX: 360-902-0809 EMAIL: BeselAJ@DSHS.WA.gov

Washington

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

EXECUTIVE SUMMARY

Please respond by providing an Executive Summary of your state's current application.

The Mental Health Division (MHD) of the State of Washington herein submits its application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2007. This document is essential by design to the well-being and quality of life of the many individuals in our state who carry psychiatric disabilities and for the people who love and care about them. As such, we seek to have this plan serve as tangible hope for a better future by clearly outlining our intentions for continued change and improvement to our community mental health services. This plan meets all of the requirements of application, has been reviewed by community stakeholders, is supported by the state Mental Health Planning and Advisory Council (MHPAC), and is consistent with federal guidelines aimed at achieving the following goals:

- 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 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 listed above, this document encompasses Washington State's commitment to bring to fruition the fundamental goals outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled, "Achieving the Promise: 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.

It should be further noted that these goals are fully embraced by the Mental Health Division, the leadership of Washington State, the Mental Health Planning and Advisory Council, and the consumers, families and advocates involved in Washington's public mental health system. Accordingly, the New Freedom goals have been 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***.

With these aims in mind, the Mental Health Division strives to combine the best practice standards of the private managed care industry with the core values of the publicly funded mental health system to create a service delivery model that promotes high quality and cost effective services which are consumer driven and focused on ***Recovery*** and ***Resiliency***. We are continually searching for improvements to our system; making certain that access to services consistently meets individual needs, that provision of community linkages are continually strengthened, and that the integration of other publicly funded services and natural supports are unfailingly pursued. The intended outcome is a delivery of care system that is fiscally sound, consumer driven, recovery oriented, and highly responsive to the needs of our citizens.

In 2005, the stage was set for change in Washington State in terms of the energy, discussion, and challenges that transpired related to our public mental health system through the following activities:

- The creation of a legislatively mandated Mental Health Task Force (MHTF) charged with assessment of the mental health system and challenged to determine recommendations for improvements;

- The significant threat of system implosion secondary to the projected financial losses related to the combination of the discontinuation of the use of Medicaid managed care savings (which had been relied upon to support individuals and services not otherwise eligible for Medicaid) and the existing Institution for Mental Diseases (IMD) Exclusion; and

- The passage of legislation that paved the way for dramatic and far-reaching revisions in the public mental health system including mental health insurance parity, approval of nearly $80 million dollars in state funding to mitigate losses related to the change in the use of Medicaid savings and the IMD exclusion, and a mandatory procurement process for the delivery of managed care services.

Momentum for change has marched ahead in 2006 through the considerable direction and support of the state legislature:

- Involvement of the MHTF has continued through oversight of the procurement process; providing direction to MHD in setting the bar for excellence and ensuring RSNs have the opportunity to rise to the requisite level needed to qualify as an RSN.

- Completion of a legislatively mandated procurement process for the fourteen (14) Regional Support Networks (RSNs) which was two fold: Request for Qualifications (RFQ) and Request for Proposals (RFP). The results were as follows:

- RFQ - only eight (8) of the original RSNs qualified.
- RFP - Five (5) of the unqualified RSNs re-submitted and passed. One (1) RSN did not re-submit. However, another RSN that passed the RFQ submitted a proposal to take over the remaining unqualified RSN and passed.
- As of September 1, 2006, Washington will now have thirteen (13) RSNs, all of which are fully qualified to deliver excellent mental health services.

- Funding requested of the legislature by the new MHD Director, Richard E. Kellogg, was awarded to address critical concerns regarding insufficient inpatient capacity. The solution attacks the issue from two fronts: the short-term need for more inpatient beds at the state hospital and the long-term need for enhanced community supports through development of eight (8) teams which will deliver the evidence based practice of Program for Assertive Community Treatment (PACT). As PACT teams are made operational, hospital wards will be closed.

Further moving our service delivery system forward has been the structural changes initiated by the new Secretary of the Department of Social and Health Services (DSHS), Robin Arnold-Williams. Secretary Arnold-Williams, who came to Washington after serving under Mike Leavitt, then Governor of Utah and now Secretary of Health and Human Services, has since combined the Division of Alcohol and Substance Abuse, the Mental Health Division, and the Medical Assistance Administration under the leadership of tenured Assistant Secretary, Doug Porter in what is now called the Health and Recovery Services Administration. This re-alignment is intended to improve collaboration and resource management, with the result being improved outcomes for the residents of our state.

Washington State is proud to be one of the seven (7) recipients of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant). The evolution of ***Transformation*** remains the driving force in Washington, with all efforts focused on the uncharted path of this journey. 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 reality.

The Governor and the Secretary of the Department of Social and Health services (DSHS) led the initiative to solicit input from stakeholders, system partners and community members who were invited to inform policy makers through both the internet and participation in a statewide forum. The forum allowed those involved to provide input, ask questions, and collaborate in the development of an initial plan outline for the grant application. An extensive survey was also disseminated and posted on the internet which provided an additional opportunity for detailed contributions to the planning effort.

Finally, the Governor completed appointment of a Transformation Work Group (TWG) comprised of consumers, cross system leaders, family members, community members, mental health providers and other interested parties. The TWG has since created task groups which have traversed even further into territory of "What would a transformed system look like", culminating in the truly collaborative development of the state's ***Transformation*** Plan, which will be submitted to SAMHSA in the fall of this year.

Accordingly, it is the sincere desire of everyone involved, from family member to administrator, from consumer to legislator, from case manager to physician that this Mental Health Block Grant plan serves in partnership with the Transformation Grant as the foundation and structure for meaningful growth and change to our public mental health system. This document is a map in evolution for a journey well underway.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2007

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

Section 1911:

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

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

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

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

Section 1912

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

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, 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).

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

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

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

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

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

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

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

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

(2) A condition under subsection (a) for a Council is that:

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

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

Section 1915:

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

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

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

Section 1916:

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

(1) to provide inpatient services;

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

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

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

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

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

Section 1941:

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

Section 1942:

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

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

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

(c) The State will:

(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.

Notice: Should the President's FY 2007 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2007 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

_____ _____

Governor Date
Christine O. Gregoire, Governor

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

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

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

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

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

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place 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, sub-grants, 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

APPLICANT ORGANIZATION	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

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:

☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action

☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:

☐ a. initial filing
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:

7. Federal Program Name/Description:

CFDA Number, *if applicable:* _____

8. Federal Action Number, if known:

9. Award Amount, if known:
$

10. a. Name and Address of Lobbying Entity
(if individual, last name, first name, MI):

b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*

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

Signature: _____

Print Name: _____

Title: _____

Telephone No.: _____ **Date:** _____

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DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 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 (0348-0046), Washington, DC 20503.

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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

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

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

Approval Expires: 08/31/2007

Washington

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

PUBLIC COMMENTS (describe process)

Section 1941 of the Block grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the plan public in such a manner to facilitate comment from any persons (including Federal or other public agency) during the development of the plans (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan in this section.

Comments and feedback on Washington's MHBG Plan are solicited and collected in a variety of ways. In addition to posting the MHBG Plan on the internet, inviting comment all year long, the Mental Health Division formally distributed the Mental Health Block Grant plan for public review during the month of July 2006. Many of the public comments from last year's application have been either addressed through the legislature, added to this plan, or are expected to be incorporated in next year's plan.

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 ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2005	Estimate/Actual FY 2006
$17,688,942.00	$47,917,076.00	$39,955,941.00

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 such 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 ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2004	Actual FY 2005	Actual/Estimate FY 2006
$162,114,757.00	**$177,398,418.00**	**$237,930,763.00**

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.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
Alston, Thressa	Others(not state employees or providers)	Ethinic Minority Subcommittee	20454 104th Ave SE Kent,WA 98031 PH:(253) 859-5309 FAX:	talston@highline.edu
Andrus, Graydon	Providers	Downtown Emergency Service Center	515 Third Avenue Seattle,WA 98102 PH:(206) 515-1524 FAX:(206) 624-4296	gandrus@desc.org
Ashley-Nelson, Cindy	Consumers/Survivors/Ex-patients(C/S/X)		604 South Woodruff Rd, H101 Spokane Valley,WA 99206 PH:(509) 768-8500 FAX:	ashleyfiles@htomail.com
Barnes, Jeanette Kay	Family Members of Children with SED	Mental Health Transformation Grant Liaison to MHPAC	PO Box 45321 Olympia,WA 98504-5321 PH:(360) 902-0847 FAX:	barneJK@dshs.wa.gov
Bates, Rebecca	Consumers/Survivors/Ex-patients(C/S/X)		525 W 2nd Ave Spokane,WA 99201 PH:(509) 892-9241 FAX:	bbates@voaspokane.org
Bauer, Roger	Others(not state employees or providers)	Okanogan Behavioral Health	PO Box 3208 Omak,WA 98841 PH:(509) 826-8420 FAX:	rbauer@okbhc.org
Colwell, Lou	State Employees	Special Ed. Sec., State Office of Superintendent Public Instruc.	PO Box 47200 Olympia,WA 98504 PH:(360) 725-6075 FAX:(360)	Lcolwell@ospi.wednet.edu

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
			586-0247	
Conant, Annie	State Employees	State Housing Agency Representative CTED	Olympia,WA 98504-2525 PH:(360) 725-2919 FAX:	anniec@CTED.wa.gov
Cooper, B.J.	Consumers/Survivors/Ex-patients(C/S/X)		2216 Sand Canyon Rd Chewelah,WA 99109 PH:(509) 935-0564 FAX:	nhbills05@yahoo.com
Crozier, Rick	Providers	Good Samaritan Behavioral Health	325 E Pioneer Ave Puyallup,WA 98372 PH:(253) 697-8547 FAX:	rickcrozier@goodsamhealth.org
Dolezal, Cheri	Providers	Clark County RSN Representative	PO Box 5000 Vancouver,WA 98661 PH:(360) 397-2130 FAX:	Cheri.Dolezal@clark.wa.gov
Egan, Kelly	Providers	MH Program Director, State Department of Corrections	PO Box 41126 Olympia,WA 98504-1126 PH:(360) 586-9524 FAX:(360) 586-4577	kjegan@DOC1.wa.gov
Elsten, Holly	Family Members of Children with SED		Wilkeson,,WA 98396 PH:(253) 310-3806 FAX:	hollyelsten@yahoo.com
Eng, Danny	Consumers/Survivors/Ex-patients(C/S/X)	DSHS Division of Vocational Rehabilitation	1310 W Sixth, #4 Bellevue,WA 98007 PH:(425) 649-4235 FAX:	Engd@dshs.wa.gov
		Adult		

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
Eschenbacher, Diane	Consumers/Survivors/Ex-patients(C/S/X)	Consumer Subcommittee	Spokane,WA 99204 PH: FAX:	dianeresch@netzero.com
Freimund, Chair, Joann	Others(not state employees or providers)	Mental Health Planning and Advisory Committee	3739 Goldcrest Hts. NW Olympia,WA 98502 PH:(360) 866-1575 FAX:	jgfreimund@aol.com
Haan, Michael	Consumers/Survivors/Ex-patients(C/S/X)		11457 70th Place S Seattle,WA 98178 PH:(206) 383-4550 FAX:	mhaan@perkinscoie.com
Jaden-Catori, Diana	Consumers/Survivors/Ex-patients(C/S/X)		Tacoma,WA 98409 PH:(253) 272-1759 FAX:	dianah42@hotmail.com
Johnson, Douglas	Providers	Greater Columbia Behavioral Health	Kennewick,WA 99336 PH:(509) 735-8681 FAX:	douglasj@gcbh.org
Lawton, Brett	State Employees	State Medicaid agency Representative DSHS/HRSA	Olympia,WA 98504-5530 PH:(360) 725-1593 FAX:	lawtobl@dshs.wa.gov
Manke, Candise	Family Members of adults with SMI		Wenatchee,WA 98807 PH:(509) 844-9601 FAX:	ablastfromthepast@msn.com
McCoy, Ronald	Family Members of Children with SED		PO Box 887 Chewelah,WA 99109 PH:(509) 935-6839 FAX:	rmccoy001@centurytel.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(Optional)
Nash, Cathii	Consumers/Survivors/Ex-patients(C/S/X)		Spokane,WA 99223 PH:(509) 536-4136 FAX:	cathiin@netzero.com
Norsen, Steve	State Employees	Mental Health Division, DSHS	Olympia,WA 98504-5320 PH:(360) 902-0848 FAX:	norsens@dshs.wa.gov
Owen, Eleanor	Others(not state employees or providers)	Family Advocate	Seattle,WA 98102 PH:(206) 322-0408 FAX:	eleanor_owen@mindspring.com
Pascua, Andy	Providers	Greater Columbia Behavioral Health	Yakima,WA 98902 PH:(509) 248-6929 FAX:	carriehp@aol.com
Putnam, Barbara	State Employees	State Children's Administration Representative	Olympia,WA 98710 PH:(360) 902-7939 FAX:	puba300@dshs.wa.gov
Trueblood, Dorothy	Family Members of Children with SED		Tacoma,WA 98409 PH:(253) 472-1442 FAX:	dorothyt@ccsww.org
Warden, Lenora	Consumers/Survivors/Ex-patients(C/S/X)		701 Commerce St, Apt 208 Tacoma,WA 98402 PH:(253) 272-1845 FAX:	noralynn57@yahoo.com
Woodrow, JoEllen	Consumers/Survivors/Ex-patients(C/S/X)		Spokane,WA 99208 PH: FAX:	gem2005us@yahoo.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	30	
Consumers/Survivors/Ex-patients(C/S/X)	10	
Family Members of Children with SED	4	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	4	
TOTAL C/S/X, Family Members and Others	19	63.33%
State Employees	5	
Providers	6	
Vacancies	0	
TOTAL State Employees and Providers	11	36.67%

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.

Washington

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for selection of council members, their terms, the conduct of meeting and a report of the Planning Council's efforts related to duties as mandated by law: Reviewing plans and submitting to the State any recommendations for modification; Serving as an advocate for adults with SMI, children with SED, and other individuals with mental illnesses or emotional problems; Monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State; The role of the Planning Council in improving mental health services within the State.

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:

A. Washington State residents acknowledge that mental health is essential to overall health.

B. Mental health care is consumer and family driven.

C. Disparities in mental health services are eliminated.

D. Early mental health screening, assessment and referral to services are common practice.

E. Excellent mental health care is delivered and research is accelerated.

F. Technology is used to access mental healthcare and information

Other Goals:

A. 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.

B. 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.

C. 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.

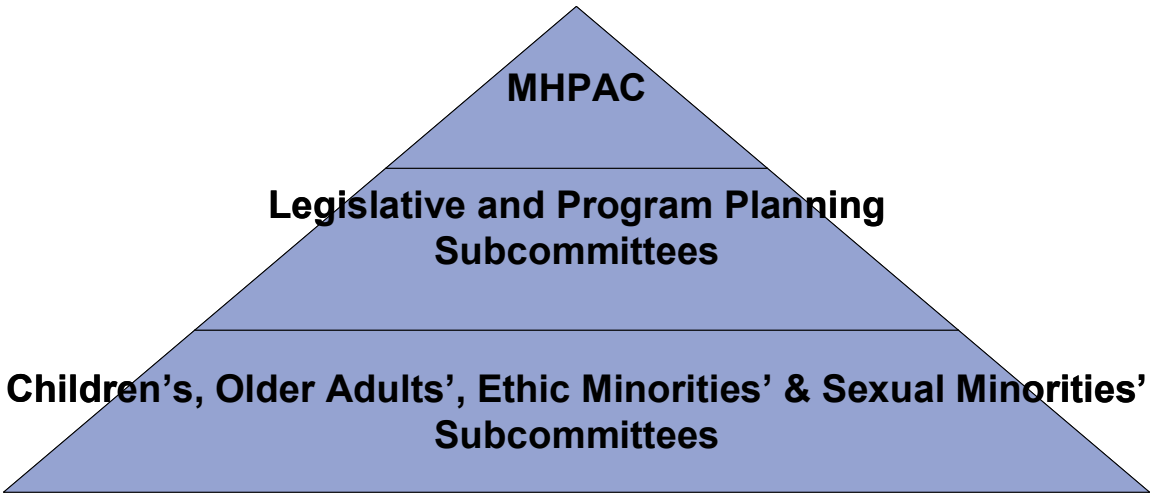
D. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults. Services shall be focused on ***Recovery*** and ***Resiliency.***

E. 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 reorganized its structure to establish the following Standing Subcommittees to carry-out its mission and to meet its goals:

- 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/Cultural Minorities 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 four remaining Subcommittees form the base of the triangle.



Note: At the July 2006 MHPAC meeting, a vote of affirmation and approval came for the addition of another subcommittee called the Adult Consumer Subcommittee, which will be comprised solely of adult consumers.

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.

Through the trainings the MHPAC has received from the National Association of Mental Health Planning and Advisory Council and the National Technical Assistance Center for State Mental Health Planning, the Council has been infused with a thorough understanding of the President's New Freedom Commission on Mental Health report, Achieving the Promise: Transforming Mental Health Care in America. As a direct result, the MHPAC changed its Bylaw goals to include the New Freedom Commission goals as well as other MHPAC goals outlined above.

Further related to 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 has lead to a change of 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.

In an effort to further the development of MHPAC skills and knowledge related to MHBG and national trends, MHD supported six (6) MHPAC members in attending the Joint National Conference on Community Mental Health Block Grants and Mental Health Statistics held in Washington, DC May 30th – June 2nd, 2006. This was a valuable opportunity for the Council members, who not only gained resources and expertise, but who provided valuable input to the conference through their participation. As a result of

their attendance, the Council will pay greater attention and request more involvement in the State Plan.

Before listing the accomplishments of the MHPAC over the last year, it should be noted that the work of the sub-committees has served not only to forward the mission and goals of the MHPAC, but to bring greater awareness and understanding to their representative populations through advocacy as well as sponsorship of conferences, trainings, and community education projects.

The following is a list of the MHPAC accomplishments for 2005-2006 has been prepared by the Chair of the MHPAC for inclusion in this document:

- Ongoing monitoring of the MHBG including considerably increased input into the MHBG applications, Implementation Reports, the RSN contracts and Modification Requests since 2005. Specific to the latter, the Council voted *not* to recommend the Division's use of FFY 2005 Modification funds for the Mentally Ill Offenders (MIO) program. The Council's reasoning was that doing so would continue the legislatively mandated use of MHBG monies without consultation of the Council which is federally mandated to oversee MHBG funds.

- MHBG funding distribution formula that is used to distribute the MHBG funds to the RSNs was reassessed by MHD this year at the recommendation of MHPAC. The Council reviewed several distribution formulas before providing their recommendation to MHD Director to use a population-based formula. MHD adopted the Council's recommendation, which will result in some fairly significant changes in how the 2007 MHBG funds are distributed with the intended goal being greater equity.

- Formation of a Council Ad Hoc Sub-committee to review MHD's Strategic Plan. This resulted in a revision of the plan to include the six goals of the President's New Freedom Commission, other state related strategies, and quantifiable measures with direct accountability.

- New Council Member's Handbook. This Handbook was the result of a new member and an ad hoc Planning and Program Subcommittee developing an orientation handbook for new members which include everything from the Federal Mandates, information from the National Council 101, our Bylaws, to travel reimbursement information.

- Developed a Packet for MHPAC's Annual Meeting which set timelines and standardized letters, criteria and scoring sheets for Service Excellent Awards.

- Legislative Subcommittee updated and distributed the Council brochure for 2006 Legislature.

- Six (6) Council members attended the Joint National Conference on Community

Mental Health Block Grants and Mental Health Statistics conference in Washington, D.C. in June returning with renewed confidence, purpose, and infused with new ideas and energy.

- Reviewed and requested improvements in MHD's Office of Consumer Affairs. This resulted in a request to MHPAC by the MHD Director to review and give input into the job description of the OCA Manager and provide on-going input to OCA's role and functioning.

- On-going monitoring of MHD's Liquidated Damages policies and recent legislative changes related to state hospital bed allocation and payment.

- Involved in the formation of the Community Transformation Partnership. This is a coalition of community organizations (NAMI, Clubhouses of Washington, MHPAC, etc) whose purpose is to promulgate these community organizations and the concepts of ***Recovery*** and ***Resiliency*** in an effort to move the system toward ***Transformation***.

- Per Federal duty to monitor, review and evaluate the allocation and adequacy of mental health services within the state, the Council received a presentation of the state's Performance Indicators. This raised so much interest and so many questions that the Council devoted a meeting to discussion with Dr. Judy Hall and Director Richard Kellogg. The result of which was that MHD will be providing data to MHPAC on a quarterly basis to support data based decision making on recommendations to MHD.

- Formation of a Council Ad Hoc Sub-Committee to work with MHD in the creation of the current RSN/MHD contracts for Pre-paid Inpatient Health Plan services to Medicaid enrollees and the RSN/MHD contract for services funded with "state only" dollars. Again, the purpose was to incorporate the President's New Freedom Commission goals and to ensure that consumer, family, and advocate voice was clearly heard from the beginning in the very important process of culture change.

- On-going involvement with the Mental Health Task Force (MHTF), including giving testimony on the Council's opinion about how to prioritize the use of state only funds afforded to the mental health system. Ultimately, the Legislature provided over $80 million dollars to ease the losses related to revisions in the use of Medicaid savings for non-Medicaid consumers and services.

- Active monitoring and support by the Legislative Sub-Committee on the Mental Health Parity bill which was passed this session, as well as other important pieces of legislation aimed at reforming the public mental health system. The President's New Freedom Commission's language and goals were profusely included.

- Participation in the development of the Peer Support Training Curriculum and ongoing advocacy for Peer Support.

- Invitation to give input, as well as to encourage input from other stakeholders, to the Seattle Regional Office Centers for Medicaid and Medicare Services Review.

- Reception of the MHBG Review Team at the April 2005 MHPAC meeting. The exit interview and final report articulate multiple compliments about MHPAC involvement in the state mental health system.

- Support of the use of Evidence Based Practices (EBPs). All MHPAC reviews of MHBG proposals, the Strategic Plan, RSN contracts, etc., are made with EBPs in mind.

- Co-sponsorship of an Americans with Disabilities Act (ADA) celebration with several other federally mandated state councils.

- Collaboration with MHD through regular meetings on policy and implementation ideas. Specific to the MHBG, MHPAC is assisting MHD in the development of a Peer Review Policy as well as a ***Recovery*** and ***Resiliency*** Policy.

- Inclusion of the MHPAC on the MHD Organizational Chart.

- Two (2) Council members were involved in the initial RSN/RFQ decisions. Two (2) different Council members were involved in the secondary RFP process.

- The Council changed its Bylaws to add an Adult Consumer Subcommittee which brings the total number of Subcommittees to seven (7).

- The Council changed its Bylaws to increase membership to thirty-one (31) in order to add a representative from DSHS's Aging and Disability Service Administration.

- The Council changed its Bylaws to include: "Services shall be focused on ***Recovery*** and ***Resiliency***".

- Completed an Annual Council Self-Evaluation which led to changes.

- Changed the format for the afternoon session of Annual Meeting (sometimes referred to as the All Stakeholder's Meeting) to include a Panel with representatives from SAMSHA, CMS, MHD, and the Transformation Grant with the purpose of looking at the different model demands, services and funding criteria and seeking integration.

- Establishment of annual awards for exceptional service. Each year a Council Subcommittee hosts this part of the Council's Annual Meeting. In years past,

awards have focused on adults, children, older adults. & ethnic/cultural community. This year's host will be the Sexual Minority Subcommittee.

- Involvement in the interview panels to hire the new MHD Director and Deputy Director.

- Participation in relationship building with all areas of state services including a Council meeting visit by DSHS Secretary Robin Arnold -Williams, a keynote luncheon speech at the Annual Meeting by Deputy Secretary of HRSA, Doug Porter, and several Council meetings attended by MHD Director, Richard Kellogg.

- Fulfillment of all of the MHPAC's duties and membership requirements mandated by Federal law.

- Involvement in the Governor's team for Washington's Transformation Grant application and subsequent appointment to the Governor's Transformation Work Group. The Council is the only Council/Agency with two (2) members on the Governor's Transformation Work Group. Council members and Sub-Committee members were represented on each of the Transformation Work Group's seven (7) Sub-Committees. Three (3) of the seven (7) Transformation Sub-Committees were co-chaired by MHPAC members.

- In response to four (4) questions posed to stakeholders by the Transformation Grant staff, Council member responses were written, collected, and shared with the rest of MHPAC. The Council then met to discuss all of the responses and came to a consensus response for each of the Transformation Grant questions. These responses were then given to the Director of the Transformation Grant as MHPAC's input to their statewide process. Below, is the submitted response:

Mental Health Transformation Project

Partnerships for Recovery and Resiliency

MHPAC List of Outcomes for Transformed Mental Health System

March 15, 2006

OUTCOMES

1. MH Intake on demand without any prerequisites (no barriers) regardless of funding and diagnoses.
2. A consumer navigator available to identify options.

3. Blended/braided funding and services (i.e. co-occurring services available statewide).
4. MHD mandates to contractors that 51% of governing boards of provider agencies is made up of consumers.
5. Simplified data/payment infrastructure at provider level.
6. No forced treatment in community and/or hospital.
7. Innovative avenues that employ consumers which support consumers to open their own businesses.
8. Fed, state and local entities have one standard reporting form and decrease inconsistencies between RCW's and WAC's for different agencies.
9. Measurable changes to contracts and funding streams.
10. Increases in linkages between and across all systems including providers (i.e. police, schools, public health, etc.).
11. Decrease in number of persons with mental illness going to jails and prisons and increase the number of persons with mental illness who live in independent housing and are employed or engaged in meaningful activities.
12. Self determination.
13. Transparent consumer voice and choice with all consumers statewide (ex. Consumer goals are visible in wrap around plan) so buy in is there.
14. Establish debit/swipe card so consumer choice is honored.
15. Bring statewide NAMI on board with concept of recovery and resiliency.
16. Community provider representation on consumer/family organization's boards.
17. Implement and use technologies and research available i.e. RFID.
18. Providers are reflective of the communities they serve.
19. Consumer representative group as part of the decision making authority.
20. Ongoing preventative and earl intervention processes across the life span.
21. Utilization of consumer knowledge.
22. Broad and accessible array of services need to be available in the community so parents don't have to give up custody of child to get MH services (i.e. reduction of parents having to give up custody of children to get them mental health services.).
23. Increase number of publicly funded recovery programs reflective of all consumer groups.
24. Establish "WARM LINE".
25. Access to care in a timely manner (i.e. care available the same day for physical and mental health).
26. Housing.
27. Sufficient number of hospital beds.
28. Appropriate evaluation of individual need and integrated services.

Although the MHPAC has enjoyed many accomplishments as a whole, each Sub-Committee has also been very active in system oversight and improvement. Some of the MHPAC Sub-Committee accomplishments include:

MHPAC/LEGISLATIVE SUBCOMMITTEE ACCOMPLISHMENTS
Developed a printed a brochure on the Council for Legislative members and staff. Listed the Council 2005 Legislative Priorities, Short Position Statements, contact information etc.

Joined several other organizations and worked with a paid advocate. Resulted in a "banner year" for mental health legislation - parity bill passed, E2SHB 1290 (Cody Bill) and E2SSP 5763 (Hargrove Bill) passed and the Legislature allocated $80 million state only dollars to replace the $82 million federal dollar loss. The Cody and Hargrove bills substantially changed the way the state will provide mental health services, i.e. an example -Request for Qualification (RFQ) from each Regional Support Network (RSN) before granting a contract. • On-going monitoring (for absences) of Council members. • On-going recruitment of Council members following geographical distribution, adequate representation of parents with SED minors, and all federal mandates. • Developed standardized Interview Questions and procedures for Recruiting new members. • Applied for and implemented a Technical Assistance Request to the National Association of Mental Health Planning and Advisory Council for Council training in January 2005. Bonnie Pate and Linda Hatzenbueler provided the training. • Planned and implemented the Annual Council/ Subcommittees/Stakeholder Service Excellence Award Meeting.
Participated in the RSN Contract Ad Hoc Subcommittee which insured that the Presidential New Freedom Commission's Goals and concepts were an integral part of the RSN Contracts.
Wrote a letter for Council vote regarding the refunding of Continuity of Care concept.
Requested Council involvement in the MHD Diversity Plan.
Reviewed the MHD Strategic Plan Ad Hoc Subcommittee product and made recommendations for a Council Vote. The Strategic Plan was essentially rewritten by the Ad Hoc Subcommittee to include the 6 President's New Freedom Commission on Mental Health Goals and definitions of recovery, resiliency and stigma and introduced accountability measurements.
Revised and recommended a Council vote on Bylaws that reflect the President's New Freedom Commission on Mental Health Goals.
Coordinated Council and non Council replies to a CMS request for feedback about implementation of the Washington Integrated Community Mental Health Program.
MHPAC/CHILDREN'S SUBCOMMITTEE ACCOMPLISHMENTS
Selection of recipient of the Ann Russell-Yeh Award
Active recruitment of new members including four youth who are currently attending meetings
Participated in the development of the successful MH Transformation grant application to

SAMHSA.
Provided consultation to the DSHS Children's Mental Health Initiative (CMHI), a joint effort of the Mental Health Division of the Health and Recovery Services Administration, Children's Administration and Juvenile Rehabilitation Administration.
Provided input into the successful Department of Health grant application to the federal Health Resources and Services Administration (HRSA).
Facilitated discussion group on Goal 4 of the President's New Freedom Commission on Mental Health: Early Mental Health Screening, Assessment, and Referral at the All Council Stakeholder meeting in Sept.
MHPAC/ETHNIC MINORITIES SUBCOMMITTEE (EMAC) ACCOMPLISHMENTS
Recommended culturally competent terms for MHD-RSN contract. • Track access to service by race/ethnicity and age group • Track services received by race/ethnicity and age group • Track results of services by race/ethnicity and age group • Track use of Minority and other specialists for special populations and results of their involvement in services
Recommended projects to be completed with Federal Block Grant funds. • Develop and deliver a minority MH training program • Develop a Minority MH Specialist practice and consultation protocol • Survey minority people who were in contact with the MH system and decided not to utilize services in order to learn why they did not enter services and what might have encouraged them to do so
Have been involved extensively in discussions with MHD, Children's Administration and Juvenile Rehab Administration related to use of evidence based practice through the Children's MH Initiative • Participated in a June 16 meeting with DSHS and provider representatives to discuss the lack of standardization of acknowledged EBPs in serving racial/ethnic minorities • Noted that the five EBPs selected by CMHI are not demonstrated to be culturally competent • Support community based organization efforts to adapt established practice and efforts to establish emerging and promising practices in community and tribal settings
Conducted a video conference forum October 21 to examine use of EBPs and the need to assure cultural competence and accountability in them.

Served as 2005's featured MHPAC subcommittee at the annual MHPAC All Council stakeholder meeting.
MHPAC/SEXUAL MINORITIES SUBCOMMITTEE ACCOMPLISHMENTS
Has focused on writing a definition and language for a sexual minority specialist that we hope will be included in the new 388-865 WAC revision.
Focused on monitoring the data element in the mental health information system in which consumers identify themselves as heterosexual, gay, lesbian, and bisexual, assuring that sexual minorities are getting access to mental health services.
Focused on increasing awareness and educating providers regarding the needs of the sexual minority population through the Saying It Out Loud Conference and the Do Ask Do Tell training. The Saying It Out Loud Conference which was held in May 2005, sponsored with DASA and King County, provided training to approximately 250 providers, consumers and advocates throughout the state.
MHPAC/OLDER ADULTS TREATMENT AND SERVICES SUBCOMMITTEE (OATS) ACCOMPLISHMENTS
Reviewed and rewrote OATS goals to better align and therefore support MHPAC's goals
Refined and then made permanent the selection criteria for the John Piacitelli Lifetime Achievement Award Reviewed and enhance the 2006-2011 Washington State Mental Health Division's Strategic Plan to be rooted in the July 2003 Presidents New Freedom Commission's Report Goals for "Achieving the Promise: Transforming Mental Healthcare in America".
Assisted the Washington Institute on Mental Health Research and Training in curriculum development for the 2005 Geriatric Specialist Training
Ensured that the 2005 Washington State Behavioral Health Conference had an aging track. This was done by assisting conference planners in locating enough presenters to support a complete track could be offered.
Advocated for older adult inclusion in the State's Transformation Grant.
Advocated for an Older Adult Initiative between the MHD and the rest of DSHS.
Reviewed the Mental Division's Federal Block Grant Plan for changes to older adult initiatives.

The following is a copy of the requisite letter from the MHPAC regarding its review, input, and endorsement of this application. The signed original was mailed to SAMHSA as per request.

July 21, 2006

LouEllen M. Rice, Grants Management Officer
Division of Grants Management
OPS, SAMHSA
One Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Rice:

I am writing to inform you that the Washington State Mental Health Planning and Advisory Council (the Council) voted on July 12, 2006 to recommend and support the Mental Health Division's application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2007.

Council members received the draft application a week before the Council meeting. During the July 12th meeting, Amy Besel, MHBG State Planner, reviewed the plan with the members. The Council members recommended several changes which were incorporated by Amy Besel.

The Council members once again noted that the plan calls for legislatively mandated FBG monies to be spent on the Mentally Ill Offender Program. For the past three years, the Council has not been able to follow its federal mandate to review and recommend this expenditure. Therefore, it has continued its vote NOT to recommend this specific part of the funding for FFY2007.

The Council would like to take this opportunity to express our appreciation to Amy Besel, who walked the Council through the new SAMHSA's format for the plan and application. She, in turn, expressed her appreciation for the help that she received from John Morrow, Ph.D., in your office.

As always, thank you for your assistance and sincere interest in our efforts to fulfill the Council's responsibility of advising the Washington State Mental Health Division.

Together, we are better utilizing and monitoring the Community Mental Health Service Block Grant funding.

Sincerely,

(Signed original mailed)

Joann Freimund, Chair

cc: Richard E. Kellogg, Director, Mental Health Division
Amy Besel, MHBG State Planner

Washington

Adult - Overview of State's Mental Health System

Adult - 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.

Adult – Overview of State's Mental Health System:

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

As the mental health authority for the 6,375,600 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 need requirements.

MHD is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several other administrations within DSHS including; the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration. HRSA sister agencies to MHD include the Division for Alcohol and Substance Abuse and the Medical Assistance Administration.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act; a measure which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of 14 Regional Support Networks (RSNs). The RSNs are under direct contract with MHD to ensure quality outpatient services for individuals with mental illness, including crisis response and management of the involuntary treatment program.

Beginning in October 1993 through 1996, MHD implemented a capitated managed care system for community outpatient mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks. In 1996, the waiver was amended to include community inpatient psychiatric care and, by 1999, all Regional Support Networks were responsible for management of inpatient community mental health care in addition to outpatient services.

The current community mental health system operates under Chapters 71.24, 71.05, 38.52, 74.09 and 71.34 of the Revised Code of Washington (RCW) and under 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.

As discussed in the Executive Summary, the RSNs under went a procurement process this past year, resulting in a reduction in the number of RSNs from fourteen (14) to thirteen (13) with the intention to better serve the entire state.

Within the managed care framework, RSNs operate under two contracts 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 services 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 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.

The Mental Health Division also oversees and operates two adult psychiatric hospitals (Western State and Eastern State) and one psychiatric hospital for children (Child Study and Treatment Center). Overall, these hospitals provide care for approximately 1,300 adults and 48 children each day. The state continues to struggle with the high expectations for patient care from the courts, the legislature, CMS, and the accrediting organizations (e.g.: The Joint Commission of Accredited Healthcare Organization), but continues to make progress in improving care.

Additionally, the Mental Health Division holds contracts for the operation of three Children's Long-term Inpatient Programs (CLIP) which operate under a residential licensure. These facilities provide services to children in need of extended-stay treatment. MHD is currently convening a workgroup inclusive of RSNs as well as other interested stakeholders to evaluate the overall access to and flow of the CLIP program. In particular, the relationship between long-term resources and acute care resources are being investigated.

Within the adult hospitals, there are two systems of care: civil and forensic. Demand for the latter has been increasing over the last decade, resulting in the legislature providing funding in 2006 to open an additional forensics ward at Western State Hospital. Options to reverse this trend are being considered on every level, with MHD assessing the need for possible expansion of both community-based Mentally Ill Offender evaluations and treatment programs.

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.

In the past, in an effort to strengthen the expectation that individuals will be served in the community whenever possible and appropriate, the state implemented Liquidated Damages (LD) as a disincentive. LDs were structured as follows: Within the legislatively funded limit, each RSN had an allotment of beds at the state hospital. When an RSN exceeded its allocated bed limit, it was charged the cost of care per individual per day. This practice, while unpopular with many, served to meet the state hospital budgetary requirements for the staff overages that came with increased numbers of patients.

However, changes have been made to the construct of Liquidated Damages, such that they are no longer in existence. What occurs now is similar, but different. RSNs still have a bed allotment; however, the distribution of beds was determined by the RSNs themselves through a consensus, which allowed for negotiation between RSNs. There remains in place the legislatively mandated funded capacity. Also the unchanged is the fact that when an RSN exceeds its number of allowed beds, it is still required to pay the cost of the care. However, half of the money that is collected is now given to those RSNs that have remained *under* their bed allotments. This change is seen as a financial incentive to hospital diversion.

Washington

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.

Adult – Summary of Areas Previously Identified by State as Needing Attention:
A brief summary of areas identified by the state in pervious State plan as needing particular attention, including significant achievements in the previous fiscal year.

The following points were previously identified as areas needing attention:

- Increased attention to residential supports, housing resources, and affordable housing to reduce homelessness and substandard housing for individuals with mental illness;
- Greater consideration to the process by which individuals who are eligible for Medicaid services can become recipients of such, allowing for increased access to not only mental health benefits, but to dental and medical services as well;
- Enhanced supports to help those consumers who want to work or go to school, bring those goals to fruition as evidence shows that feeling productive and having purpose in one's life is critical to not only decreasing one's symptomology, but to making meaningful recovery a reality;
- Superior efforts to increase cultural competency and community education, thereby decreasing discrimination and stigmatization; and
- Expansive involvement of consumers in directing the mental health service delivery system in Washington, thereby providing them with what they say they need, when they need it, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Please see Adult – Recent Significant Achievements for some of they ways in which these challenges were addressed this year and are continuing to be so this year as well.

Washington

Adult - New Developments and Issues

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

Adult- New Developments and Issues

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

The primary structural change for Washington has been through the RFQ/RFP process, more fully described the Executive Summary and Recent Significant Achievements. Other developments that may affect mental health service delivery include this year:

- Plans to reassess the Involuntary Treatment Act (ITA);
- Intention to evaluate inpatient capacity (acute and long term) for children/youth;
- Expectation that the State Medicaid Plan will be revised; and
- Discussion about the potential to re-visit the Waiver.

Washington

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Adult- Legislative Initiates and Changes

Legislative Initiatives and Changes, if any

Washington State's legislative body is activity involved in the effort to improve our public mental health system. Through the creation of the Executive Committee on Mental Health Task Force (MHTF), the legislature has become more knowledgeable of the needs, concerns, and desires of those served by public mental health as well as more supportive of MHD and DSHS in efforts to facilitate change, growth and ***Transformation***. The impacts of the legislative initiatives and changes listed below are fully described in "Adults- Recent Significant Achievements" section, but are offered here as an overview:

- RFQ/RFP Process
- Increase Resources for Persons with Co-Occurring Disorders
- DD/MHD Collaborative Work Plan
- Mental Health Insurance Parity
- Funding for both PACT teams and Hospital Level of Care
- Jail Services
- Expedited Eligibility
- Opportunity to re-assess Involuntary Treatment Act (ITA)
- Opportunity to Change MHBG Funding Distribution

Washington

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.

Adult- Description of Regional Resources

Adult - Brief description of regional resources, community providers, other county or city resources.

RSN Estimated Revenues
Fiscal Year 2006 and 2007

	FY 2006		FY 2007	
RSN	Medicaid	Non Medicaid	Medicaid	Non Medicaid
Chelan Douglas	5,336,649	1,151,363	5,782,234	1,775,375
Clark	13,062,846	6,303,128	15,589,861	6,920,673
Grays Harbor	3,977,428	2,425,089	5,132,855	1,246,695
Greater Columbia	30,375,556	13,316,377	35,332,472	11,250,312
King	76,039,444	26,722,176	82,354,582	32,103,972
NEWRSN	3,729,434	2,658,407	n/a	n/a
North Central	7,272,634	4,348,485	14,287,446	3,666,153
North Sound	34,952,456	17,028,672	39,335,338	18,300,342
Peninsula	15,497,528	4,590,032	16,790,578	5,843,666
Pierce	32,374,831	16,912,101	36,151,123	12,913,333
Southwest	5,758,399	2,144,803	6,448,304	1,738,922
Spokane	26,189,257	6,043,210	28,383,479	7,489,664
Thurston Mason	9,944,226	5,887,125	12,666,053	4,768,639
Timberlands	5,450,215	1,985,013	6,419,806	1,685,426
Total	269,960,903	111,515,980	304,674,130	109,703,172

Note: Non Medicaid revenue also includes funding related to Expanding Community Services (ECS), Incentive Fund, 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 2006 and 2007 based upon funding distribution formulas. This table does not include MHBG funding, the distribution table for 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 non-profit organizations or conduct other activities in support of enhancing their fiscal resources.

Washington

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.

Adult- Description of State Agency's Leadership

A description of how the State mental health agency provides leadership in coordinating mental health services with 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 services in Washington.

MHD is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several other administrations within DSHS including; the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration. HRSA sister agencies to MHD include the Division for Alcohol and Substance Abuse and the Medical Assistance Administration.

MHD has historically contracted with fourteen (14) Regional Support Networks (RSNs), but secondary to the recent procurement process, will only be contracting with thirteen (13) RSNs with the creation of new contracts in September 2006. These RSNs serve as the managed care entity over the many Community Mental Health Agencies with whom RSNs sub-contract for the provision of direct care services.

MHD provides leadership to the RSN via contract negotiation, development, execution, and monitoring. The Division also provides technical assistance upon request as well as offers support and training to RSNs in areas of identified need. For example, one RSN requested assistance in improving its fiscal tracking tools. A team of MHD staff responded on site. More recently, it was determined that the RSNs as a whole would benefit from a targeted exercise in better understanding utilization management and review techniques and tool. The Division took a leadership role in convening the RSNs for this quality improvement project and solicited the technical support of other agencies within the Health and Recovery Services Administration to provide content expertise.

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 gives great weight to its role as a collaborator with the Mental Health Planning and Advisory Council (MHPAC), allied systems of care, other state agencies, the Transformation Work Group (TWG), RSNs, the Children's Mental Health Initiative Committee, providers, and consumers/families/advocates at large.

Recent interagency activities have resulted in 178 community placements for persons residing at Western State Hospital's geriatric ward through the Expanding Community Services (ECS) initiative and the reduction in census at Western State Hospital's wards for persons with developmental disabilities, with the census for this special population dropping from 93 to 22 through the MHD/DD Collaborative Work Plan.

In addition to oversight of the mental health system, MHD is responsible for resolution of consumer grievances 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.

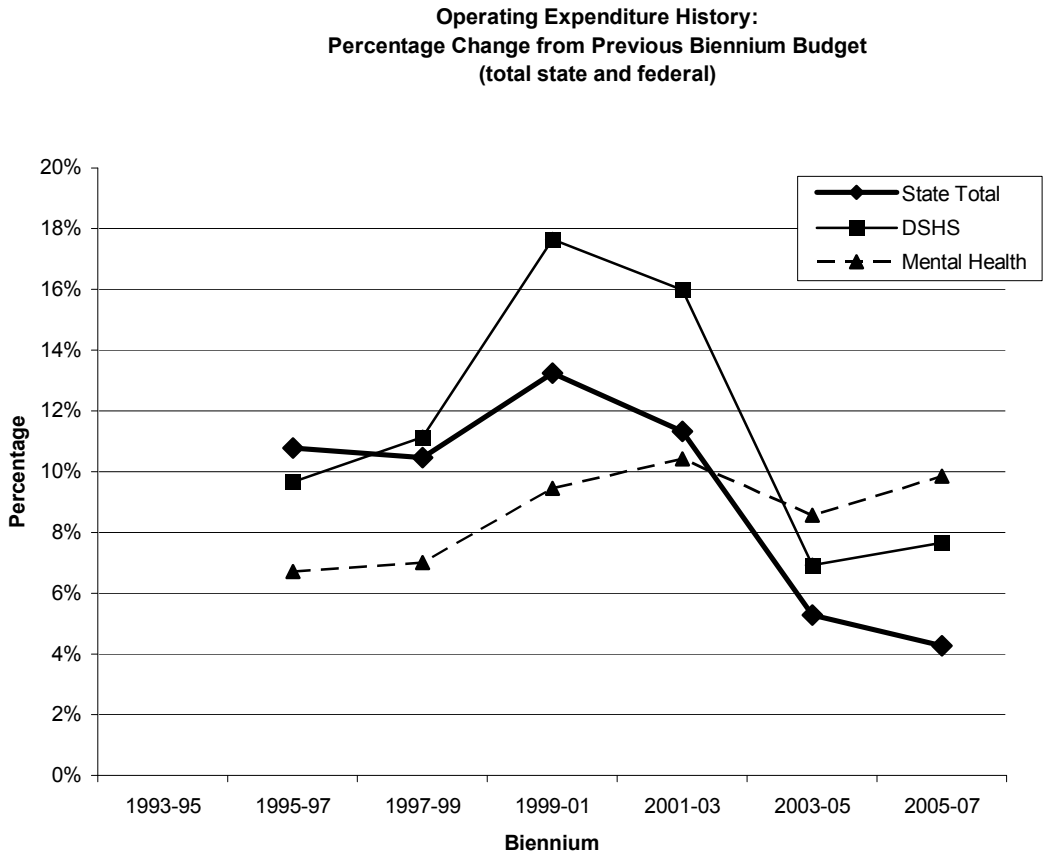
Last year, the MHD employed approximately 65 persons at headquarters and nearly 1,700 persons at the state hospitals. However, with the re-alignment this year within HRSA, MHD's headquarters Information Technology staff and Fiscal Department employees were moved under the direction of other Divisions; the Division of Information Systems and Division of Budget and Finance respectively. Accordingly, MHD now has approximately 40 staff.

In the mid-1990s, Washington was granted a Medicaid 1915b waiver through the Federal Health Care Financing Administration (HCFA), now CMS. The waiver permits the State to purchase both outpatient and inpatient mental health services through PIHPs administered by RSNs. The services contained in the waiver are being reassessed this coming year by the Division, with invitation to MHPAC for participation in the process. The amount of funding allocated to each RSN is determined by a capitated formula. This formula was originally based primarily on Medicaid-eligible individuals, but, under a planned transition, the formula has been shifting to give greater consideration to mental illness prevalence factors.

Thus MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY05, this included community mental health services to 126,009 individuals, with 29.8% (37,552) of those served being children under the age of 18. During that period, community inpatient psychiatric services were provided to 8,219 individuals.

Washington utilizes a 2-year budget, with the beginning of the biennium's first fiscal year starting on July 1 of odd-numbered years. In April 2005, the Washington Legislature approved a FY06-07 biennium State budget totaling over $49 billion, with over $17 billion (more than a third) allocated to DSHS. Of the DSHS budget, MHD's biennium budget was established at $1.3 billion (approximately $686 million per year), or about 8 percent of the DSHS budget.

A review of the past several biennial budgets reveals that, since the 1993-95 biennium, the State's operational budget has increased by 69 percent, the DSHS budget by 90 percent, and the MHD budget by 60 percent. As shown in the graph below, relative to State and DSHS budgets, MHD has fared better in more recent budgets in terms of percentage increase from the budget level of the previous biennium.



Source: data from the Legislative Evaluation and Accountability Program Committee, http://leap.leg.wa.gov/leap/oversight/index_finalh.asp; http://leap.leg.wa.gov/leap/Budget/detail/2005/o0507f.asp).

Washington

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.

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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 see Adult – Overview of State's Mental Health System. However, to augment the following is offered:

The planning system and infrastructure for the delivery of children's mental health services is much the same as the adults. The RSN's must provide a complete array of services to children through sub-contracts with the local community mental health agencies for provision of direct care services to individuals in this vulnerable population who are found to have Serious Emotional Disturbances (SED) and for whom the medical necessity criteria are met.

Between nine percent and thirteen percent of children (age 9-17) have serious emotional disturbances that effect their functioning in family, school or community activities. There are an additional number of children identified by the school system as having a serious behavioral disability. These children are served not only by the mental health and the school systems, but often times are recipients of services by the Children's Administration (child welfare system), Juvenile Rehabilitation Administration, Medical Assistance Administration, Division of Alcohol and Substance Abuse, and/or the Department of Health.

Youth may have multiple issues including: mental illness, substance abuse, repeated patterns of property destruction, assaultive behavior, sexually offending behavior, fire-setting behavior, and/or significant cognitive impairments. 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 including: child welfare, mental health, juvenile justice, substance abuse, developmental disability and special education.

All too often, children are not identified as having mental health problems and those who do not receive timely and effective services may end up in the juvenile justice system. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low prioritization for resources (Surgeon General's Report on Children's Mental Health, 2000).

It is important that care coordination exists for these children and their families. The family should not have the additional burden of coordinating with multiple systems that assist them. To the contrary, the systems should work together to serve the child. Additionally, it should also not be necessary for parents to relinquish custody and care of their children to get services they need as has been the case in the past wherein a parent who could not meet the state eligibility criteria to obtain care for their child made 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.

A growing network of formal (those with 501(c) 3 status) and informal networks of parents and advocates is beginning to be recognized by allied systems of the mental health structure resulting in an increasing number of conversations with other programs about the utilization of parents, neighbors and friends in the support of children with SED. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to help children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are, unfortunately, not yet seen universally as a resource. This group, however, has a strong belief in their role as a system partner and plans to continue to be involved as coordination and recognition continue to grow.

One way this coordination is happening is through the Statewide Action for Family Empowerment of Washington (SAFE-WA) formerly known as the Parent Council. This valuable organization has been supported by the Mental Health Division through MHBG funds, was the recipient of a SAMHSA grant in 2001, and has recently received its 501(c) 3 status. SAFE-WA is comprised of eleven family-driven organizations and a youth organization. SAFE-WA meets quarterly to bring a united voice to the Mental Health Division's management on prominent children's issues.

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. What has not accompanied this, however, is the funding and high level commitment in allied systems of care to support the growth and cohesion of children's services.

Imperative to the development of an effective system of care for children with SED and their families is collaboration. In an effort to reduce gaps in care, improve consistency of supports, and reduce duplication of services, MHD is working closely with other DSHS agencies such as the Juvenile Rehabilitation Administration and the Children's Administration in creating the Children's Mental Health Initiative. Through this joint venture, all parties hope to increase resource management and find better ways to incorporate evidenced based practices with the ultimate goal being improved care with demonstrated outcomes for children with complex, multi-service needs.

Washington

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.

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The following points were previously identified as areas needing attention in the 2006 MHBG Plan:

- Decreased utilization of inpatient care and juvenile justice system;
- Increased family involvement and empowerment;
- Increased community education; and
- Increased utilization of evidence based practices.

Please see Child – Recent Significant Achievements for some of they ways in which these challenges were addressed this year and are continuing to be so this year as well.

Washington

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, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

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Please see Child - Recent Significant Achievements

Washington

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Child - Legislative Initiates and Changes

Child - Legislative Initiatives and Changes, if any

Please see Child - Recent Significant Achievements

Washington

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.

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This is a joint response. Please see Adult – Description of Regional Resources.

Washington

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.

Child- Description of State Agency's Leadership

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

This is a joint response. Please see Adult – Description State Agency's Leadership.

Washington

Adult - Service System's Strengths and Weaknesses

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

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Washington's strengths include:

- A dynamic, collaborative, and comprehensive infrastructure;
- A diverse and inclusive community support system;
- A cross-system, legislatively driven, new resource for co-occurring disorders including crisis intervention and treatment through the Omnibus Bill;
- A dramatic change to Washington's mental health delivery system with the legislative mandate for a procurement process for the provision of services as well as legislation requiring mental health parity;
- A steady increase in consumer and family involvement in meaningful ways through collaboration with MHPAC; Transformation Work Group; the newly forming Consumer, Family and Youth Network; Consumer Round Table; Office of Consumer Affairs; and the development of Peer Counselor Services, including provision for billing of Peer Counselor Services under the State Plan.
- A demonstrably clear and strong commitment to providing increased support and training for use of evidence based practices across all populations including children, older adults, other vulnerable populations, and otherwise difficult to engage adults with severe mental illness and serious emotional disturbances;
- A coordinated dialogue and sincere efforts to improve relationships with and services to Washington's esteemed and diverse Native American Tribes;
- A necessary plan to decrease state hospital use through the implementation of eight (8) PACT teams; and
- A commitment to the ***Transformation*** of our service care delivery system, evidenced through MHD's Strategic Plan as well as this document.

While the community mental health system in Washington holds a strong and positive foundation, it is equally replete with opportunities for improvement, growth, and change as it faces considerable challenges related to all of the above.

For example, with the changes to our infrastructure comes the challenge of maintaining an undisrupted continuum of quality services and clear leadership as MHD is re-aligned with other Divisions. While MHD is expected to reap some benefits through this strategic reorganization, there is at the same time a call for a reduction in work force of 1,000 middle-management employees mandated by the Governor. These two efforts to streamline and improve the overall social and health system necessitate an increase in support to MHD staff in relation to their ability to "get the job done" and to not only maintain, but to move forward, the necessary business of public mental health in Washington. Considerable energy will need to be put forth to ensure that communication, cooperation, and collaboration are functional and meaningful during this process, as these will be paramount to successful ***Transformation*** of the mental health system in Washington.

Despite the call for overall reduction in workforce for the Division of Social and Health Services, the Secretary has understood the need for increased staffing at the MHD

headquarters to meet the requisite work demands, including improves oversight of the RSNs. In fact, the Secretary has authorized the MHD to hire seven (7) new staff for the purposes of contract monitoring, fiscal monitoring and quality oversight. Building the MHD headquarter workforce to a level that can successfully manage both ongoing and new tasks has been established as a priority for the new MHD Director, Richard E. Kellogg who is continuing to assess the need for potential additional staff.

Also needing a high level of commitment and oversight is the implementation of the 20005 Omnibus Bill which calls for, in addition to other items, the development of a cross-system co-occurring disorders pilot and an intensive chemical dependency case management pilot. Although the latter is primarily the responsibility of the Division of Alcohol and Substance Abuse, these resources are reflective of the service needs of many of our consumers. As such, provision of these services will need to be closely monitored for measurable outcomes to ensure effectiveness and sustainability. This will further require a knowledgeable MHD workforce with manageable workloads.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment areas, funding provided is not identified to specific clients, nor is it targeted for certain services or programs. Rather, RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive. Increased funding and greater consistency between RSNs is a constant goal.

Due to this broad provision of funding and vaguely defined outcomes, the Mental Health Division is often unable to clearly identify whether funds provided are sufficient to accomplish the goals set forth in statute, rule and contract. MHD is actively increasing the oversight and monitoring functions performed in an effort to ensure the delivery of quality mental healthcare that is focused on ***Recovery*** and ***Resiliency*** goals.

A significant concern has been related to the system's dependence on the use of unspent Medicaid savings to provide services for non-Medicaid clients or to deliver services not covered by Medicaid. As of July 1, 2005, the state complied with a CMS directive to end this practice. While this CMS decision lead to massive efforts to assess the service needs of non-Medicaid clients across the state and a coordinated movement to obtain the necessary state funds needed to cover those costs, Washington's need to diversify its resources and increase utilization of appropriate Medicaid funding remains focal. To that end, MHD is preparing to assess the service packages provided in the State Medicaid Plan to look toward a better array of services that will enhance ***Transformation*** efforts. As noted before, basic changes to the manner in which Washington utilizes IMD settings and to the State's ability to provide other non-Medicaid services will need to occur for ***Transformation*** to become reality.

As a result of participating in the Sixteen-State Pilot Indicator Project, the MHD is moving toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the MHD, RSNs, and providers have spent

considerable time maintaining an updated data dictionary to improve data reporting. This shift may be hampered by new federal requirements placed on managed care entities as a result of the Balanced Budget Act (BBA) of 1997 and by some reporting requirements of the Health Insurance Portability and Accountability Act (HIPAA). These federal requirements were primarily implemented in SFY 2003; one pushing process, the other pushing outcomes. However, as they proceed, active planning, designing, training, adequate implementation time-lines and funding are required to ensure their success.

In summary, many of Washington's strengths serve also as our greatest challenges, begging for attention and resources to continue the ***Transformation*** efforts. Services need to be consumer driven and based, accessible to all who need them, and stakeholders (including legislators, law enforcement, administrators, providers, consumers, family members, advocates, children, youths, and the community at large) must understand that every consumer holds the ability to attain ***Recovery*** and that child and youth can improve their ***Resiliency;*** Further, that every individual possesses the right to have a meaningful life in their own community

Washington

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.

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- *Housing*: Lack of safe and affordable housing
- *Benefits:* Too many individuals need mental heath treatment, yet are not eligible. State-only dollars cannot meet the call for 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 are offered. 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 mental health system to move toward ***Transformation***.

All of the issues above have been unveiled through the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the MHPAC, providers, multiple other community organizations, and consumer/ family voice.

Washington

Adult - Plans to Address Unmet Needs

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

Adult – Plans to Address Unmet Service Needs

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

As with most public mental health systems, Washington State struggles with having limited resources to meet the basic needs of its consumers. Recognizing this, MHD seeks creative ways to encourage the RSN's to address the call for ***Recovery***, not just maintenance, which unfortunately can be perceived as a message to "do more with less". As we move forward to implement the changes intended to promote greater consistency and more equitable access to high quality services, remaining aware of potential shortcomings within the system must be a priority as well.

With everyone involved from consumers and family members to the Governor, Washington has a reasonable grasp on where, in our continuum of care, needs exist. While we are currently experiencing an unprecedented focus on the mental health system and the services provided therein, special attention will be devoted to the following fundamental items as we look to the future:

- ***Housing*:** Increased attention to residential supports, housing resources, and affordable housing to reduce homelessness and substandard housing for individuals with mental illness. The disconnect between MHD and HUD is significant and seen as an essential building block to improving safe and affordable housing;
- ***Benefits:*** Greater consideration to the process by which individuals who are eligible for Medicaid services can become recipients of such, allowing for increased access to not only mental health benefits, but to dental and medical services as well. Expansion of the recently implemented legislation calling for Expedited Eligibility determinations for persons being released from jails, prisons, or IMDs;
- ***Inpatient Capacity***: Increased resources to support the immediate need for greater inpatient capacity while at the same time developing PACT teams across the state. With improvements to housing, benefits, and community support, the spike in the need for greater inpatient capacity will diminish;
- ***Vocational or Meaningful Activities:*** Enhanced supports to help those consumers who want to work or go to school do so, as evidence shows that feeling productive and having purpose in one's life is critical to not only decreasing one's symptoms, but to making meaningful ***Recovery*** a reality. Particular focus will be given to encouraging the development of ICCD Club Houses and the expansion of Peer Counselor certification program. In relation to this, the MHD Director and the Transformation Grant Director are involved in early discussions to coordinate with the area community colleges to develop a curriculum and level of certification that does not currently exist, giving Peer Counselors opportunity to obtain an Associate of Arts (AA) degree. Additionally, more support needs to be given to the creation of opportunities to develop and engage in a variety of meaningful activities, including Drop-In Centers, for older adults or for adults for whom work is not part of their personal ***Recovery***; and
- ***Understanding of Recovery and* Resiliency*:*** Increased training is expected in

early intervention and prevention, cultural competency, and community education, thereby decreasing discrimination and stigmatization. As the leadership of the public mental health system, MHD will promote statewide and local ***Recovery*** Policies developed in collaboration with MHPAC. MHD will continue to encourage and solicit expansive involvement of consumers in directing the mental health service delivery system in Washington, thereby providing them with what they say they need, when they need it, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Washington

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.

Adult – Recent Significant Achievements

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

- **RFQ/RFP Process**: The completion of the legislatively mandated RSN procurement process has resulted in the communication of clear expectations across the entire array of RSN responsibilities including quality, diversity, access, fiduciary responsibility, technical capability, program development. Through establishing these expectations, many RSNs were able to articulate their ability to provide the level of excellence in services sought by the state. For the RSNs that did not originally qualify, the RFP process provided an opportunity to shape and enhance their resources and continuum of services. In all, the procurement process has resulted in clearer expectations to the RSNs and improvement in the ability of the RSNs to meet those expectations.

- **Funding for High Intensity and Hospital level of care**: Funding requested of the legislature by the new MHD Director, Richard E. Kellogg, was awarded to address critical concerns regarding insufficient inpatient capacity. The solution attacks the issue from two fronts: the short-term need for more inpatient beds at the state hospital and the long-term need for enhanced community supports through development of eight (8) teams to deliver the evidence based practice of Program for Assertive Community Treatment (PACT). As PACT teams are made operational, hospital wards will be closed. Washington's PACT teams will vary from the standard in that every PACT team will have a Peer Counselor. The decision on the part of the legislature to fully fund this initiative is indicative of the legislature's considerable level of understanding and commitment to meeting of the current needs of the public mental health system while investing in the future expectations for the provision of mental health services to be community-based.

- **Enhanced opportunity for system and community collaboration**: The Mental Health Division (MHD) is actively working to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support Networks (RSNs), consumers, families, MHPAC, Transformation Work Group, community mental health providers, state hospital patients, labor unions and allied systems. Some of these allied systems include formal systems such as the Children's Administration, the Aging and Disability Services Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Office of Superintendent of Public Instruction, the Department of Corrections, and the Division of Vocational Rehabilitation, to name a few. As noted earlier, with the reorganization initiated by the DSHS Secretary, greater inter-agency collaboration is expected.

  MHD leadership and staff members meet regularly with RSN administrators and assure that there is representation from the RSNs on any committee created to develop or establish policy. These committees also include providers, consumers, parents and family advocates and at times, allied system partners. Topics for

discussion range from the call for evidenced based practices to the need for Washington Administrative Code changes.

MHD also meets with the Washington Community Mental Health Council, an association representing most of the community mental health centers that operate under subcontract with the RSNs to deliver direct services to consumers. MHD seeks and receives input as well from community mental health centers that do not belong to the council, but who subcontract with the RSNs.

Another valuable tool for increased collaboration in the enhancement of a comprehensive community based system of care is the Inpatient Roundtable, which is a technical assistance group comprised of staff from MHD, the Medical Assistance Administration, RSNs and community hospitals. This knowledgeable team has been on hiatus due to limitations related to the RFQ/RFP process, but will be reconvened and return to a schedule of routine meetings to discuss various issues that arise relating to community inpatient services. The Roundtable has historically worked diligently to find reasonable solutions, while offering creative ideas for system improvement.

In addition to building upon the formal system infrastructure above, the use of other community resource programs to strengthen and diversify the community mental health system are frequently utilized such as churches, food banks, homeless shelters, the YMCA and YWCA. The mental health system also relies on natural support systems such as friends and neighbors through the use of Individually Tailored Care Plans and Wrap Around services, which are consumer focused, strengths-based and needs driven.

- **Increased efforts to coordinate physical and mental health:** Washington's Medicaid Integration Project (WMIP), effective January 2005, came to fruition through the collaboration of DSHS with Molina Healthcare of Washington, Inc (Molina). The goal has been to manage and provide medical and chemical dependency services through Molina's provider network, with an initial requisite enrollment of 6,000 individuals (with option to dis-enroll) in a county north of Seattle. 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.

While WMIP was initially focused on integrating medical and substance abuse treatment, this pilot has been expanded to include individuals with mental illness,

many of whom struggle with complex medical needs and substance abuse as well. Inpatient care related to mental illness will also be incorporated into the plan. Outpatient mental health services were recently added and 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.

- **Increased avenues for consumer participation and representation**: A State-wide Consumer, Family and Youth Network is being developed under the leadership of consumer staff involved in the Transformation Grant. The intention is to help build an independent and sustainable coalition that will eventually attain 501(c) 3 status. The Network will facilitate a more unified consumer voice regarding the direction of the mental health system.

  Another channel for adult voice will come through the creation this year of a seventh subcommittee to the MHPAC, which will be the Adult Sub-Committee. This group will assess and address the needs specific to adult consumers of the mental health system and is being developed at the request of consumer members of MHPAC. One of its first tasks is to review the job description for the Manager of the Office of Consumer Affairs (OAC); a position that is temporarily vacant.

  OCA meets the requirements described in the MHD managed care waiver from the Centers for Medicare and Medicaid Services (CMS) and serves as an "independent" but internal component of MHD's Management Team, reporting to the Director's Office. OCA provides MHD staff and MHBG contract holders with liaison and consumer-run advocacy and support services. While OCA has held an active role in the State Behavioral Health Conference, trainings for Ombudsmen and Quality Review Teams, as well as resolutions of consumer complaints at the Division level, its primary program has been the "ORCA Conference Series" (Outreach, Recovery, and Consumer Advocacy).

  ORCA is used to provide outreach and education services, while at the same time being utilized as a mechanism for voice collection through major conference events in each state region. Topics are consumer driven and follow the advocacy recommendations of CMS evaluations and MHD Quality teams.
  Between OCA, the Adult Consumer Sub-Committee, and the Consumer, Family and Youth Network, opportunities for consumer's to provide input into the public mental health system have never been greater.

- **Expansion of Peer Counselor and Recovery training:** Consumer training and employment is also possible through a newly implemented comprehensive training and certification program for Peer Counselors. To fully integrate this service, the State's Medicaid Plan was recently amended to allow peer support as a billable treatment modality under the Medicaid State Plan. To be accepted for the MHD-sponsored training, an individual must self-identify as a consumer of the public mental health system with one year in recovery.

*The term, **"consumer"** is defined in the Washington Administrative Code (WAC) and includes the parents or legal guardians of children under the age of 13 when they are involved actively in the treatment of the child*. Individuals applying for certification must be Registered Counselors with the Department of Health, must successfully complete forty hours of in-class training that is experiential and informational in format and the individual must pass both oral and written exams. Accommodations are provided for individuals with special needs and every opportunity is provided to enhance the success of the participants.

Upon completion of the requirements for peer counselor based on the Medicaid State Plan, a letter of completion is issued by the MHD verifying that the minimum qualifications have been met. Licensed community mental health agencies are beginning to hire and employ peer counselors to meet the requirement that all state plan services be available in each RSN. MHD anticipates expansion of peer support by continuing the trainings in the upcoming year and by enhancing an internet site devoted to this model of care focused on ***Recovery*** and ***Resiliency***.

Wellness Recovery Action Plan (WRAP) training is also being provided this year to all certified Peer Counselors as well as others interested in this dynamic, evidence-based program. This training series will result in 75 certified WRAP trainers in a "train the trainers" model. Discussion is also underway to provide WRAP training specific to a youth audience.

In an effort to increase collaboration between MHD and Transformation Grant initiatives, staff members from both entities have been meeting regularly to develop and implement ***Recovery*** and ***Resiliency*** trainings across life-span, socio-economic, and cultural/ethnic boundaries.

- **Increased focus on quality and accountability:** As part of quality management, there have been three MHD sponsored System Improvement Groups, which have included consumers, parents, family advocates, community mental health centers, Washington Institute for Mental Illness Research and Training (WIMRT), and Regional Support Networks. System Improvement Group recommendations have been incorporated into the Division's quality management plan and into the activities of program planning, policy direction, and contract development.

  On a state-level, the Governor has instigated GMAP (Government Management Accountability and Performance) which requires all state agencies to conduct business under the framework of measurable outcomes, quality services, and responsible finances. Every administration, division and agency with state government must demonstrate these GMAP expectations as evidenced by tying all budgeting activities to GMAP goals and indicators.

- **Increase resources for persons with co-occurring disorders**: MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee made up of providers from mental health, chemical dependency, other cross-systems and consumers. This group, having been in existence for approximately thirteen years, continually seeks to address the co-morbidity issues of mental illness and substance related disorders. The two divisions often engage in joint studies including developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

  Of significant note this past year specific to co-occurring disorders, was the passage of the Omnibus Mental Health Reform Bill. This legislation lays the ground work for a truly integrated crisis system aimed at providing the right services to dually-diagnosed consumers in crisis as well as attempting to reduce hospitalizations and jail recidivism. Specific provisions include:

    - Establishment of a process to identify individuals with co-occurring mental illnesses and substance abuse disorders through the consistent use of standardized screening and assessment processes;
    - Expansion of the use of therapeutic courts (e.g., drug, mental health and family therapeutic courts);
    - Improvements in access to services by providing Medicaid processes so that someone released from jail or prison can have Medicaid benefits restored quickly so they receive the treatment they need to reduce the risk of re-offending;
    - Improvements in access to inpatient services by creating a new facility licensure;
    - Authorization for the creation of a combined mental and chemical dependency crisis response system in two pilot sites establishing secure detoxification facilities;
    - Authorization for the creation of a combined mental and chemical dependency project to provide intensive case management services; and
    - A mandate for the study of outcomes specific to both pilots.

  Additionally, the State Legislature awarded $18.8 million dollars in state funds and $10.5 million in federal funds to more than double the chemical dependency treatment services to Medicaid-enrolled disabled adults.

- **Mental Health Insurance Parity:** With the passage of Substitute House Bill 1154, comes another significant move towards ***Transformation***. 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 facilitating ***Recovery*** and ***Resiliency*** for thousands of Washington's residents who struggle with mental health issues, but for whom treatment has been beyond reach due to their financial limitations coupled with inadequate insurance coverage.

- **Olmstead Grant supported training to direct care providers:** Other resources sought by MHD include SAMSHA grant funds awarded for the design and implementation of cross-system trainings with the Aging and Disability Services Administration and the Division of Alcohol and Substance Abuse. This was an annual $20,000 grant for three years beginning in 2001. Training has focused on residential providers and the development of cross-system crisis plans with multiple steps that can be utilized prior to calling the crisis line. Trainings also included presentations by individuals who have first-hand knowledge regarding local systems and provide direction on concerns such as when to call the crisis line and what to expect from them.

- **DD/MHD Collaborative Work Plan:** Through this innovative working agreement, MHD and the Division of Developmental Disabilities have worked to improve access to services, appropriateness of treatment, and accountability for services. Its keys to success have been that fact that it is formalized in writing, funded through the legislature, and facilitated by the DD/MHD Cross-System Committee, with the support of state-wide regional coordinators and the 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. As evidenced in the table below, more people are leaving the hospital than entering, fewer are being admitted, of those 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:

Measurable Outcomes	1998	2005
Number of DD/MI consumers in WSH	93	29
Number of first time admissions	61	6
Number of re-admissions	32	1
Mean length of stay	171	129
Total Admissions	93	7
Total Discharges	75	13
Average number of days away between hospitalization	33.1	397.3

- **Support of Evidence Based Practices:** In addition to the upcoming development of PACT teams, demonstration of Washington's desire to promote use of evidence based practices is seen through MHD's contract with the Washington Institute of Mental Illness Research and Training (WIMRT) for the development and publication of an exceptional handbook titled, "Mental Health Best Practices for Vulnerable Populations" which includes, but is not limited to, evidence based practices for such traditionally underserved groups as sexual minorities, individuals with developmental disabilities, older adults, and individuals with diverse cultural issues such as Native American Tribes. This handbook has been provided to other states upon request in the service of technical assistance.

  MHBG funds are also being used to support development of EBPs specific to Older Adults included training on the implementation and use of 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. MHD will continue to actively enhance the outreach capacity and specialized services needed by this traditionally underserved population.

- **Jail Services:** Through budget proviso, the legislature allocated 5 million dollars over the biennium for the provision of services to persons with mental illness who are incarcerated. Funds are being used to perform screenings on every person referred by the jail staff. From there, intakes are being completed on persons who fall under the legislatively defined "priority populations." Following this step, the Access to Care Standards (ACS) are applied. If a person is found to meet the ACS, then the RSN ensures that complete transitional services are provided, including resources to meet physical and mental health, residential, and financial needs. If the individual is not found to meet the ACS, then at the very least, the RSN is ensuring the submission of an application for available benefits to the Department of Social and Health Services. This process required multiple contractual agreements as well as over 60 Memorandums of Understanding (MOUs) across the state, moving the entire system toward greater collaboration in serving this population.

- **Expedited Eligibility:** Authorized by passage of SB1290 and funded through the Jail Services Proviso above (418K of the 5M), is the expectation that a review and determination of eligibility for TXIX services be expedited for persons who have a serious mental illness, who have been on TXIX or SSI some time in the past 5 years, who are currently residing in either a jail, prison, or state psychiatric hospital, and who are currently not receiving benefits. MHD has actively partnered with sister agencies, including Economic Services Administration, Department of Corrections, and Disability Determination Services, as well as the

RSNs, jails, psychiatric hospitals, the Washington Association of Sheriffs and Police Chiefs (WASPC) and other interested stake holders to build this network of resources. Doing so is expected to reduce recidivism, decrease bureaucracy, and improve ***Recovery*** outcomes.

- **Improved Tribal Relations and Supports:** The establishment of a Tribal Liaison position stationed at MHD to provide coordination with Washington's 29 federally recognized tribes in addition to three non-federally recognized tribes has been an imperative part of the mental health and tribal coordination. Tribal members who are Medicaid enrolled retain the option to receive public mental health services through the RSNs or may choose to receive services through the tribal mental health system. The DSHS Administrative Policy 7.01 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. A recent Memorandum of Understanding (MOU) was executed between DSHS and the Nisqually Tribe, recognizing the full faith and credit of tribal court orders for the first time. Other tribes have subsequently expressed interest in developing similar MOUs with DSHS.

  Further enhancing Tribal/State relations was a Tribal Summit held three years ago, convened to focus on mental health issues. Active participants included members of various tribal councils, native healers and spiritual leaders as well as the Director of the MHD and other state employees. Tribal Summit work groups focused on ways to decrease disparities in access to services while increasing the quality of care for the State's Native American population.

- **Increased focus on MHBG funds:** MHD has begun conducting on-site program and fiscal reviews of each RSN related to the use of MHBG funds. These reviews, which have resulted in significant 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.

  In addition to increased accountability through monitoring, MHD has improved the process by which an RSN submits and receives approval for its planned use of MHBG funds. In support of paperwork reduction and to streamline and expedite the contracting process, MHD developed electronic forms for the RSNs to use in Initial Proposals, Contract Amendments, Progress Reports and Implementation Reports.

  Additionally, a new process for review of RSN MHBG plans has been developed. RSN MHBG plans are for the first time being reviewed by a team of persons including MHD staff and members of MHPAC. The review team will first apply the identified *guiding principles* and *spending categories* (see "Adult – Grant Expenditure Manner"). The team will then review two newly required pieces of

the proposal approval process. First, the RSN must provide a narrative description of how the services it is planning on supporting will promote ***Transformation, Recovery or Resiliency***. The second requirement is that the RSN demonstrate that its Advisory Board (which is required through WAC to have >51% Consumer membership) has had involvement in development or review of the RSN's plan as evidenced by either meeting minutes or a letter of opinion on the proposed plan.

To support RSN Advisory Boards in providing informed and meaningful feedback to their particular RSN specific to MHBG, MHPAC invited the RSN Advisory Boards to its Annual Meeting last year. There, participants were shown a power point presentation which provided detailed education on the MHBG. Feedback regarding the Annual Meeting noted this particular training as one of the most valued parts of the event. Following this, all RSNs were provided an electronic copy of the presentation and asked to follow-up with their respective Advisory Boards. The ultimate goal is to educate everyone about the MHBG so that these funds may be maximized to their fullest potential in moving Washington toward ***Transformation.***

Washington

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.

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.

For the Division:

- Continued efforts to increase expertise of a highly skilled workforce within MHD;
- Stability of hierarchy, cohesion of merged divisions, and staffing at adequate levels to accomplish the exceptionally challenging and powerfully important work that lies before the Division.
- Expansion and inclusion of consumer and family voice in Division efforts to guide the mental health system toward greater alignment with the over-arching goals of President's New Freedom Commission recommendations (outlined in the Executive summary of this document) for improvements to the service delivery system. This will be achieved through utilization of partnerships with MHPAC and its Sub-Committees, the Consumer, Family, and Youth Network, the Office of Consumer Affairs and the National Alliance for Mental Illness (NAMI).

For the State Mental Health System:

- Care that is based in ***Recovery*** and ***Resiliency***;
- Housing that is safe and affordable;
- Vocational opportunities that are meaningful and feasible;
- Services that are culturally competent and accessible to all who are eligible;
- Access to services that are cohesive and well coordinated, demonstrating enhanced relationships between state agencies, RSN's, providers, Tribes, consumers, families, and communities, thereby facilitating a seamless continuum of care for recipients of mental health services in Washington State.

To achieve these goals, MHD will continue to focus its resources on the fundamental and imperative evolution of ***Transformation***. Accordingly, in determining how MHBG funds are utilized, the Division uses the six ***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. Work in tandem with the Division's Strategic Plan which, again, 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 voice;
4. Link well to other resources and ***Transformation*** activities;
5. 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
6. Align well with other Division initiatives or legislatively mandated expectations.

It is the Mental Health Division's vision, held with clear determination, to transform mental health services in the State of Washington, enabling the promotion of real choices for real recovery. In accordance with the recommended changes outlined in the July 2003 Final Report of the President's New Freedom Commission on Mental Health entitled: "Achieving the Promise: Transforming Mental Health Care in America", coupled with the collective use of all available financial and human resources, MHD hopes to provide our citizens with the highest quality of mental health services available; services that are consumer driven, evidence based, outcome directed and supportive of individual ***Recovery*** and ***Resiliency***.

Washington

Child - Service System's Strengths and Weaknesses

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

Child – Service System Strengths and Weaknesses

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

In 2002, the Department of Social and Health Services formed a workgroup known as, "The Select Committee on Adolescents in Need of Long Term Placement' ("the Committee"), to examine the continuum of care and the sufficiency of services and housing options for youth with the most complex needs. The Committee has published a report that details the current status of services available for these children and makes strong recommendations for sweeping systems change, including adoption of Evidence Based Practices.

A DSHS Children's Mental Health Services Workgroup was convened in December 2003 by the DSHS Assistant Secretaries for the Children's Administration, the Juvenile Rehabilitation Administration, and the Health and Rehabilitative Services Administration, of which the MHD was a division. The Workgroup had thirty members, ten connected with each Administration, including field staff, providers, parents, foster parents, researchers, advisory board members, advocates, DSHS partners and other state agencies, meeting bimonthly through June. A report was presented to the three Assistant Secretaries at the end of July 2004 with recommendations for the improvement of mental health services and how they are delivered by DSHS. A SAMHSA System Improvement Grant was submitted to assist in the implementation of these reform efforts, but was not awarded.

As a result of this work group, and under the direction of the three DSHS assistant secretaries, the Children's Mental Health Initiative was born. As described above, this collaborative effort between the Mental Health Division, the Juvenile Rehabilitation Administration and the Children's Administration was formed to decrease duplication and increase resource management in an effort to provide more comprehensive services to children with SED and multi-system involvement.

One recent accomplishment of this group was the delivery of a report in February 2005 to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs have been selected for broad implementation throughout all three systems. They include:

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are expected to generate treatment outcomes for children, youth and families which will hopefully result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced ***Resiliency***. The initiative will target implementation efforts by

focusing on workforce development. By supporting specialized training and certification for clinicians, significant work force enhancement can be achieved without disruption to usual funding levels and service priorities. A comprehensive implementation plan has been developed for each EBP with anticipated completion by the end of the biennium.

Another strength of Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The goal of this endeavor is the identification of promising programs where public schools and public mental health providers may collaborate effectively. A report was subsequently submitted to the legislature in June of last year identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified will be disseminated through the public schools and public mental health systems within the coming months

Washington

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.

Child – Unmet Service Needs

Child –An Analysis of the unmet service needs and critical gaps with in the current system and identification of the source of data which was used to identify them.

While considerable progress continues to be made in many parts of our system, the following areas require more work to be done in facilitation and coordination of care across Washington's multi-service delivery system for children:

- *Formal Systems Use:* Continued utilization of inpatient care and involvement with the juvenile justice system is too high;
- *Natural Supports:* Too few families feel empowered or involved in the care of their loved one. More training and support are needed to enhance optimal use of this valuable natural resource. ;
- *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;
- *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; and
- *Evidence Based Practice:* Increased utilization of available evidence based practices is called for across the entire children's system of care.

Washington

Child - Plans to Address Unmet Needs

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

Child – Plans to Address Unmet Service Needs

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

- *Formal Systems Use:* MHD is convening a workgroup to assess the flow of the Children's Long-term Inpatient Program (CLIP) and the community acute care resources currently available to children and youth. Greater collaboration is sought system-wide through the efforts of the Children's Mental Health Initiative as well
- *Natural Supports:* MHD will continue to support activities and trainings which are geared toward enhancing familial empowerment and participation in the care and treatment of loved ones with SMI and SED including the annual Dad's Retreat, the SAMHSA Alternatives Conference, SAFE-WA, and Parent Connectors.
- *Understanding of Recovery and Resiliency:* The need for a comprehensive ***Recovery*** and ***Resiliency*** training campaign 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. Some ideas under consideration include Wellness Recovery Action Plan (WRAP) training exclusive to youth and Youth Peer Counselor training. Additionally, there was an entire track devoted to this and children/youth at the state Behavioral Health Conference. MHD also sponsors a youth retreat focused on this.
- *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 "what they want to be when they grow-up" will only instill hope for the future, which is the core of ***Recovery*** and ***Resiliency***.
- *Evidence Based Practice:* Through the Children's Mental Health Initiative (CMHI) legislative funding has been secured for the implementation of three EBPs focused on this age group: therapeutic foster care, multi-systemic therapy, and functional family treatment, with more to be phased-in. Training will continue to be offered around EBPs and research of promising best practices.

Through all of these efforts, the goal of MHD is to ensure that children with SED are treated, nurtured, and strengthened by the services that are provided to them so that they may know stability at home and school, enjoy better health and overall functioning, and ultimately come to realize their dreams, and those of their families', for a future rich in ***Resiliency***.

Washington

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.

Child – Recent Significant Achievements

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

Within the Department of Social and Health Services and other state agencies including Juvenile Rehabilitation Administration (JRA) and the Children's' Administration (CA) a number of initiatives have been undertaken towards improving cross systems collaboration in an effort to enhance development of a comprehensive community-based mental health system specific to children and youth.

- **Select Committee on Adolescents in Need of Long-Term Placement**

Of significance is the establishment of a taskforce to study the highest need youth served by multiple systems within the department. This taskforce, known as the Select Committee on Adolescents in Need of Long Term Placement, was made up of community leaders and advocates, including members from the Consumer, Family and Youth Network, as well as DSHS administrators. The Committee published its final report in December 2002 making recommendations for improving the services and outcomes for youth with the highest need.
The MHD 2003-2005 contract with the RSNs includes a requirement for the RSNs to use treatment interventions that are research-based and shown to be effective in achieving positive outcomes when providing mental health services to children and youth. This requirement is the result of a recommendation of the Select Committee on Adolescents in Need of Long Term Placement.

- **Treatment Foster Care Taskforce**

Acting on these recommendations, the DSHS Children's Administration (CA) formed the Treatment Foster Care Taskforce. This taskforce met during 2003 to review the foster care system. It made recommendations of the type of foster care and treatment most likely to be effective and beneficial with high need youth in the foster care system. The final report is in draft form only and has not been published.

- **MHD/JRA Development Of Cross Systems Protocols and Transition Agreements**

MHD and the Juvenile Rehabilitation Administration (JRA) worked together to develop cross systems protocols and transition agreements between each of the Regional Support Networks (RSN) within the public mental health system and each of the corresponding JRA regions. These agreements, completed in 2003, facilitate a smooth transition from JRA facilities to the community for youth who have mental health diagnoses.

- **MHD/CA Development of Cross Systems Protocols and Dispute Resolution Agreement**

MHD included in its 2001-2003 contracts with the RSNs, a requirement that each RSN develop cross-system service delivery protocols for the coordination and integration of services with each of the DSHS CA Regions. Protocols were completed in October 2003 and presented at a December 2003 joint meeting of the RSN Administrators and CA Regional Administrators attended by the Assistant Secretaries of the Health and Rehabilitative Services Administration (HRSA), CA and JRA. The 2003-2005 RSN contracts with the MHD include a requirement that the RSN implement these protocols. In addition, a Dispute Resolution Agreement between MHD and CA was finalized after meetings which included input from the RSNs, CA regions and DSHS headquarters staff.

- **SAMHSA Planning Grant Received for the Implementation of Evidence-based Practices**

In October 2003, the MHD received a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for the development of the use of evidence-based practices. Efforts to identify and plan for the implementation of evidence-based practices (EBPs) are underway with a workgroup consisting of service systems stakeholders.

- **Children's Mental Health Initiative**

Especially significant is the Children's Mental Health Initiative (CMHI) which grew out of DSHS Leadership's commitment to respond to concerns and improve care delivery. The Children's Mental Health Initiative (CMHI) represents a sustained commitment on the part of DSHS and the assistant secretaries of HRSA, CA and JRA to provide better coordination of services for children and youth with complex mental health and social needs. Children and youth whose needs span one or more of the child serving systems represent the costliest care and the greatest coordination challenges and are the target population for this initiative.

CMHI leadership includes a director-level committee that meets regularly to steer the project and advise the assistant secretaries on a regular basis. Staff members from each administration meet to coordinate independent and joint efforts related to the implementation of evidence-based practices (EBPs). Considerable progress has been made guided by the following vision of "improved mental health services for children and youth":

I. Services and supports are evidence-based and service providers are well trained in these practices.

II. There is movement towards "integration of business services," including simplified access, joint contracts, and sharing of some system resources.

III. The Department partners with tribes, minority communities and other interested parties to foster promising practices achievement of evidence-based practice status.

IV. Family and stakeholder voice is valued and incorporated into planning.

Progress includes:

- Implementation of Evidence-Based Practices
- Integration of Business Practices
- Tribal and Minority Collaboration
- Family and Stakeholder Voice

I. Implementation of Evidence-Based Practices

Many mental health practices, including therapy interventions, have been studied to determine how effectively they impact the lives of children, youth, and families. Within the child/youth populations served by DSHS, effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; avoidance of higher cost and more restrictive levels of care such as children's long-term inpatient treatment, and reduced levels of juvenile crime.

The current work of CMHI includes implementation of five EBPs:

- Multidimensional Treatment Foster Care (MTFC)
- Functional Family Therapy (FFT)
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Family Integrated Transitions (FIT)
- Multi-System Therapy (MST)

DSHS CMHI chose these EBPs on the basis of the recommendations of an "expert panel" of researchers from across the state. These practices range from institutional and out-of-home (treatment foster care) to community and home-based interventions all designed to avoid placement or placement disruption and reduce the need for chronic and/or institutional care. To date, progress includes:

- The expansion of MTFC, to include 30 additional treatment foster care beds for the Children's Administration and 10 treatment foster care beds for youth with primary mental illness and behavioral disorders in the Mental Health System.

- Statewide training in Trauma-Focused Cognitive Behavioral Therapy expected in its first round to result in treatment teams having the capacity to serve 1,440 youth annually. Training will include six months of bi-weekly

consultation with national and local trainers to ensure fidelity and appropriate adaptation where needed.

- Early collaboration between MHD, JRA and DASA to expand implementation of FIT for youth with co-occurring substance abuse and mental health disorders in facility and community based care. This will likely mean additional contracting by the Department with FIT model developers at the University of Washington, Division of Public Behavioral Health and Justice.

- Expansion of Functional Family Therapy through Children's Administration, which has previously been available only within JRA.

- A children's mental health track with emphasis on evidence-based practices for youth was sponsored by the Mental Health Division at the annual Washington Behavioral Healthcare Conference, June 14-16, 2006 in Wenatchee, WA, and covered issues related to trauma, ethnicity, and substance abuse.

Additionally, the 2006 Legislative Budget included an allocation of $450,000 to support and study the implementation of an evidence-based pilot program addressing the mental health needs of youth as determined within the community through an RFP process. This pilot will be operational by January 2007.

II. Integration of Business Practices.

CMHI is developing an instrument with the assistance of the Washington State Institute on Public Policy (WSIPP) that will be used by all three administrations to match children and youth to the appropriate evidence-based practice or practices. This domain-based tool will be modeled upon WSIPP's Washington State Juvenile Court Assessment and will create the foundation for prospective cross system efficiencies to be employed in assessment and case-management.

III. Tribal and Minority Collaboration

A number of forums have been held with researchers and providers representing diverse ethnic, minority and tribal groups that have addressed the perceived effectiveness and cultural relevance of EBPs. Discussion is ongoing and commitment is firm on the part of DSHS to explore potential funding strategies to support the evolution of promising practices, particularly those in use by tribes and minority communities, into evidence-based practice status.

IV. Family and Stakeholder Voice

The Department is involving parents and families in an ongoing way to share information and gather input – assuring a formal feedback mechanism for updates and stakeholder input through:

- Semi-annual meetings with families and youth
- Contracting with Statewide Action for Family Empowerment of Washington (SAFE-WA) to provide orientation to parents regarding EBPs
- Potential creation of a Parent/Family Advisory Group

CMHI is a high priority of the Secretary of DSHS who has directed the Assistant Secretaries to support the project and ensure accountability and ongoing partnership. To ensure effective coordination among many stakeholder groups and initiatives, MHD regularly updates and obtains input from the children's subcommittee of its Mental Health Planning and Advisory Council (MHPAC) and coordinates with the Mental Health Transformation Grant.

Additionally, in 2005, the Division of Alcohol and Substance Abuse (DASA) received a Statewide Coordination Grant from SAMHSA Center for Substance Abuse Treatment (CSAT) to develop a statewide infrastructure that fosters cross system planning, knowledge and resource sharing to enhance the existing adolescent substance abuse treatment system. The Mental Health Division, Children's Administration and Juvenile Rehabilitation Administration participate in the Statewide Leadership Council and subcommittees of this grant chartered to address resource gaps and improve licensing and certification standards, training in evidence-based practices and treatment integration through cross system collaboration.

Other system-wide activities of achievement include:

- Development of Governor's Department of Early Learning
- Legislative support through funding several EBPs for children/youth
- Youth membership on the Children's sub-committee for MHPAC
- MHD staff member appointment to the State Interagency Coordinating Council, which serves in an oversight/advisory role to the Infant Toddler Early Intervention Program (ITEIP). ITEIP is Washington's Individual with Disabilities Education Act (Part C) program for children ages 0-3.
- Development of two pilot projects through the Health and Recovery Services Administration and the State Department of Health to address early intervention for maternal depression, serving as a preventative measure affecting infant development and decreasing potential for children to develop Serious Emotional Disturbance.
- Ongoing seclusion and restraint grant at the state psychiatric hospital for children, Child Study and Treatment Center.

Washington

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.

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.

This is a joint response. Please see Adult – State's Vision for the Future. However, to augment:

Washington's Recent Significant Achievements related to children and youth are examples of our future vision in action now. Children *are* our future, and as such, they have an inherent right to experience an environment wherein everyone works collaboratively to ensure their well-being and their development as healthy and happy individuals. The Mental Health Division goal is to see that children with SED are wholly supported, with all available resources, to become contributing members of society, where they can live, learn, and grow to their fullest potential.

Washington

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.

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.

MHD is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several other administrations within DSHS including; the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration. HRSA sister agencies to MHD include the Division for Alcohol and Substance Abuse and the Medical Assistance Administration.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act; a measure which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of 14 Regional Support Networks (RSNs). The RSNs are under direct contract with MHD to ensure quality outpatient services for individuals with mental illness, including crisis response and management of the involuntary treatment program.

Beginning in October 1993 through 1996, MHD implemented a capitated managed care system for community outpatient mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks. In 1996, the waiver was amended to include community inpatient psychiatric care and, by 1999, all Regional Support Networks were responsible for management of inpatient community mental health care in addition to outpatient services.

The current community mental health system operates under Chapters 71.24, 71.05, 38.52, 74.09 and 71.34 of the Revised Code of Washington (RCW) and under 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.

As discussed in the Executive Summary, the RSNs under went a procurement process this past year, resulting in a reduction in the number of RSNs from fourteen (14) to thirteen (13) with the intention to better serve the entire state.

Washington

Adult - Available Services

Adult - 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.

Adult – Available Services

Adult- 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 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 under the Individuals with Disabilities Education Act
Case Management Services
Services for persons with Co-Occurring Disorders
Other Services leading to reduction in Hospitalization

Under the direction of CMS, MHD has separated what was previously a single contract into two separate contracts with the RSNs: the PIHP contract for Medicaid services and the "state only" contract for non-Medicaid services and individuals. The latter assigns the RSNs responsibility for services described in state statute. These services include community support, employment, and residential services for persons meeting 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, the 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 (CMHAs), coordinate with rehabilitation and employment services to assure 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; and
- Interaction with the consumer's employer to support stable employment and advise 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 in this is the fact that the RSNs are required to prioritize the expenditure of their state-only funds on covering the costs of inpatient care, providing crisis intervention services, and residential resources. Once those 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 are also 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 expired before they can get to the business of providing the other services listed above.

As previously noted, RSNs are required to provide crisis services to persons in their communities. This includes administration of the involuntary treatment program. In most communities, the crisis services and involuntary treatment services are highly integrated. 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 crisis intervention or for those individuals presenting with mental health crises. These difficult situations are 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 many consumers receiving services through the CMHAs, there is on file an Individual Crisis Plan (ICP). The ICP contains the preferred intervention strategies put forth by the consumer and their families. Further, many consumers also utilize Advance Directives 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 the involuntary treatment program.

Involuntary treatment services, as part of crisis services, are 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. General criteria for such involuntary services include being determined by a Designated Mental Health Professional (DMHP) to be either gravely disabled or at risk of harm to self, others, or property as a result of a mental disorder. Alone, neither risk of harm nor a mental disorder, are sufficient to justify the loss of an individual's right to make decisions about their own care. Further, the danger must be the result of the mental disorder. MHD has been given the authority to re-evaluate the laws that govern involuntary civil commitment this year and will do so with a cadre of partners.

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 freestanding evaluation and treatment facilities, in one of the three state-operated psychiatric hospitals or in one of the three Children's Long Term Inpatient Residential Treatment Facilities for Psychiatrically Impaired Youth.

As a separate contract, the RSNs also operate as a pre-paid inpatient health plan (PIHP) by administering 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 face-to-face treatment activities designed to help the consumer attain goals as prescribed in the consumer's individual service plan. These services shall 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

responsible reviews of medications and their side effects and consumer/family education related to these. This service shall be rendered face-to-face by a person licensed to perform such services.

- 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 persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. These services include a mix of individual, group services, and crisis services.

All of these important PIHP services are funded according to the number of Medicaid eligible persons living within each RSN's catchment area. The funding mechanism does not necessarily mirror demand for mental health services, since community mental health service demand tends to be stable as Medicaid caseloads vary.

As prepaid inpatient health plans, RSNs authorize and pay for voluntary community inpatient psychiatric care for residents in their catchment 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. With the intention to help provide some relief to the hospitals, the legislature recently approved an MHD request for hospital rate increase for those hospitals certified to accept individuals who are involuntarily detained. Another effort to ease the financial strain comes from MHD bringing together a Utilization Management and Review workgroup, offering technical assistance to the RSNs in better managing their most expensive cost-inpatient care.

Washington State continues to seek creative solutions to providing comprehensive medical services to all of our state's 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 several community clinics that provide service on a sliding scale basis, for persons with limited resources. Case managers at the Community Mental Health Care Agency (CMHA) level, work with their respective consumers' Primary Care Physicians (PCP) to ensure physical issues are addressed.

While considerably more needs to be done to improve the provision of health services to consumers with 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 the Regional Support Networks (RSN's) and the Healthy Options Plans requires 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 a county north of Seattle, 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 were added in October and 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.

Washington hospitals are facing financial hardship and consequently curtailing services in many communities. In February 2000, the state Department of Health reported that the community hospitals had the lowest net income for any annual period since the state began to collect hospital financial information more than 40 years ago. While hospital costs continue to rise, reimbursements have not kept pace. New life saving technologies – including pharmaceuticals – improve patient care but cost more, and the additional costs are typically not reimbursed by all insurers. Accordingly, hospitals are experiencing a worsening shortage of nurses and other medical personnel exacerbated by rapidly increasing recruitment and retention costs.

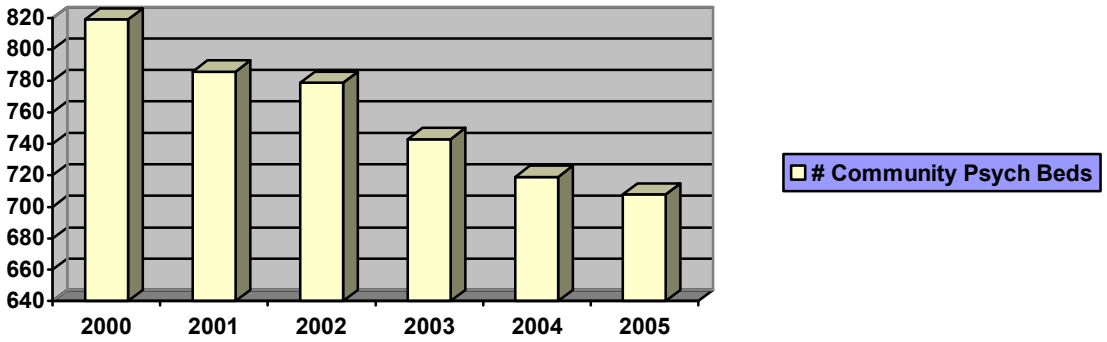
The 1997 Federal Balanced Budget Act cut more than $1 billion dollars in payments to Washington State's community hospitals from 1998-2002. The 2000 state legislative session provided clear evidence that the combined effects of the state's I-601 spending limit, the significant loss of revenue as a result of the state's I-695, and increased demands for education and transportation dollars will continue to place the state's health care budget in serious jeopardy of erosion.

Hospital operating margins have dropped to historically low levels. This shortfall often forces hospitals to decrease services as well as inhibits investment in new medical

technologies or renovation of aging buildings and facilities. Hospitals experiencing years of low or negative operating margins face an uncertain future including, in some cases, the threat of closure.

Recent years have been marked by significant changes in the mental health inpatient service delivery system. There has been planning and implementation for greater use of community hospitals for inpatient psychiatric services in lieu of utilization of the state hospitals. With no end in sight to the rising costs of care, hospitals that once took psychiatric patients through the Medicaid system no longer will, or in the worst case scenario, these community hospitals have closed their doors completely.

As the table below depicts, Washington State has seen a decrease over the past five years of 111 community hospital beds for persons with psychiatric disabilities in need of acute care and stabilization, leaving the residents of our state with only 143 beds, which represents a 14% decrease in inpatient mental health capacity while demand for these services continue to rise.



Source: Washington Hospital Association

Exacerbating these financial stressors has been the change in the way in which CMS has viewed the use of Medicaid savings. In the past, whether or not a facility was an Institution for Mental Disease (IMD) was of little or no consequence in relation to payment for this level of care in that RSN's could use the Medicaid savings remaining from their capitated rates to cover the costs of this service as well as other non-Medicaid services.

Now, however, RSN's must rely on their scarce "state-only" dollars to pay for these important services or risk the facilities closing. If the latter were to occur, the only safe place for someone needing inpatient or IMD level of care would be the state hospitals, which as mentioned earlier, have a mandated census limit. When an RSN exceeds that limit, Liquidated Damages go into effect, further impacting the financial penalty. Consequently, the monetary resources that would have been available to provide for other critical services, such as residential and vocational supports, are diminished or become non-existent, as most of these "state only" funds are needed to cover the cost of IMD and inpatient care.

The Washington State Legislature rose to the call for help by providing nearly $80 million dollars in "state-only" funding to support continuation of non-Medicaid services. While they have infused the system with new state dollars during this budget cycle, changes must occur related to our state's use of IMDs, for there are no guarantees that this level of funding will be sustained.

To address the hospital capacity issue, the legislature approved 6.5 million dollars over the 2005-2007 biennium for the provision of a base-rate increase in the amount hospitals are paid for non-Medicaid recipients. However, this applied only to those hospitals that are certified to provide care to persons detained under the state's Involuntary Treatment Act (ITA) through the Revised Code of Washington (RCW) 71.05 (adults) and 71.34 (children/youths). Of the 27 community hospitals that provide inpatient psychiatric care, only 16 are certified by MHD to accept ITA'd persons.

In 2004, the legislature approved funding for MHD to contract with the Boston firm, Public Consulting Group (PCG) to conduct an update of their 2002 study of inpatient and residential resources for adults and children. Contained in the October 2004 final recommendations of the PCG study was the assertion that Washington should add 680 beds to its residential and inpatient capacity to meet current and projected needs.

To address this, MHD sought funding for two adult Evaluation and Treatment facilities last year and is currently evaluating options for increasing similar resources for children/youth. While there is clearly much more work to be done, MHD remains committed to working with all stakeholders in developing solutions that make sense in terms of clinical need, public safety, and fiscal soundness.

Washington

Adult - Estimate of Prevalence

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

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) between **172,434 – 330,887**. 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. All numbers reported are based on data from fiscal year 2005

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

Estimated SMI	Total Adults Served	Estimated SMI Served	Quantitative Target
330,887	87,863	69,2881	50,000

Washington

Adult - Quantitative Targets

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

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 FY2005 as well as the projected number served in FY2006. 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 2006 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 2005, the estimated adult population was 4,546,538 and the projected population for 2006 is 5,640,330, which represents an increase of 2.4%. Therefore, we increased our FY05 Service numbers by 2.4% to represent our best estimate of a FY2006 projected Service rate.

Projected Service Rates				
Time Period	**FY05 Adults Served**		**FY06 Adults Projected**	
SMI Status	**SMI**	**Total**	**SMI**	**Total**
Adults Served	**74,149**	**87,863**	**75,632**	**89,971**
WA Adult Population	**245,513**	**4,546,538**	**246,125**	**4,655,654**
Penetration Rate	**30.1% of adults with SMI are served by the Mental Health Division**	**1.9% of all adults in Washington State are served by the Mental Health Division**	**30.7% of adults with SMI will be served by the Mental Health Division**	**1.9% of all adults in Washington State will be served by the Mental Health Division**

This table shows that the Mental Health Division serves 30.1% of the adults in Washington State who are estimated to have a Serious Mental Illness and 1.9% 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. (Amy, more here about who we serve and why).

Washington

Adult - Outreach to Homeless

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

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For the past three (3) years, MHBG funds have been used to support several facilitated planning sessions in various parts of the state. Common Ground, a well established private, non-profit housing specialty agency, has conducted the planning sessions in RSNs designated by the state PATH contract. The planning sessions have occurred primarily in locations where there was no current PATH project.

Planning sessions have been provided in six locations around the state in the last three years. Two new PATH projects have been established among the six planning recipients. One location applied for and received federal housing funding to establish a twelve unit facility to serve mentally ill people.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in May 2005. PATH recipients and others who serve homeless, mentally ill people received financial assistance to support their attendance at the conference.

This year, in addition to support for people to attend the annual conference on homelessness, board members of the Coalition were sponsored to attend the annual behavioral health conference coordinated by Washington Community Mental Health Council under contract with MHD. These two efforts are intended to promote greater interaction and coordination of efforts among providers of mental health and housing services locally and statewide.

As a recipient of PATH grant funds and with additional SAMHSA technical assistance, Washington has also been involved in promoting SSI/SSDI Outreach Access and Recovery (SOAR) for the last year and a half. A joint training project with PATH in Oregon was staged in March 2005. Subsequently, in the fall of 2005, MHD sponsored PATH training conducted through the SOAR project. MHD also has assisted staff from Washington, who attended SOAR train the trainers training in Washington, D.C. in December 2005, to arrange training for PATH and other providers of services to homeless people.

The RSNs with the highest estimated numbers and percentages of homeless mentally ill are listed in the table below. There are PATH projects in seven of the eight RSNs with highest percentages and numbers of projected homeless mentally ill people. Previously there was a PATH project in Clark RSN, but a decision was made locally not to continue the project.

STATE OF WASHINGTON 2003 Final Homelessness Mental Illness Estimates by RSN					
RSN	Estimated Number of Homeless Persons	# Homeless SMI Using 35% Estimate	Total Pop (2000 Census)	% Homeless SMI to Population	PATH Funding
Spokane	3,699	1,295	417,939	0.310	Yes
King	7,980	2,793	1,737,034	0.161	Yes
Pierce	2,698	944	700,820	0.135	Yes
Clark	1,071	375	345,238	0.109	Declined
Peninsula	1,001	350	322,447	0.109	Yes
Greater Columbia	1,711	599	599,730	0.100	Yes
North Sound	2,711	949	961,452	0.099	Yes
Thurston-Mason	724	253	256,760	0.099	Yes
North Central	369	129	130,690	0.099	DNA
Chelan-Douglas	280	98	99,219	0.099	DNA
Timberlands	263	92	93,408	0.099	Withdrew
Southwest	262	92	92,948	0.099	Yes
Northeast	195	68	69,242	0.099	DNA
Grays Harbor	189	66	67,194	0.099	DNA
State Totals	23,154	8,104	5,894,121	0.137	

DNA--Did not apply

Although PATH funding is targeted to outreach and engagement of seriously mentally ill, homeless adults, the broader range of services listed below are integrated and augmented with additional local funds:

- Outreach and Engagement
- Screening and Diagnostic Treatment
- Habilitation and Rehabilitation
- Community Mental Health Services
- Alcohol or Other Drug Treatment
- Staff Training
- Case Management Services
- Referrals for Primary Health Services, Education Services, Job Training, and Housing Services
- Technical assistance in applying for housing

Washington

Adult - Rural Area Services

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

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While 80% of the population resides on the Western half of the state, Washington has many rural areas within that populous as well as the on the less populated Eastern side of the state.

Living outside of urban areas can prove very challenging when it comes to accessing treatment, with the barriers being not only such obvious needs as transportation and treatment availability, but also more discrete issues such as increased isolation and a culture of intense privacy.

Some of the ways in which MHD has addressed the need for rural outreach has been through supporting training activities on the specialized needs of consumers in these less populated areas. Additionally, RSN's have been required to ensure rural services are provided to a minimum of 25,000 individuals. One tool available for increased access to rural consumers is the use of six (6) tele-video sites for the provision of services that are not required by state plan to be face to face.

Consumers have truly played a significant role in this issue as well. As communication, education, and interaction between consumers, their families, providers and other professionals increased through participation in statewide trainings, mental health councils, forums, etc., word quickly traveled around the state regarding the types of services that were being provided in the more densely populated areas. The voices of the rural citizens and their advocates, who were demanding the right to the same services provided to their urban counterparts, was one of the issues that prompted legislative action to increase consistency in state services through the RFQ/RFP process.

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 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 are eligible, such as Medicaid and Social Security Disability;
- Increased demands for measurable outcomes that demonstrate consistency across population densities and age span.

Specific to rural consumers, MHD anticipates that through the passage of recent legislation, aimed at increasing consistency in access to state plan services, individuals who are eligible for these services shall receive them, regardless of where they live.

Rural isolation is not limited to Washington State. However, MHD hopes to make a significant impact on the provision of services to these persons on a personal, local, regional and state level as every resident in our state matters. Washington envisions a

future wherein everyone who needs public mental health services receives the services they need, regardless of where they reside.

Washington

Adult - Resources for Providers

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

Adult – Resources for Providers

Adult-Describes financial resources, staffing and training for MH providers necessary for the Plan

Each Regional Support Network (RSN) receives funding from three (3) main resources: Medicaid, the State Legislature, and the Mental Health Block Grant. The RSNs operate under a capitated system and contract with Community Mental Health Agencies (CMHAs) which are licensed by the State Department of Health and certified by the Mental Health Division.

How much money a single agency receives is decided at the RSN level. CMHAs are generally resourceful in collaboration with other community resources such as the United Way, faith-based organizations, grant opportunities, and advocacy groups such as the National Alliance for Mentally Ill (NAMI).

Caseloads vary greatly; however, it is fair to say that an average caseload for a case manager (CM) in an urban CMHA is about 50 consumers. CMHAs provide training to their CMs on topics of concern and need.

MHD requires training at the provider level through its contracts with the RSNs. Additionally, MHD offers many opportunities for expanding the provider skill base. 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 Standards
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 Enforcement	DD/MHD training to community hospitals regarding serving DD/MI population

This year's State Behavioral Healthcare Conference accommodated a record breaking nearly 700 participants (providers, consumers, families, system professionals), with major training tracks targeting EBPs, Children Services, Consumer/Family Voice/Advocacy, and Data Driven Decision Making. MHD and RSNs worked together to fund over 150 consumer scholarships and contracted with the Washington Community Mental Health Council (WCMHC) to bring the conference to life.

MHD's agenda for next year includes comprehensive training curriculum on the Program for Assertive Community treatment (PACT) model as we move forward with implementation of eight (8) PACT teams across the state. MHD will also work in collaboration with the Transformation Work Group (TWG) for the provision of trainings on ***Recovery*** and ***Resiliency***, with efforts to assess other training and system-building activities that could be achieved through coordination of resources.

Washington

Adult - Emergency Service Provider Training

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

Adult – Emergency Service Provider Training

Adult – Provides for training of providers of emergency health services regarding mental health.

As the state's Disaster Mental Health Coordinator, MHD took the lead in orchestrating the necessary services to be provided to evacuees of Hurricane Katrina who came to Washington. Under the direction of Governor Christine Gregoire, Emergency Operations were activated during Labor Day Weekend, 2005. Emergency management staff planned for the arrival of up to 2000 Gulf Coast evacuees by adapting the Washington Repatriation Plan to meet the circumstances of the disaster. The revised plan, known as ***Operation Evergreen***, was based upon the assumption that as many as 2000 evacuees would arrive in Washington with little or no warning.

Throughout Operation Evergreen, the daily counts reported by the American Red Cross continued to rise. Individuals and families were unexpectedly arriving on their own around the state. Evacuees hitchhiked, rode buses and airplanes or used some combination of transportation to get to Washington. One New Orleans cab even made the trip. Some relied on hurricane relief funds while others had transportation purchased by friends or loved ones already in Washington.

As of September 30th, 2005, estimates for evacuees ranged as high as 4,599. The table below outlines the avenues of initial contact:

Date	Source	Indicator
10/10/05	FEMA Registrations	1,717 registrations
10/05/05	FEMA Registrations	1,651 registrations
09/25/05	FEMA Registrations	1,498 registrations
09/25/05	FEMA Registrations	1,435 registrations
09/28/05	American Red Cross	582 mental health contacts
09/26/05	American Red Cross	957 cases opened
09/26/06	Office of Superintendent of Public Instruction (note: data submission by the 296 school districts was voluntary, so estimated numbers are higher than reported)	232 enrollments
10/07/05	DSHS – Community Service Office	564 family units/ 1,042 guests applied for benefits
09/26/05	DSHS – Community Service Office	431 family units/ 834 guests applied for benefits
10/10/05	Disaster Assistance Hotline	>700 calls received
09/27/05	Homeless Shelters	Two shelters reported serving evacuees

To aid in coordinating the delivery of comprehensive support to the "guests" in our state, a "one-stop" ***Welcome Center (WC)*** was equipped and opened Memorial Day weekend in Tumwater (just south of Olympia). The WC offered driver's license replacement, issuance of identification, determination of eligibility for public assistance and disaster related entitlements, free pet care services and vaccinations, pediatric health screens, American Red Cross services, disaster counseling, employment resources, housing assistance and access to communication through the internet and use of cell phones, assistance with FEMA registration, coordination and scheduling of transportation, and breakfast/lunch, snacks and childcare. More than 90 families/individuals utilized the WC during its seven days of operation. The operation was closed when it appeared that the evacuees were well-connected with area services which were able to assist in meeting individuals' basic needs and help them move forward in their personal journeys through this life-changing natural disaster.

In addition to the Welcome Center, the mental health system was mobilized to meet the mental health needs of evacuees, many of whom were in need of continuing mental health treatment. Through the creation of the ***Crisis Counseling Program***, Five (5) regions were identified to be partners in the provision of emergency counseling services by virtue of their locations and number of evacuees: King, Pierce, Clark, Snohomish and Spokane. Each region then contracted with a local Community Mental Health Center for the delivery of direct care services.

Every outreach crisis counselor and key personnel from each region received two (2) days of training provided through a consultant coordinated by the Disaster Technical Assistance Center. An additional day of training was provided by FEMA Region X to share information about the FEMA benefits and programs that were available to evacuees.

Overall, types of services provided to evacuees included:

- Individual Crisis Counseling
- Group Counseling
- Education (including direct mailing of informational packets sent to all of the FEMA registrants, flyers posted in public areas, and a media campaign of public service announcements and press releases)
- Referrals (e.g. area volunteer services, churches, Community Mental Health Agencies for longer team mental health treatment Services).
- Toll Free Hotline

Another way in which MHD supports mental health training to providers of emergency health services is through the coordination of four (4) trainings with providers, RSNs, and law enforcement for the provision of the evidence based practice called ***Crisis Intervention Training*** (CIT).

These trainings are based on the Memphis model of CIT implementation which is one of the first and most widely implemented programs for mental health/law enforcement crisis

intervention models. Law enforcement officers often act as paramedics for psychiatric emergencies in the community. In a survey of law enforcement professionals in three U.S. cities, officers reported that within the previous month they responded to an average of six (6) calls that involved a person with mental illness who was in crisis. Persons with mental disabilities report high rates of contact with the police. A survey of 360 psychiatric outpatients at an urban mental health clinic demonstrated that 48.6 percent of them had a history of arrest. Officers working in jails and prisons also have contact with citizens who have a psychiatric disability. It has been estimated that the prevalence of severe mental illness in jails and prisons is three to five times higher than that in the community.

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 goals 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 collaboratively work with the court systems to reduce the incarceration rate of people with a serious mental illness who are in need of treatment when applicable

This training 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:

1. Recognize signs and symptoms of mental illness
2. Recognize whether those signs and symptoms represent a crisis situation
3. De-escalate mental illness crises
4. Know where to take consumers in crisis

5. 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 with 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 about 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.

While MHD is currently supporting four (4) CIT trainings across the state, many RSNs have partnered with their local NAMI and law enforcement officials to provide this valuable training. For example, Clark County RSN alone reports having trained over 400 officers to date.

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 persons with a dual diagnosis of mental illness and develop mental 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 being well trained and educated about persons with mental illness and available services will only help move our state toward ***Transformation***.

Washington

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Adult – Grant Expenditure Manner

Adult- Describes the manner in which the State intends to expend the grant under section 1911 for fiscal year(s) involved.

Of the estimated 8.4 million dollars awarded to Washington State, 5% (grant limit) stays at MHD for administrative costs. Of the *remaining* 95%, legislation has required that 80% to be distributed to the RSNs. The other 20% (approximately 1.5 million) is utilized by MHD for selected activities. In determining which initiatives would be funded this year, MHD developed the following list of guiding principals 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.

2006's "20%" was focused supporting the following, which will remain the focal spending focuses for 2007.

- **Consumer, advocate, and family voice** driven and promoted activities

- **Vocational** initiatives that lead to meaningful employment

- **Residential** resources that promote safe and affordable housing

- **Tribal** supports that improve infrastructure and services to tribal communities

- **MHPAC** resources that ensure consumer participation continues to increase and that state-wide diversity is represented

- **Data Development** to validate success our areas for improvement

The primary ways in which these focused have been supported include:

- **Conferences** such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethic minorities, and youth/parent advocacy.
- **Trainings** for issues or populations such as disasters, assisting consumer's in applying for Medicaid, increasing housing access, implementation of evidence–based practices, targeted trainings for geriatric specialists, ethnic minority specialist, chemical dependency specialists, older adults, ombuds, and peer support counselors as well as trainings for building and sustaining skills and obtaining and maintaining employment, including consumer-run organizations.
- **Research and data collection** on such things as evidence–based practices, promising and best practices, consumer satisfaction, club houses, and services to persons who are incarcerated or have co-occurring disorders.

Washington's MHBG for FFY 2007 estimated funding represents a reduction of $166,246.

FFY 2005 (actual)	**FFY 2006** (appropriation)	**FFY 2007** (estimate)	**Difference** (+/- 2006)
$8,400,033	**$8,514,188**	**$8,347,942**	**-$166,246**

MHD was given the authority through legislative budget proviso to change the way in which we distribute MHBG funding last year and again this year:

ESSB 6090 (j) "The department is authorized to continue to expend federal block grant funds, and special purpose federal grants, through direct contract, rather that through contracts with regional support networks; and to distribute such funds through a funding distribution formula other that the one established pursuant to RCW 71.24.035 (13)."

MHD decided to continue to distribute the same percentage of the overall MHBG funds to the RSNs. However, in concert with the Mental Health Planning and Advisory Council's (MHPAC) strong endorsement of changing the distribution formula, several potential distribution formula options were presented to the entities below on the following dates:

- 04/11/06 MHPAC,
- 04/12/06 MHD Mgmt. Team,
- 04/27/06 RSN Administrators, and
- 05/10/06 MHPAC (a second time for a vote).

In taking into consideration the voted upon recommendation of the MHPAC, as well as feedback from MHD Mgmt. Team and RSN Administrator's, MHD Director, Richard Kellogg, authorized changing the MHBG funding distribution formula to one based solely upon population.

Reasons for choosing Population Distribution Formula**:**

- The MHPAC formally voted to recommend this to the MHD Director.
- It is consistent with the other distribution formula used for determining non-Medicaid funding to the RSNs, which the legislature has directed the MHD to utilize.
- MHD has a source (Office of Financial Management) from which we could update the data required for distribution based upon population every year without the expense of additional studies.

RSN	80% to RSN Using Population Distribution
Chelan Douglas RSN	98,387
Clark County RSN	370,727
Grays Harbor RSN	66,096
Greater Columbia RSN	607,557
King County RSN	1,712,352
North Central RSN	128,500
Northeast WA RSN	67,138
North Sound RSN	983,871
Peninsula RSN	317,036
Pierce County RSN	715,792
Southwest RSN	90,812
Spokane RSN	413,150
Thurston Mason RSN	261,355
Timberlands RSN	91,664
Total	5,924,436
Total MHBG Award	8,347,942
5% for MHD Admin.	(417,397)
20% of remaining 95% for MHD initiatives & support of MHPAC	(1,586,109)
80% of remaining 95% for RSNs	6,344,436
Minus Legislatively Mandated MIO CTP	(420,000)
Remaining Available to RSN	5,924,436

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

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. A review team consisting of state MH Program, Fiscal, Monitoring, Quality Assurance and Improvement staff as well as members of MHPAC 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 2007 MHBG funding include, but are not limited to:

- Continuing Education and Employment Services to consumers
- Homeless Outreach
- Outreach to Older Adults
- Resource Center for non-Medicaid Consumers
- EBP trainings (e.g.: DBT, WrapAround)
- Community based services to consumers is rural areas
- Development of consumer-run programs/ businesses and drop-in centers
- Creation of new residential and hospital diversion resources
- Expansion of co-occurring disorder treatment
- Stigma reduction
- Development of Club Houses using Fountain House model
- 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

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ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	92,173	88,009	0	88,025
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #1: Increase Access to Services for Adults with SMI

Target: Adults served through the public mental health system: 88,025
Basic Tables 2A and 2B will provide breakout by Age, Gender, and Race/Ethnicity in Implementation Report.

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: This is a new target/measure this year so no target is provided for 2006. In previous plans, WA used a penetration rate rather than an actual count.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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/families served by multiple agencies.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	2.20	3.65	3.50	3.50
Numerator	266	418	--	--
Denominator	11,976	11,458	--	--

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 – 3.5%

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 readmitted 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:

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 persons discharged from the state hospitals are seen within 7 days.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	2.80	4.50	3.80	4.40
Numerator	331	516	--	--
Denominator	11,976	11,458	--	--

Table Descriptors:

Goal: #3: Decrease percentage of persons who are readmitted to an inpatient setting within 180 days of discharge.

Target: The percentage of adults readmitted to any inpatient setting within 180 days of discharge – 4.4%

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:

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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.

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.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #4: Increased number of evidence-based practices provided to adults.

Target: Establish a baseline of the number of EBPs provided to adults throughout the state.

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 EBPs provided throughout the state to adults.

Measure: Number of EBPs provided to mental health consumers through out 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: This is a new target/measure this year so no target is provided for 2006.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 (6) 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #5: Increase the number of EBPs received by adults

Target: Establish a baseline of the number of EBPs received by adults throughout the state.

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.

Measure: Number of EBPs received by adult mental health consumers through out 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: This is a new target/measure this year so no target is provided for 2006.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 (6) 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	58.70	0	0	59.20
Numerator	1,101	0	--	--
Denominator	1,876	0	--	--

Table Descriptors:

Goal: #6: Improve client perception of care.

Target: The percentage of adults who report achieving positive outcomes on the MHSIP Survey: 59.2%.

Population: Adults with Serious Mental Illness

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

Indicator: Regional Support Networks (RSNs) will work to improve client perception of care as evidenced by the number of adults surveyed who agree with the items on the MHSIP regarding their perception of positive outcomes.

Measure: Numerator: Number of persons who responded that they agreed or strongly agreed to the positive outcomes scale on the MHSIP survey.

Denominator: Number of total MHSIP respondents.

Sources of Information: This is new data being acquired through the MHSIP survey conducted by Washington Institute of Mental Illness research and Training (WIMIRT). 2006 data will not be available until August 2006.

Special Issues: This is a new target/measure this year so no target is provided for 2006. In the past, WA has measured perception of care using a different scale on the MHSIP. Additionally, WA has only conducted the Adult MHSIP every other year, with the off years being used to conduct youth surveys. Beginning with this application, 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). No Numerator or Denominator required. 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 will also be supported.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 1.07. Increase in Employment or Return to School - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	11.40	10.80	10.90	11
Numerator	9,435	8,613	--	--
Denominator	82,446	79,540	--	--

Table Descriptors:

Goal: #7: Increase the number of persons who are engaged in employment related activities or attending school.

Target: The percentage of adults, between ages of 18-64, who were engaged in employment at any time during the fiscal year: 11.0%.

Population: Adults with Serious Mental Illness

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 or sheltered workshops at anytime in the fiscal year.

Denominator: Number of total adults (18-64) served in the community outpatient services.

Sources of Information: MHD-Consumer Information System (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 support.

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

Action Plan: 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.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 1.08. Decrease Criminal Justice Involvement - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	20.30	20.20	20	N/A
Numerator	25,947	0	--	--
Denominator	127,519	0	--	--

Table Descriptors:

Goal: #8: Decrease the number of persons who have had criminal justice system involvement including arrest and incarcerations.

Target: The percentage of adult consumers involved with criminal justice: 20.0%.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adult consumers who have had involvement with the criminal justice system including arrest and incarcerations

Measure: Numerator: Number of adults (18+) who were arrested convicted or adjudicated in the fiscal year.

Denominator: Number of total adults (18+) served by the mental health division in the fiscal year.

Sources of Information: Data is obtained by merging the MHD data with the Washington State Patrol and Office for the Administrator of the Courts data.

Special Issues: MHD has not been able to obtain timely data due to system limitations. Most recent is for fiscal year 2004. Data for fiscal year 2006 will not be available until 2008.

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 (MHPAC) 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 State Mental Health contract, the provision of Jail Transition Services, required by 2006 legislative budget proviso including assistance with applications to Medicaid. Support outcomes of Safety Summits. Assess ability to improve more timely data collection for this NOM.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 1.09. Increase Social Supports - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	20.30	0	20.20	20
Numerator	25,947	0	--	--
Denominator	127,519	0	--	--

Table Descriptors:

Goal: #8: Decrease the number of persons who have had criminal justice system involvement including arrest and incarcerations.

Target: The percentage of adult consumers involved with criminal justice: 20.0%.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of adult consumers who have had involvement with the criminal justice system including arrest and incarcerations.

Measure: Numerator: Number of adults (18+) who were arrested convicted or adjudicated in the fiscal year.
Denominator: Number of total adults (18+) served by the mental health division in the fiscal year.

Sources of Information: Data is obtained by merging the MHD data with the Washington State Patrol and Office for the Administrator of the Courts data.

Special Issues: MHD has not been able to obtain timely data due to system limitations. Most recent is for fiscal year 2004. Data for fiscal year 2006 will not be available until 2008.

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 (MHPAC) 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 State Mental Health contract, the provision of Jail Transition Services, required by 2006 legislative budget proviso including assistance with applications to Medicaid. Support outcomes of Safety Summits. Assess ability to improve more timely data collection for this NOM.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 1.10. Increase Family Stabilization/Living Conditions - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #9: Increase the number of social and natural supports reported by consumers.

Target: Establish a baseline for Adult "Social Connectedness" by using WA State's TELESAGE consumer survey in 2007 and then set a targeted goal for improvement in 2008.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: RSNs will work to assist adult consumers in increasing their social and natural supports.

Measure: Numerator: Number of adults (18+) who responded that they agreed or strongly agreed to experiencing meaningful relationships on the "Social Connectedness" scale of the TELESAGE survey in a fiscal year.
Denominator: Number of total adults (18+) who responded to TELESAGE survey in a fiscal year.

Sources of Information: MHD's TELESAGE survey conducted by Washington Institute for Mental Illness Research and Training.

Special Issues: MHD has not measured this in the past so no data is available for reporting at this time.

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #1 & #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #1 & #5. Having meaningful relationships is a necessary part of increasing 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 spectrum of administrator, providers, consumers and family members. Continue to require through contract that consumer's are informed of their right to have and are encouraged to have family/friends involved in their Recovery plan/treatment. Continue to support Tribal activities that enhance that community's whole-wellness. Support Mental Illness Education and Stigma Reduction activities.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 1.11. Improved Level of Functioning - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #11: Improve level of functioning as evidenced by increased involvement in meaningful activities.

Target: Establish baseline for "Involvement in Meaningful Activities" by using WA State's TELESAGE consumer survey in 2007 and then set a targeted goal for improvement in 2008.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

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 (18+) who responded positively to "Involvement in Meaningful Activities" scale of TELESAGE survey in a fiscal year.
Denominator: Number of total adults (18+) who responded to TELESAGE survey in a fiscal year.

Sources of Information: MHD's TELESAGE survey being conducted by Washington Institute of Mental Illness Research and Treatment.

Special Issues: This is a new measure/target so now previous data is available to report. After establishing a baseline in 2007, a targeted goal for improvement in 2008 will be established.

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, social interaction.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 4.1 Services to Rural and Homeless Populations - Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	97.10	91.10	91.20	92.20
Numerator	53,714	51,186	--	--
Denominator	55,336	56,170	--	--

Table Descriptors:

Goal: #10: Increase family stabilization as evidenced by consumers maintaining housing.

Target:

Population: The percentage of adults and older adults who maintain their housing over a fiscal year: 91.2%

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase the number of adults and older adults who maintain their housing over a fiscal year.

Measure: Numerator: Number of adults (18+) who maintained housing in a fiscal year.
Denominator: Number of total adults (18+) who were served in community outpatient services and who had 2 or more living situations reported in a 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 of consumers through the RSNs.

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. 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 likelihood of recovery.

Action Plan: Continue to encourage creation and development of safe, appropriate, sustainable, and affordable housing. Continue to support mental illness education, stigma reduction, Recovery, employment, benefit application, and other factors that lead to stable housing. Continue to enhance relationships with state housing agency and homelessness reduction efforts.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 4.2 Improved Services to Consumers in Rural Areas- Adult

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	57,024	57,221	57,225	57,230
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #2: Improve Services to Consumers in Rural Areas

Target: RSN Community-Based Services provided to persons in rural areas: 57,230

Population: Adults with Serious Mental Illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase access to community based services for persons in rural areas

Measure: Number of persons served by rural RSNs in community outpatient services. (No numerator of denominator required).

Sources of Information: MHD's Consumer Information System (CIS).

Special Issues: Rural RSNs are particularly challenged in providing community based mental health services due to the expansiveness of their catchment areas. Nevertheless, many of these RSNs are seeking to use MHBG funds for rural outreach and expansion of rural mental health services. Also, stigma can be especially difficult to overcome in these areas, which is something also being addressed by rural RSNs. This is expected to have a positive impact on number of persons served in rural outpatient services.

Significance: This is a recommended National Outcome Measure (NOM) expected to become a required. Goal supports New Freedom Commission (NFC) goal #3, #4, & #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3, #4, & #5. MHD is committed to ensuring rural and homeless populations are well-served by the public mental health system.

Action Plan: Continue to encourage infrastructure development and support training on effective strategies for the delivery of rural mental health services across life-span and diverse populations including stigma reduction, outreach, and engagement.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 5.1 Research and Quality Improvement

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	80
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #1: Improve quality of services supported with MHBG funds.

Target: Washington will achieve a score of 80 on MHBG State Plan Peer Review.

Population: Adults with Serious Mental Illness, Children and Youth with Serious Emotional Disturbance.

Criterion: 5:Management Systems

Indicator: Overall quality of serves provided through MHBG funds will be monitored and assessed for improvement through MHBG Peer Review process

Measure: Total score based upon point value for each section of evaluation.

Sources of Information: MHBG Peer Review Report conducted by members of Idaho's MHPAC

Special Issues: Current lack of Peer Review policy and procedure to meet requirements called out in funding agreement resulted in State Auditor finding despite written statement from SAMHSA that Washington had met this requirement.

Significance: MHD is committed to improving the quality of services supported through MHBG funding regardless of impetus for implementation of new MHBG Peer Review Policy and Procedure.

Action Plan: Continue to support quality review and improvement activities including consumer/family surveys, MHBG Peer Review, support of Consumer, Youth, and Family Network, research and training on EBPs and quality Review team. Continue to increase focus on contract monitoring and compliance.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 5.2 Workforce Development

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	6
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #2: Develop and enhance highly skilled workforce.

Target: Support 6 members of MHPAC in attending national MHBG Conference.

Population: Adults with Serious Mental Illness, Children and Youth with Serious Emotional Disturbance.

Criterion: 5:Management Systems

Indicator: MHD will work to improve the skills and efficacy of Division staff as well as members of MHPAC through select trainings and conferences.

Measure: Number of MHPAC members who attend national MHBG conference.

Sources of Information: MHD self report

Special Issues: There are limited resources available for workforce improvement

Significance: MHD is committed to improving the skills of MHD staff and members of MHPAC in an effort to ensure the public mental health system provided excellent mental health services that align well with the principles of Recovery and Resiliency and that move the system toward Transformation.

Action Plan: Continue to support MHPAC activities including opportunities for attend national conference. Continue to support MHD staff training opportunities as well as Emergency/Disaster Preparedness. Focus will also be on trainings in Recovery and resiliency, EBPs, cultural competency, housing, employment, and safety.

ADULT - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 5.3 Recovery-Oriented System of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	6
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #3: Facilitate growth of Recovery-Oriented system of care

Target: Support 6 trainings in Recovery and Resiliency.

Population: Adults with Serious Mental Illness, Children and Youth with Serious Emotional Disturbance.

Criterion: 5:Management Systems

Indicator: MHD will work to increase the understanding of and commitment to a Recovery-Oriented system of care.

Measure: Number of Recovery and Resiliency trainings provided this year.

Sources of Information: MHD self report

Special Issues: MHD is collaborating with Transformation Grant staff.

Significance: MHD is committed to the growth of a Recovery-Oriented system of care, as it is believed that improving understanding of and commitment to this will reduce stigma and foster the cultural changes necessary to move the public mental health system toward Transformation.

Action Plan: Continue to support Transformation of mental health system to one that is Recovery-Oriented and consumer driven by collaboration with Transformation Work Group on Recovery trainings. Support other recovery trainings such as WRAP, Change Model, or Motivational Interviewing across entire spectrum of administrations, providers, and consumers/family members. Collaborate with MHPAC to create MHD Recovery and Resiliency Policy.

Washington

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.

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

Washington

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.

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 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 under the Individuals with Disabilities Education Act
Case Management Services
Services for persons with Co-Occurring Disorders
Other Services leading to reduction in Hospitalization

This is a joint response. Please see "Adult – Available Services" as well all "Child – System of Integrated Services".

Washington

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 – Estimate of Prevalence

Child- An estimate of the incidence and prevalence in the State of Significant Emotional Disturbance among children/youth.

Children (0-17 years)

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 **78,049 and 93,685**. 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. All reported numbers are based on data from fiscal year 2003.

Table 2: SED Estimates for Children (0-17 years of age)

Estimated SED	Total Children Served	Estimated SED Served	Quantitative Target
93,658	37,842	24,407	20,000

Washington

Child - Quantitative Targets

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

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/youth (0-17 years) served in FY2005 as well as the projected number served in FY2006. This information is reported for children/youth with serious emotional disorders and for the total child/youth 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 Children's 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 children/youth served with Serious Emotional Disorders and the total number of children/youth served. Then, by using an estimate of the number of children/youth in Washington State with Serious Emotional Disorders and the total population, prevalence rates are reported for the State.

Any data in the Child Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. FY2006 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 2005, the estimated population was 1,709,862 and the projected population for 2006 is 1,730,393, which represents an increase of 1.2%.

Projected Penetration Rates				
Time Period	**FY05 Served**		**FY06 Projected**	
SMI Status	**SED**	**Total**	**SED**	**Total**
Adults Served	**34,092**	**37,842**	**34,501**	**38,296**
WA Child/Youth Population	**78,049-93.658**	**1,709,862**	**78,985-94,781**	**1,730,393**
Penetration Rate		**2.2% of all children/youth in Washington State are served by the Mental Health Division**		**2.2% of all children/youth in Washington State will be served by the Mental Health Division**

Washington

Child - System 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. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Child – System 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. Examples of integrated services include:

Social Services;
Educational services including services provided under the Individuals with Disabilities Education Act;
Juvenile Justice Services;
Substance abuse services; and
Health and mental health services

Public mental health services are provided to children under the same Regional Support Network managed care system as the adults. Each RSN is required to hold Memorandums of Understanding with the allied systems of care related to children in their regions. Great focus 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 are integrated throughout the mental health system and allied system of care and are available statewide. The RSNs are responsible for coordinating the care of adolescents 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. 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 will continue to encourage other child-serving agencies within DSHS to recognize children as "our state's children" and will continue to discuss and find ways to eliminate the barriers to sharing information and data. Mental Health Division continues to encourage other state agencies such as schools and health departments to break down all barriers and to share data whenever possible 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 welfare (called General Assistance to the Unemployable- GAU). Additionally, there are also several community clinics that provide service on a sliding scale basis, for children of families with limited resources. The Governor, Christine Gregoire, has embarked on a note-worthy effort to ensure every child in Washington State has healthcare coverage by 2010, which is consistent with and 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, ethnicities, etc. While it is preferable to serve children in their homes within the structure of their natural supports, sometimes children require the specialized care of inpatient services at the State Hospital's Child Study and Treatment Center (CSTC) or one of the Children's Long-term Inpatient Program's (CLIP) residential facilities. Screening and referral protocols are in place for these services to improve access; however, there are often waiting lists for admission regardless. This past year, the CLIP facilities were contracted with directly by MHD for the provision of these services, which has increased the amount of money available for services by eliminating the administrative fees of the RSNs.

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 Parent Community Connector project and the Parent Council 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 a special-needs child/youth. The Community Connectors and the Parent Council, allows for parents to help other parents who find themselves in a similar situation. These "other" parents must have children, grandchildren or foster children with complex needs and be willing to network within their community.

Many efforts have been made to improve the continuum of services to children across all social and health services. In 2002, the Department of Social and Health Services formed a workgroup known as, "The Select Committee on Adolescents in Need of Long Term Placement' ("the Committee"), to examine the continuum of care and the sufficiency of services and housing options for youth with the most complex needs. The Committee has published a report that details the current status of services available for these children and makes strong recommendations for sweeping systems change, including adoption of Evidence Based Practices.

A DSHS Children's Mental Health Services Workgroup was convened in December 2003 by the DSHS Assistant Secretaries for the Children's Administration, the Juvenile Rehabilitation Administration, and the Health and Rehabilitative Services Administration, of which the MHD was a division. The Workgroup had thirty members, ten connected with each Administration, including field staff, providers, parents, foster parents, researchers, advisory board members, advocates, DSHS partners and other state agencies, meeting bimonthly through June. A report was presented to the three Assistant Secretaries at the end of July 2004 with recommendations for the improvement of mental health services and how they are delivered by DSHS. A SAMHSA System Improvement Grant was submitted to assist in the implementation of these reform efforts, but was not awarded.

As a result of this work group, and under the direction of the three DSHS assistant secretaries, the Children's Mental Health Initiative was born. As described above, this

collaborative effort between the Mental Health Division, the Juvenile Rehabilitation Administration and the Children's Administration was formed to decrease duplication and increase resource management in an effort to provide more comprehensive services to children with SED and multi-system involvement.

One recent accomplishment of this group was the delivery of a report in February 2005 to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs have been selected for broad implementation throughout all three systems. They include:

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are expected to generate treatment outcomes for children, youth and families which will hopefully result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced ***Resiliency***. The initiative will target implementation efforts by focusing on workforce development. By supporting specialized training and certification for clinicians, significant work force enhancement can be achieved without disruption to usual funding levels and service priorities. A comprehensive implementation plan has been developed for each EBP with anticipated completion by the end of the biennium.

Yet another strength of Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The goal of this endeavor is the identification of promising programs where public schools and public mental health providers may collaborate effectively. A report was subsequently submitted to the legislature in June of last year identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified will be disseminated through the public schools and public mental health systems within the coming months.

Further enhancing the construct of the system of integrated services for children is the creation this past year of the Department of Early Learning. Governor Gregoire's vision and leadership lead to the creation of this new agency which has been designed to streamline resources and improve services to children in need of early intervention and support so that they may successfully transition into the public school system.

Washington

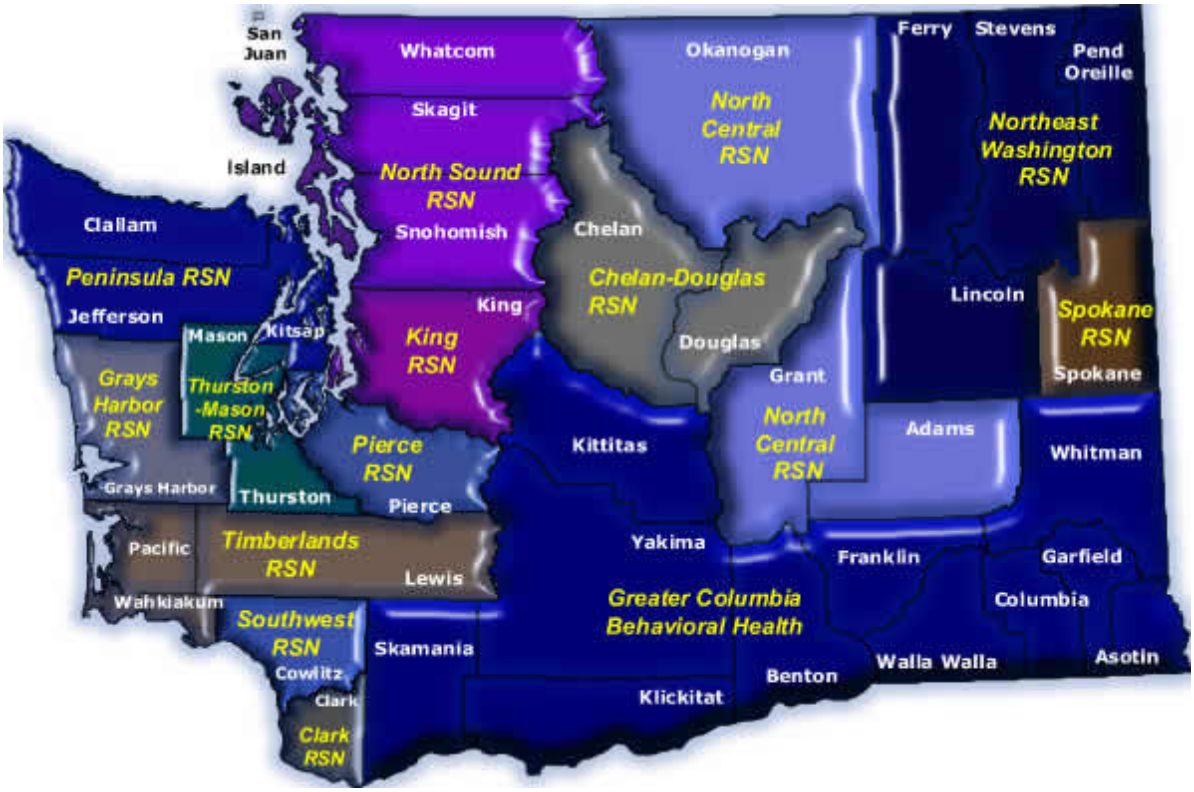
Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Child – Geographic Area Definition

Child- establishes defined geographic areas for provision of services of such system.

Services are provided to children through the same Regional Support Network (RSN) system as the adult. The map below reflects the current catchment areas for each RSN. However, as a result of the RFQ/RFP process, the section denoted as **Northeast Washington RSN** will become part of **North Central RSN** beginning September 1, 2006.



Washington

Child - Outreach to Homeless

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

Child – Outreach to Homeless

Child- Describe State's outreach to and services for individual who are homeless.

This is a joint response. Please see Adult- Outreach to Homeless

Washington

Child - Rural Area Services

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

Child – Rural Area Services

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

This is a joint response. Please see Adult- Rural Area Services

Washington

Child - Resources for Providers

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

Child – Resources for Providers

Child-Describes financial resources, staffing and training for MH providers necessary for the Plan

This is a joint response. Please see Adult- Resources for Providers

Washington

Child - Emergency Service Provider Training

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

Child – Emergency Service Provider Training

Child – Provides for training of providers of emergency health services regarding mental health.

This is a joint response. Please see Adult- Emergency Service Provider Training

Washington

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

Child – Grant Expenditure Manner

Child- Describes the manner in which the State intends to expend the grant under section 1911 for fiscal year(s) involved.

This is a joint response. Please see Adult – Grant Expenditure Manner

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CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Increased Access to Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	38,927	37,552	37,560
Numerator	0	0	--	--
Denominator	0	0	--	--

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: 37,580

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 of Denominator required.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: This is a new target/measure this year so no target is provided for 2006. In previous plans, WA used a penetration rate rather than an actual count.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.

Action Plan: Support the growth of a culturally competent workforce by training those who serve children and youth within the following special populations: American Indians, Alaska Natives and their communities, Ethic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping children and youth obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers/families served by multiple agencies. Encourage early prevention and intervention activities through collaboration with schools, foster care system, and juvenile justice.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	2.20	3.65	3.50	3.50
Numerator	266	418	--	--
Denominator	11,976	11,458	--	--

Table Descriptors:

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

Target: The percentage of children and youth readmitted to any inpatient setting within 30 days of discharge – 3.5%

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 were 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: This is a new target/measure this year so no target is provided for 2006. In previous plans, WA used a penetration rate rather than an actual count.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 persons discharged from the state hospitals are seen within __ 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	1.10	2.80	0	2.70
Numerator	12	29	--	--
Denominator	1,128	1,036	--	--

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 – 2.7%

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 were then readmitted 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 discharges from any inpatient setting.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: This is a new target/measure this year so no target is provided for 2006. Previous plan was to maintain a readmission rate

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Practices

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #4: Increase the number of evidence-based practices provided to children and youth.

Target: Establish a baseline of the number of EBPs provided to children and youth throughout the state.

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 through out 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: This is a new target/measure this year so no target is provided for 2006.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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'd EBP start-ups. Disseminate EBP Resource Guides. Support Mental Health Specialist trainings.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #5: Increase the number of EBPs received by children and youth

Target: Establish a baseline for the number of EBPs received by children and youth throughout the state.

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: Number of EBPs received by children and youth mental health consumers through out 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: This is a new target/measure this year so no target is provided for 2006.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. 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 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: Client Perception of Care

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	65.30	0	65.40
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #6: Improve client perception of care- children and youth.

Target: The percentage of children and youth who report achieving positive outcomes on the MHSIP Survey: 65.4%

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 of Mental Illness research and Training (WIMIRT). 2006 data will not be available until September 2006.

Special Issues: This is a new target/measure this year so no target is provided for 2006. In the past, WA has measured perception of care using a different scale on the MHSIP. Additionally, WA has only conducted the Child/Youth MHSIP every other year, with the off years being used to conduct Adult surveys. Beginning with this application, 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). No Numerator or Denominator required. 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 child/youth/family voice. In particular, Recovery, Consumer Driven service system, and culturally competent care initiatives will be emphasized. OMBUDS training will also be supported. Individual choice, satisfaction, and safety will continue to be encouraged for children/youth/families. Parent support and empowerment will continue to be supported, including having a parent serve on MHD Management Team.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 3.07 Increase in Employment or Return to School - Children and Youth

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #7: Increase the number of children and youth who are engaged in employment related activities or attending school.

Target: Establish a baseline for “Number of Days Attended” through the MHSIP survey in 2007 (new question on survey) and then establish a targeted goal for improvement for 2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children's Services

Indicator: Regional Support Networks (RSNs) will work with providers to increase school attendance for children/youth receiving public mental health services.

Measure: Numerator: Number of children and youth (0-17) who were employed either part-time or full-time, in supported employment or sheltered workshops at anytime in the fiscal year. Denominator: Number of total children and youth (0-17) served in the community outpatient services.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: WA has measured other activities such as school performance in the past. Thus, no data is provided related to this new measure. Also as noted above, although the MHSIP survey has been conducted on a yearly rotation between adults and youth/children, it will, beginning in 2007, be conducted every year for both populations as per SAMHSA requirements re: yearly NOM reporting related to this indicator.

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 (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 Subcommittee of MHPAC will continue to be encouraged.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 3.08 Decrease Criminal Justice Involvement - Children and Youth

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	19.50	19.30
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #8: Decrease the percentage of children and youth consumers who have had involvement with the juvenile justice system

Target: The percentage of youth consumers who were also involved with the juvenile justice system in the past year: 19.3%.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children's Services

Indicator: RSNs and MHD will work to decrease the number of youth consumers who were also involved with the Juvenile Justice System in a fiscal year.

Measure: Numerator: Number of children and youth (0-17) who were arrested convicted or adjudicated in the fiscal year.
Denominator: Number of total children and youth (0-17) served by the mental health division in the fiscal year.

Sources of Information: Data is obtained by merging the MHD data with the Washington State Patrol and Office for the Administrator of the Courts data.

Special Issues: MHD has not been able to obtain timely data due to system limitations. Most recent is for fiscal year 2003. Data for fiscal year 2005 will not be available until November 2006.

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 (MHPAC) Goal #4

Action Plan: Continue to require RSNs to ensure community mental health agencies provide services to youth released from juvenile justice facilities. Support cross-system collaboration within DSHS as well as schools, providers, and community. Continue to support training of Law Enforcement in EBP of Crisis Intervention Training (CIT). Assess ability to improve more timely data collection for this NOM.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 3.09 Increase Social Supports - Children and Youth

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #9: Increase the number of social and natural supports reported by children and youth consumers.

Target: Establish a baseline for children and youth "Social Connectedness" by using WA State's TELESAGE consumer survey in 2007 and then set a targeted goal for improvement in 2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 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 (0-17) who responded that they agreed or strongly agreed to experiencing meaningful relationships on the "Social Connectedness" scale of the TELESAGE survey in a fiscal year.
Denominator: Number of total children and youth (0-17) who responded to TELESAGE survey in a fiscal year.

Sources of Information: MHD's TELESAGE survey.

Special Issues: MHD has not measured this specific target in the past so no data is available for reporting at this time.

Significance: This is a recommended National Outcome Measure (NOM) expected to become required. 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 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 3.10 Increase Family Stabilization/Living Conditions - Children and Youth

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	98	98.20	0	98.40
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #10: Increase family stabilization as evidenced by children and youth maintaining housing.

Target: The percentage of children and youth who received outpatient mental health services who did not become homeless in the fiscal year: 98.4%

Population:

Criterion: 3:Children's Services

Indicator: Children with Significant Emotional Disturbance (SED)

Measure: Numerator: Number of children and youth (0-17) with 2 or more living situations who did not become homeless in a fiscal year
Denominator: Number of total children and youth (0-17) served in community outpatient service in a fiscal year.

Sources of Information: MHD's Consumer Information System (CIS).

Special Issues: This is a new target/measure so no target was established for 2006. 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.

Significance: This is a recommended National Outcome Measure (NOM) expected to become required. 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 likelihood of recovery.

Action Plan: Continue to support development residential resources and encourage the development of safe, affordable housing. Continue to support mental illness education, stigma reduction, recovery, resiliency, employment and other factors that lead to stable housing. Continue to require and further encourage development of cross-system collaboration efforts for families served by multiple agencies within DSHS and the community.

CHILD - GOALS TARGETS AND ACTION PLANS

Name of Performance Indicator: 3.11 Improved Level of Functioning - Children and Youth

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Projected	FY 2007 Target
Performance Indicator	0	0	0	0
Numerator	0	0	--	--
Denominator	0	0	--	--

Table Descriptors:

Goal: #11: Improve level of functioning for Children and Youth as evidenced by increased involvement in meaningful activities

Target: Establish baseline for "Involvement in Meaningful Activities" by using WA State's TELESAGE consumer survey in 2007 and then set a targeted goal for improvement in 2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children's Services

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 (0-17) who responded positively to "Involvement in Meaningful Activities" scale of TELESAGE survey in a fiscal year.
Denominator: Number of total children and youth (0-17) who responded to TELESAGE survey in a fiscal year.

Sources of Information: MHD's TELESAGE survey being conducted by Washington Institute of Mental Illness Research and Treatment.

Special Issues: This is a new measure/target so no previous data is available to report. After establishing a baseline in 2007, a targeted goal for improvement in 2008 will be established.

Significance: This is a recommended National Outcome Measure (NOM) expected to become required. Goal supports New Freedom Commission (NFC) goal #3, #4, #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3, #4, #5. Being involved in meaningful activities is a necessary part of increasing potential for resiliency.

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 creativity, spirituality, education, employment, social interaction.

Washington

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

Washington

Adult - Summary of Areas Previously Identified by State as Needing Improvement

Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Washington

Adult - Most Significant Events that Impacted the State Mental Health System in the Previous FY

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Washington

Adult - Purpose State FY BG Expended - Recipients - Activities Description

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Washington

Child - Summary of Areas Previously Identified by State as Needing Improvement

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

Washington

Child - Most Significant Events that Impacted the State in the Previous FY

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

Washington

Child - Purpose State FY BG Expended - Recipients - Activities Description

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

No Indicator Form Data available

No Indicator Form Data available

Washington

Appendix B (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.