

Washington

UNIFORM APPLICATION FY 2008 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2008

(generated on 8-28-2007 12.56.00 PM)

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 0930-0168.

Table of Contents

State:
Washington

Face Page	pg. 4
Executive Summary	pg. 5
Certifications	pg. 9
Set-Aside For Children Report	pg. 20
MOE Report	pg. 21
Council List	pg. 23
Council Composition	pg. 28
Planning Council Charge, Role and Activities	pg. 29
Public Comments on State Plan	pg. 46
Adult - Overview of State's Mental Health System	pg. 48
Adult - Summary of Areas Previously Identified by State as Needing Attention	pg. 52
Adult - New Developments and Issues	pg. 54
Adult - Legislative Initiatives and Changes	pg. 56
Adult - Description of Regional Resources	pg. 58
Adult - Description of State Agency's Leadership	pg. 60
Child - Overview of State's Mental Health System	pg. 63
Child - Summary of Areas Previously Identified by State as Needing Attention	pg. 66
Child - New Developments and Issues	pg. 68
Child - Legislative Initiatives and Changes	pg. 70
Child - Description of Regional Resources	pg. 72
Child - Description of State Agency's Leadership	pg. 74
Adult - Service System's Strengths and Weaknesses	pg. 76
Adult - Unmet Service Needs	pg. 78
Adult - Plans to Address Unmet Needs	pg. 80
Adult - Recent Significant Achievements	pg. 86
Adult - State's Vision for the Future	pg. 94
Child - Service System's Strengths and Weaknesses	pg. 97
Child - Unmet Service Needs	pg. 100
Child - Plans to Address Unmet Needs	pg. 102
Child - Recent Significant Achievements	pg. 104
Child - State's Vision for the Future	pg. 108

Planning Council Letter for the Plan	pg. 231
Appendix A (Optional)	pg. 233
Adult - Transformation Efforts and Activities in the State in Criteria 1	pg. 118
Adult - Estimate of Prevalence	pg. 120
Adult - Quantitative Targets	pg. 122
Adult - Transformation Efforts and Activities in the State in Criteria 2	pg. 124
Adult - Outreach to Homeless	pg. 126
Adult - Rural Area Services	pg. 130
Adult - Older Adults	pg. 132
Adult - Transformation Efforts and Activities in the State in Criteria 4	pg. 135
Adult - Resources for Providers	pg. 137
Adult - Emergency Service Provider Training	pg. 139
Adult - Grant Expenditure Manner	pg. 143
MHBG Transformation Expenditures Reporting Form	pg. 148
Adult - Goals Targets and Action Plans	pg. 150
Child - Establishment of System of Care	pg. 176
Child - Available Services	pg. 178
Child - Transformation Efforts and Activities in the State in Criteria 1	pg. 180
Child - Estimate of Prevalence	pg. 182
Child - Quantitative Targets	pg. 184
Child - Transformation Efforts and Activities in the State in Criteria 2	pg. 186
Child - System of Integrated Services	pg. 188
Child - Geographic Area Definition	pg. 194
Child - Transformation Efforts and Activities in the State in Criteria 3	pg. 196
Child - Outreach to Homeless	pg. 198
Child - Rural Area Services	pg. 200
Child - Transformation Efforts and Activities in the State in Criteria 4	pg. 202
Child - Resources for Providers	pg. 204
Child - Emergency Service Provider Training	pg. 206
Child - Grant Expenditure Manner	pg. 208
Child - Goals Targets and Action Plans	pg. 210

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

X **FY2008** **FY 2008-2009** **FY 2008-2010**

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 GOVERNOR 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: 07/01/2007

TO: 06/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Judy Gosney 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: 360-902-0827

FAX: 360-902-0809

EMAIL: gosneja@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 is pleased to submit its application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2008. This plan meets all of the requirements of the 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 older adults, homeless people and rural populations;
- Expanding the promotion of recovery and community integration of people with psychiatric disabilities; and
- Delivering accountability through uniform reporting on access, quality, and the outcome of services.

In tandem with the federal guidelines listed above, this document encompasses Washington State's commitment to the 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.

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

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. MHD and its Contractors are continually searching for system improvements; improved access to

services that meet individual needs, family and natural supports are utilized, and that community partnerships are strengthened.

In the last three years the system has undergone many changes. 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 the projected financial losses related to the combination of the discontinuation of the use of Medicaid managed care savings; and
- The passage of legislation that included 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 a mandatory procurement process for the delivery of services

Momentum for change continued in 2006 through the considerable direction and support of the state legislature:

- Involvement of the MHTF continued through oversight of the procurement process.
- 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 has thirteen (13) RSNs.
- Funding awarded to address critical concerns regarding insufficient inpatient capacity. The funding did two things: provided for the need for more inpatient beds at the state hospital (short-term) 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.

Washington State continues to be proud to be one of the recipients of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant).

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.

In 2007

- Mental health parity was expanded to include small business and the timeline from implementation was moved forward.
- Legislature provided transformation requirements for employment, housing, benefit redesign and a review of the Involuntary Treatment Act and inpatient utilization management. This work has been done through stakeholder involvement and outside contractors. Reports are due at the end of June 2007.
- Significant work has occurred with the all Tribes in the state of Washington. Not only did they meet with the contractors doing the work above but, MHD has instituted a Tribal mental health workgroup to improve working relationships and to create better services.
- The legislature provided funding for two (2) evidence based-pilot-programs both amended to allow for children to remain in their parent's custody while receiving out-of-home care.
- Mental Health Clubhouses also were part of the 2007 legislative focus. Clubhouse services are part of our current managed care system and the legislation sets some guidelines for certification.

The mental health system in the State is now in a place to move forward to creating quality care for the consumers of services across the lifespan.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

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

Section 1911:

- Subject to Section 1916, the State¹ will expend the grant only for the purpose of:
- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
 - ii. Evaluating programs and services carried out under the plan; and
 - iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

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

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, 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).

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.

~~XXXXXX~~
Christine O. Gregoire, Governor

Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

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

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

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

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

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

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

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

3. CERTIFICATION REGARDING LOBBYING

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

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

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
APPLICANT ORGANIZATION		DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

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

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <div style="display: flex; justify-content: space-between;"> Prime Subawardee </div> <div style="margin-left: 150px;">Tier _____, if known:</div> 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 <i>(if individual, last name, first name, MI):</i> 	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i> 	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.		
Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
Federal Use Only:		

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 Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE	
APPLICANT ORGANIZATION		DATE SUBMITTED

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 2006	Estimate/Actual FY 2007
<u>\$17,688,942</u>	<u>\$39,955,941</u>	<u>\$35,526,070</u>

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 2005	Actual FY 2006	Actual/Estimate FY 2007
<u>\$177,398,418</u>	<u>\$237,930,763</u>	<u>\$236,727,429</u>

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(If available)
Adair, Traci	State Employees	Social Services	P.O. Box 45600 Olympia, WA 98504-5600 PH:(360) 725-2455 FAX:	AdairT@dshs.wa.gov
Alston, Thressa	Others(not state employees or providers)	Ethnic Minority Subcommittee	20454 104th Ave SE Kent, WA 98031 PH:(253) 859-5309 FAX:	talston@highline.edu
Bates, Rebecca	Family Members of Children with SED		525 W 2nd Ave Spokane, WA 99201 PH:(509) 892-9241 FAX:	bbates@voaspokane.org
Bauer, Roger	Providers		PO Box 3208 Omak, WA 98841 PH:(509) 826-8420 FAX:	rbauer@okbhc.org
Christie, Mary	Family Members of adults with SMI		PO Box 333 Puyallup, WA 98372 PH:(253) 845-0152 FAX:	
Clement, Dan	Providers	Emergency Service Center	1216 20th Avenue East Seattle, WA 98112 PH:(206) 621-7027 FAX:	dclement@desc.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Collison, Fran	State Employees	Mental Health	Olympia, WA 98504-5320 PH:(360) 902-0864 FAX:	collifk@dshs.wa.gov
Conant, Annie	State Employees	Housing	906 Columbia St. SW Olympia, WA, 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
Critchlow, Brien	Consumers/Survivors/Ex-patients(C/S/X)		507 East 131st Street, Lot C Tacoma, WA 98445 PH:(253) 301-0579 FAX:	critchlowb01@comcast.net
Crozier, Rick	Providers	Good Samaritan Behavioral Health-older adult program	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

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Eng, Danny	State Employees	Vocational Rehabilitation	14360 SW Eastgate Way N 40-3 Bellevue, WA 98007 PH:(425) 649-4235 FAX:	Engd@dshs.wa.gov
Groves, Joanne	Consumers/Survivors/Ex-patients(C/S/X)		7101 Roosevelt Way NE, Apt 203 Seattle, WA, WA 98115 PH:(206) 550-9075 FAX:	yakama962@comcast.net
Hammond, Russ	State Employees	Education	PO Box 47200 Olympia, WA 98504 PH:(360) 725-6075 FAX:	Russell.Hammond@k12.wa.us
Johnson, Douglas	Providers	Greater Columbia Behavioral Health	101 North Edison Kennewick, WA 99336 PH:(509) 735-8681 FAX:	douglasj@gcbh.org
Lawton, Brett	State Employees	Medicaid	P.O. Box 45530 Olympia, WA 98504-5530 PH:(360) 725-1593 FAX:	lawtobl@dshs.wa.gov
Lewis, Vanessa	Family Members of Children with SED		6486 19th Street W #B Fircrest, WA 98466 PH:(253) 565-2266 FAX:	vlewis@washingtonpave.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
McClain, Dwight	Consumers/Survivors/Ex-patients(C/S/X)		2022 S Woodlawn RD Spokane Valley, WA,WA 99216 PH:(509) 928-9695 FAX:	dwightmcclain@comcast.net
McCoy, Ronald	Family Members of Children with SED		PO Box 887 Chewelah,WA 99109 PH:(509) 935-6839 FAX:	rmccoy001@centurytel.net
Murphy, Michelle	Consumers/Survivors/Ex-patients(C/S/X)		366 Columbia Point Drive Richland, WA,WA 98352 PH:(509)371-4451 FAX:	mnmurphy@bechtel.com
Nash, Cathii	Family Members of Children with SED		3908 East 17th Spokane,WA 99223 PH:(509) 536-4136 FAX:	cathiin@netzero.com
Owen, Eleanor	Family Members of adults with SMI		906 East Shelby Seattle,WA 98102 PH:(206) 322-0408 FAX:	eleanor_owen@mindspring.com
Peterschick, Erin	State Employees	Mental Health	PO Box 45321 Olympia, WA,WA 98504-5321 PH:(360) 902-0870 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Putnam, Barbara	State Employees	Social Services	14th and Jefferson MS: 45710 Olympia, WA 98710 PH:(360) 902-7939 FAX:	puba300@dshs.wa.gov
Saltrup, Tom	State Employees	Criminal Justice	PO Box 41123 Olympia, WA 98504-1126 PH:(360) 725-8692 FAX:	tesaltrup@DOC1.wa.gov
Stolberg, Matthew	Consumers/Survivors/Ex-patients(C/S/X)		23 46 S "L" Street Tacoma, WA 98405 PH:(253) 383-3741 FAX:	matthewsstolberg@hotmail.com
Warden, Lenora	Consumers/Survivors/Ex-patients(C/S/X)		701 Commerce St, Apt 208 Tacoma, WA 98402 PH:(253) 272-1845 FAX:	norallynn57@yahoo.com
Waters, Bill	Others(not state employees or providers)	Washington State Clubhouse Coalition	P.O. Box 5000 Vancouver, WA 98666-5000 PH:(360) 397-2130 FAX:	bill.waters@clark.wa.gov
Woodrow, JoEllen	Consumers/Survivors/Ex-patients(C/S/X)		1818 West Northridge Court #205 Spokane, WA 99208 PH:509-325-7828 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)	8	
Family Members of Children with SED	4	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	2	
TOTAL C/S/X, Family Members and Others	16	53.33%
State Employees	9	
Providers	5	
Vacancies	0	
TOTAL State Employees and Providers	14	46.67%

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.

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.

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.

Washington Planning Council Charge, Role and Activities

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

VISION:

Plan, Advocate, Evaluate

MISSION:

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

GOALS:

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

Primary Goals:

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

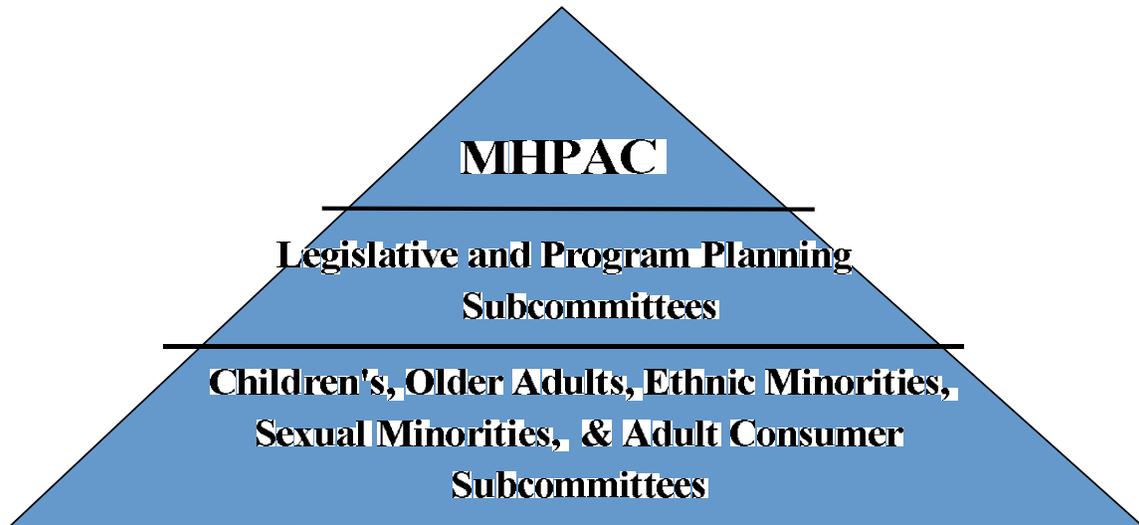
Other Goals:

1. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.
2. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.
3. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care. Support research and use of promising practices through continuous quality improvement.
4. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults. Services shall be focused on Recovery and Resiliency.
5. Support education about mental illness and other mental disorders in an effort to reduce stigma.

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

- Adult Consumer Subcommittee,
- Legislative/Administrative Subcommittee,
- Program/Planning Subcommittee,
- Children's Treatment and Services Subcommittee,
- Sexual Minority Treatment and Services Subcommittee,
- Older Adult Treatment and Services Subcommittee, and
- Ethnic/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 five remaining Subcommittees form the base of the triangle.



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

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

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 led 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 four (4) 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, 2007. 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, as well as Transformation Grant Plans.

Before listing the accomplishments of the MHPAC over the last year, it should be noted that the work of the subcommittees 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 2006-2007 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 2006. Specific to the latter, the Council voted not to recommend the Division's use of FFY 2005 funds for the Mentally Ill Offenders (MIO) program and continues to do so today. 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 past 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 were distributed with the intended goal being greater equity.
- 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 Excellence Awards.
- Legislative Subcommittee updated and distributed the Council brochure for 2007 Legislature and sought approval from the MHD. NAMPAC organized a general Council meeting to discuss collaboration and lobbying efforts with the Secretary of DSHS, the Director of Mental Health and the Council.
- Four (4) 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 give input into the job description of the OCA Manager and provide on-going input to OCA's role and functioning. One member of the Council was requested to take part in the interviews and Stephanie Lane was hired to assume the role of OCP (Office of Consumer Partnerships), effective August 1, 2007.
- 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. Dr. Hall requested, and received, an MHPAC representative become part of the Performance Indicators Workgroup monthly meetings.
- 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.
- 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 include: “Services shall be focused on “Recovery and Resiliency”.
- 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, sexual minority & ethnic/cultural community. This year’s host will be the Adult Consumer Subcommittee.
- 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 and T-Grant Director, Ken Stark.
- Fulfillment of all of the MHPAC’s duties and membership requirements mandated by Federal law.
- Established protocol guidelines of communication between members, subcommittee members and the MHD and vice-versa. These lines of protocol will also be in effect for T-Grant staff and the Council.
- Re-wrote and ratified the bylaws to include e-mail communications and the need for confidentiality in our discussions.
- Included a guest speaker time-period in all of our public meetings,

**Involvement in the Governor’s team for Washington’s Transformation
Grant application and subsequent appointment to the Governor’s
Transformation Work Group.**

The Chair and Vice-Chair were appointed to sit on the Transformation Work Group (TWG) in January, 2006 by Governor Gregoire. This group is composed of a broad spectrum of Executive and Deputy Directors from agencies that all interact with the Mental Health Division. (i.e. the Mental Health Division, Drug, Alcohol and Substance Abuse, NAMI, Department of Corrections, Children's Administration, the RSN's, Department of Health, Department of Education, Voc Rehab, Veteran's Administration, Juvenile Rehab, Aging and Disability Services, Health and Recovery Services) The TWG meets quarterly and reviews the T-Sig Grant Plan and activities. Other than the Chair and Vice-Chair, three other MHPAC members (Cheri Dolezal, Tom Saltrup, and Barb Putman) have been appointed to sit on the TWG by the Governor to represent their agencies.

In an effort to accomplish the Needs and Assessment portion of the T-Sig Grant, seven subcommittees were formed to hold public meetings and forums throughout the State. The assistance from MHPAC to the Subcommittees was large, with eleven current MHPAC members sitting on the Subcommittees and five Subcommittee members becoming successful candidates to sit on MHPAC this last year. Three of these subcommittees were co-chaired by members of the Council. Two other Needs and Assessment programs were run by the University of Washington Training Institute (WIMIRT) and included 13 researchers to conduct face-to-face interviews and a phone bank that interviewed over 1000 consumers. Five MHPAC members acted as researchers for the face-to-face interviews. These Subcommittee meetings were recorded and posted on the TWG website along with the anonymous interviews and then presented to the TWG for assessment and planning.

One of the many T-Sig activities was the formation of WHEN, a consumer run council that will represent consumer voice and direction to the Grant, as well as the MHD. It currently is applying for 501(c) 3 status and includes many members of the MHPAC membership.

In April of the last year, Erin Peterschick was assigned to be the T-Grant Liaison to MHPAC as well as the Program and Planning Subcommittee. Although she has no voting rights on the Council, her direction and voice has been invaluable. Both Ken Stark (T-Grant Project Director) and David Brenna (T-Grant Senior Policy Analyst) have attended many of our Council meetings this past year to solicit ideas and support, from and to, MHPAC. In November, the Vice-Chair of MHPAC, along with Ken Stark, Cheryl Strange (Assistant to Richard Kellogg, head of MHD) and T-Grant staff traveled to the T-Sig meeting in Washington DC to represent Washington State Transformation to SAMSHA.

Transformation Initiative Activities

In October, 2006, and under the direction of Richard Kellogg, Director of the Mental Health Division, a Task Force was initiated to solicit input from providers, stakeholders and consumers to inform Department of Social and Health Services leaders to how best implement legislative and budget initiatives. The Task Force is a participatory process

that seeks to share information in regard to the Initiative implementation and related activities. Strategies include: Statewide implementation of PACT teams (Program of Assertive Community Treatment), a study of the Medicaid benefits package, expanded housing options for individuals with mental illness, a review of the State's involuntary commitment statute, and development of a utilization review system. Many members of MHPAC sit on the Task Force and many more have participated in the community forums. Mr. Kellogg has made many presentations to the Council on the progress of the Initiative and its plans. The final drafts of the Initiatives will be presented to the Council for vote of acceptance or comment. The Council views the Initiatives in an extremely positive light and find that the activities are very transformative, both in concept as well as practice.

Other Transformative Practices

Mid-2006, MHPAC was asked to have a spokesperson sitting in on the monthly meeting of the MHD's Performance Indicator Workgroup. This Workgroup's primary responsibilities include reviewing data for the Performance Indicator (PI) report, reviewing the format and content of the report; and developing new indicators as interests and needs change, and as new data becomes available. Its direction is lead by Dr. Judy Hall. The addition of an MHPAC voice to the Workgroup has created the forward thinking desires for updated and transformative information and data. Aside from the 'official' voice of MHPAC, three other members of the Council are on the PI Workgroup as well.

The Community Transformation Partnership (CTP) serves as a focal point for information disseminated by the TWG and project staff to consumer organizations, informal networks, and individual consumers and families. The CTP represents several independent consumer and family organizations that assisted in the original T-Grant proposal and was originally facilitated by our Council Chair, Joanne Freidmund. Our current Vice-Chair sits on the Partnership, representing MHPAC to date; they have ratified their bylaws and prioritized their 2007 legislative agenda. The CTP membership represents well over 400 individuals concerned with the rights of consumers in the mental health system and focuses on issues such as parity, co-occurring disorders, criminal justice, access to care standards and cross-system collaboration.

In an effort to become even more transformative, the Council sent out letters of interest in collaboration to other agency consumer groups. To date, the Washington State Council on Aging (SCOA) has offered one of its members to sit on our Council as a liaison and one of our Council will sit on their's. As we move past the summer recess, we know that more consumer groups will be responding to our invitations.

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:

Program Planning / Legislative Subcommittee Accomplishments

1. Developed a printed a brochure on the Council for Legislative members and staff. This brochure is for information about MHPAC only and does not seek to lobby or play a part in the political arena.
2. 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 in the 2006 / 2007 budget. 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.
3. On-going monitoring (for absences) of Council members.
4. On-going recruitment of Council members following geographical distribution, adequate representation of parents with SED minors, and all federal mandates.
5. Developed standardized Interview Questions and procedures for Recruiting new members.
6. Applied for and implemented a Technical Assistance Request to the National Association of Mental Health Planning and Advisory Council for Council training in February, 2007. Judy Stange and Joe des Raimés provided the training.
7. Planned and implemented the Annual Council / Subcommittees / Stakeholder Service Excellence Award Meeting.
8. 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.
9. Wrote a letter for Council vote regarding the refunding of Continuity of Care concept.
10. Requested Council involvement in the MHD Diversity Plan.
11. 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.

12. Revised and recommended a Council vote on Bylaws that reflect the President's New Freedom Commission on Mental Health Goals.
13. Coordinated Council and non-Council replies to a CMS request for feedback about implementation of the Washington Integrated Community Mental Health Program. Quarterly reviews were held of the WIMP throughout 2007.
14. The Vice-chair of MHPAC was sent to Peer Review meeting in September of 2006 to request assistance in design and implementation of its legislative subcommittee activities. NAPHAC held a joint meeting in February, 2007, of our Council with Robin Arnold-Williams, Secretary of DSHS, Richard Kellogg, Director of the Mental Health Division, and Ken Stark, Director of the State T-Grant. The need for collaboration was established and a better working relationship has developed.
15. It was another banner year for mental health legislation in Washington and the two Subcommittees were very busy monitoring and establishing relationships. Bills that were signed into law:

2SHB 1095, CH 3 (2007) allows for payment at lower costs to the Medicare / Medicaid populations.

2SHB 1088, CH 359 (2007) will affect delivery of services to children by increasing access to care, increased access points through the Healthy Options Insurance plan and an emphasis on early intervention and prevention. The law also stresses the use of evidence based practices in its language. Parents and family are being given more voice than ever before.

EHB 1217, CH 414 (2007) will help to establish more clubhouse rehabilitation services throughout the State.

SSB 5533, CH 375 (2007) establishes procedures for individuals with mental illness that may have committed a criminal act. Mental health treatment will be the alternative to arrest for certain individuals alleged to have committed misdemeanor crimes. Also authorized were "crisis stabilization units" to provide additional resources for these individuals.

SHB 1456, CH 360 (2007) provides greater protection for mental health professionals that may need to conduct home visits.

EHB 1460, CH 8 (2007) requires that insurance carriers in Washington State provide parity between mental health services and medical / surgical services.

ESB 6018, CH 120 (2007) further clarifies to crisis responders involuntary treatment options and detention possibilities for both the mentally ill and the co-occurring diagnosed

2SSB 5093, CH 5 (2007) established insurance coverage for children whose parents may be on public assistance.

2SHB 1201, CH 315 (2007) will aid foster children who are on Medicaid transition into adulthood, with seamless care.

ESHB 1131, CH314 (2007) establishes a pilot program to offer passports to college for foster children.

In an effort to show legislative and executive support for these newly established laws, Governor Gregoire issued the following statement to accompany her proposed 2007-2009 budget:

Message from the Governor

It is time to invest in our future. I am honored to be your Governor and I respect the trust you place in me to do the right thing for Washington and make the changes that Washington families can count on.

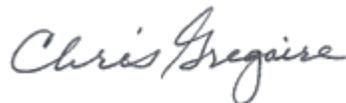
I have visited every part of our state, fields and factories, islands and inlets, cities and rural communities. I have listened carefully to people from all walks of life and all corners of

Washington, and I hear again and again that people care about education, health care and jobs and economic development.

I am investing in what matters most to Washingtonians and I'm calling for accountability to make sure it happens.

By changing government and making strategic investments that offer opportunity, predictability, accountability and security, we will provide:

- An education system that families can rely on;
- An economy that offers opportunities for family-wage jobs;
- High-quality health care that families can afford;
- An environment where families can thrive; and
- Communities where families feel safe.



Adult Consumer Subcommittee Accomplishments

1. Helped re-write the MHPAC bylaws and were ratified as a Standing Subcommittee
2. Drafted a Mission Statement
3. Drafted a Vision Statement
4. Drafted a list of changes to be made to the OCA position
5. Drafted a list of personal recommendations and hiring qualifications for the vacant OCA position. A member of this Subcommittee sat in on the interview process.
6. Joined the Legislative Subcommittee in their meeting at the State Capital, in order to meet the Legislators and their staff.
7. Hosted the Awards portion of the September 2007 All Stakeholder/All Subcommittee Annual Meeting.

MHPAC/Children's Subcommittee Accomplishments

In the last year, the Children's Treatment & Service Committee engaged in the following activities:

1. reviewing and updating the process for recruitment and application to the subcommittee including the application form
2. recruiting individuals to fill vacant positions, interviewing candidates, selecting new members, and electing new officers,
3. proposed incorporation of youth voice into the children's subcommittee
4. addition of SAFE-WA representative to the subcommittee
5. review of RSN FBG\$ spent on children's programs
6. development of matrix for FBG money review
7. development of critical thinking questions for MHPAC subcommittee FBG review
8. development of Meghan Marie Doggett Youth Award
9. selection of 2007 recipients of the Ann Russell Yeh & Meghan Marie Doggett awards

10. review of HB1088, implications for children's mental health statewide, and strategic planning on how to advise MHD, via MHPAC, on this legislation as it is rolled out over the next two years

Ethnic Minorities Subcommittee (EMAC) Accomplishments

1. EMAC continues to proactively focus its efforts in addressing primarily the impact of legislation, public policies, and practices particularly on affected ethnic/cultural minorities in institutional, residential facilities, and/or community settings with the goal of promoting cultural competency and cultural diversity in the planning for provision of mental health services.
2. EMAC welcomed three new community members: a Native American from King RSN, an Asian from King and a Hispanic from Spokane.
3. A new EMAC chair was appointed this year.
4. EMAC appointed an additional Committee member to serve on the Mental Health Planning and Advisory Council
5. EMAC members participated in the Transformation Grant Project activities, specially the ad hoc Cultural Competence Task Group meetings to review cultural competence training curriculum. EMAC assisted in identifying potential trainers for cultural competency training.
6. EMAC assisted in the planning and delivery of the 7th annual Mental Health Specialist forum
7. EMAC reviewed the *2007 RSN Mental Health Block Plan* and requested allocation of Federal Block Grant funds be used toward promoting cultural competence, specifically to support the annual specialist conference and for the initial development of a specialist protocol and standards.
8. EMAC recommended that the Mental Health Planning and Advisory Council and other groups include three questions when reviewing spending plans and policies:
 - a. How would this work with limited English proficient populations?
 - b. How will cultural differences be incorporated into the outcomes of any given policy or plan?
 - c. Will this activity be fair and equal for consumers across population groups?
9. Participated in statewide focus group meetings to provide input into the preliminary Statewide Mental Health Housing Plan.

10. EMAC participated in the Racial Disparities Committee meetings to help identify strategies for collecting data for multi-racial consumers.
11. EMAC continues to proactively work on developing guidelines for the content of specialist consultations, as they relate to APA standards of diagnostic formulation, treatment planning, documentation and overall service provision, and developing protocols for the reporting, billing and data collection of minority specialist consultations.

Older Adult Treatment & Services Subcommittee (OATS) Achievements

1. Were successful in getting an Aging and Disabilities Services representative on MHPAC.
2. Reviewed 2006 Washington State Comprehensive Mental Health Plan and made suggestions for additional focus on older adults.
3. Reviewed 2006 Washington State Performance Indicator Group data and made suggestions to the State as to how certain indicators could be changed to better track older adult access issues.
4. Were successful in placing an OATS member on the EBP Task Group of the Transformation Work Group to represent older adult issues.
5. In November, 2006 the MHD Director, Richard Kellogg attended the OATS meeting to receive a briefing re: status of mental health services for older adults in Washington State.
6. Developed initial guidelines re: What Recovery Means For An Older Adult
7. Reviewed RSN proposals for 2007 FBG monies and reported to MHPAC our analyses, trends, etc. Advocated for more older adult-specific funding.
8. April 2007: Participated in the National MHPAC Older Adult Meeting in Washington DC.
9. To ensure that there was an older adult track in the 2007 Washington State Behavioral Healthcare Conference, OATS took the responsibility for organizing and arranging for speakers on older adult issues.
10. Three OATS members are currently participating on the Washington State Transformation Grant's Prevention Advisory Group, charged with identifying various preventative and early intervention strategies across the age spectrum.

Sexual Minorities Subcommittee Accomplishments

1. Hosted the 2006 MHPAC Annual Stakeholder meeting, and received excellent reviews from all in attendance – our presentation included mini-training by Yvonne Hedgepeth, and a presentation from Camp Ten Trees.
2. Updated and distributed statewide Sexual Minority Mental Health Resource Guide.
3. Contributed to, and co-sponsored the annual Saying It Out Loud Conference at Shoreline, May 2007.
4. Continued to advocate for the revision of WACs to include Sexual Minority Mental Health Specialists.
5. Initiated contracts for the production of a training DVD about mental health counseling cultural competency for sexual minorities.

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 11, 2007 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 2008.

Council members received the draft application a week before the Council meeting. During the July 11th meeting, Ronda Kenney, MHBG State Planner, reviewed the plan with the members. The Council members recommended several changes which were incorporated by the State Planners, Ronda Kenney and Judy Gosney.

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 four 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 the Mental Health Division Planners, who walked the Council through the new SAMHSA's format for the plan and application.

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)
Cathii Nash, Chair

cc: Richard E. Kellogg, Director, Mental Health Division
Judy Gosney and Ronda Kenney, MHBG State Planners

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.

Comments and feedback on Washington's MHBG Plan are solicited and collected in a variety of ways. The following is a sample:

- When the Regional Support Networks (RSN) submit their proposed plan, it is required that it be reviewed by their Advisory Board for community input.
- Regional Support Network plans were reviewed by the MHPAC at their June meeting to allow time for them to provide feedback to the RSNs prior to the July plan review. MHPAC were also invited to join with MHD staff in their review.
- The Mental Health Division formally distributed the Mental Health Block Grant plan for public review during the month of July 2007.
- In addition, the MHBG Plan is posted on the internet, inviting comment all year long.

Additionally, this year MHD reviewed the input gathered by the outside consultants through their stakeholder work on the benefit redesign. They conducted 9 separate focus groups and meet with many individuals. MHD also reviewed the input of the community to the Transformation Grant in 2006 when drafting this plan to further coordinate the efforts of that work.

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 public mental health authority for the 6,375,600 (OFM estimate of 2006) 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. The public system also operates the mental health crisis and involuntary treatment act for the citizens of the State.

The Secretary of the Department of Social and Health Services DSHS is appointed by the Governor to this Cabinet-level position, overseeing several administrations within DSHS including; the Health and Recovery Services Administration (HRSA), Aging and Disability Services Administration (ADSA), the Children’s Administration (CA), the Economic Services Administration (ESA), and the Juvenile Rehabilitation Administration (JRA). MHD is a division within the Health and Recovery Services Administration.

Other division within HRSA include the:

Division of Finance and Rate Development which provide fiscal and budget services for the administration;

Division of Eligibility and Service Delivery which provide the Medicaid hotlines for clients and providers, including authorization lines, eligibility policy issues, CSO intake worker training and provider enrollment;

Division of Medical Benefits and Care Management which includes care management, quality oversight, family services, benefits management (FFS and managed care), and the coordinated care pilots: Medicaid Integration Partnership, GA-U managed care and the Chronic Care program;

Division of Systems and Monitoring: the high tech services, audits and data sifting role and provides services and technical expertise to the entire administration. The division includes Claims Processing, the Veterans Project, Medicaid Eligibility Quality Control and consolidated IT services;

Division of Legal Services: comprised of rule writers, the Fair Hearings process, Human Resources, public disclosure, contracts and workforce advancement;

Division of Disability Determination Services; and,
the Division of Alcohol and Substance Abuse.

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.

Within the managed care framework, 13 RSNs operate under two contracts to provide mental health services to persons across the lifespan with MHD. One contract is a Prepaid Inpatient Health Plan (PIHP) for Medicaid enrollees and the other is a State funded contract for non-Medicaid eligible persons or for non-Medicaid services to

Medicaid enrollees called the State Mental Health Contract (SMHC). Under both contracts the RSNs are to ensure the provision of community inpatient and outpatient mental health services. While a few RSNs provide some direct crisis services to consumers, the majority of services are provided through contracts that the RSNs hold with Community Mental Health Agencies (CMHA) which then in turn deliver the services in their respective communities.

MHD also operates the three psychiatric hospitals in Lakewood (outside of Tacoma) and Medical Lake (outside Spokane). Two of the three hospitals serve adults and the third is for children and youth. MHD also contracts with three Children's Long Term Residential Programs located in Seattle, Tacoma and Spokane. These facilities provide services to children in need of extended-stay treatment.

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 Community Integration Assistance Program (formally the 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.

MHD provides policy and collaboration with other Agencies and Departments providing mental health services. Included in that collaboration, but not limited to are:

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

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

A stronger relationship is developing with Washington's 29 federally recognized tribes and three non-federally recognized tribes as an important part of the mental health system for Tribal members. The DSHS Administrative Policy 7.01 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.

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

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

Outpatient mental health services are provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP (6000) are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

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

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:

- 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 all systems providing mental health service to move toward Transformation.
- Access to entitlements: 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;

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.

As described throughout this plan there continues to be ongoing focus on mental health and system transformation. New and ongoing issues that continue to impact service delivery are:

- The ongoing legislatively driven System Transformation Initiative;
- The ongoing implementation of Evidence Based Practices (EBP);
- The ongoing development of the co-occurring disorders programs and the GAIN-SS screening and assessment;
- The planning to implement new legislation to provide an opportunity for a mental health treatment alternative to arrest for certain individuals;
- The continued effort for cross system collaboration as the work within both the MHD and the Transformation Grant continues; and,
- The planned development of mental health specialist protocols.

On August 15, 2007, Pierce County RSN submitted a letter to Governor Gregoire stating that as of October 1, 2007 they would no longer be willing to sign a contract delivering mental health services. At the time of this writing, the MHD is working to select an alternate provider for the service area. As more is understood, this plan will be modified as needed to include updates.

Washington

Adult - Legislative Initiatives and Changes

Adult - 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 Joint Legislative and Executive Task Force on Mental Health services and Financing (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" and "Adults-Plans to Address Unmet Service Needs" section.

- Revised implementation date for Mental Health Insurance Parity
- Maintained emphasis on jail services
- Continued emphasis on STI
- Continued emphasis on system access and accountability
- Introduction of requirement for MHD to certify Clubhouses
- Legislation to provide an opportunity for a mental health treatment alternative to arrest.
- Legislation to provide greater personal safety to mental health professionals to ensure that no mental health crisis outreach worker will be required to conduct home visits alone.
- Worker Wage increases

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	RSN Estimated Revenues Fiscal Year 2007 and 2008			
	Fiscal Year 2007		Fiscal Year 2008	
	Medicaid	Non Medicaid	Medicaid	Non Medicaid
Chelan Douglas	5,782,234	1,775,375	5,396,463	2,608,501
Clark	15,589,861	6,920,673	15,292,470	8,407,341
Grays Harbor	5,132,855	1,246,695	5,156,333	1,440,618
Greater Columbia	35,332,472	11,250,312	34,994,001	13,473,078
King	82,354,582	32,103,972	80,648,463	38,183,995
North Central	14,287,446	3,666,153	14,214,184	3,910,702
North Sound	39,335,338	18,300,342	38,884,228	22,169,125
Peninsula	16,790,578	5,843,666	16,535,766	7,359,959
Pierce	36,151,123	12,913,333	34,985,447	16,755,938
Southwest	6,448,304	1,738,922	6,266,962	1,868,328
Spokane	28,383,479	7,489,664	27,987,821	9,385,874
Thurston Mason	12,666,053	4,768,639	12,981,983	6,310,588
Timberlands	6,419,806	1,685,426	6,281,605	2,035,950
Total	304,674,130	109,703,172	299,625,727	133,909,998

Note: Non Medicaid revenue also includes funding related to Double Staff Bill (SHB 1456), Direct Care Wage Increase, Expanding Community Services (ECS), PALS, PACT and Jail Services

The table above provides estimates of the amount of funding available through the state of Washington to each Regional Support Network (RSN) for State Fiscal Years 2007 and 2008 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.

The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several administrations within DSHS including; Health and Recovery Services Administration (HRSA) which encompasses mental health, substance abuse and physical health, the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration.

MHD contracts with thirteen (13) Regional Support Networks (RSNs). These RSNs serve as the managed care entity over the many Community Mental Health Agencies (CMHAs) with whom RSNs subcontract for the provision of direct care services.

MHD provides leadership to the RSN via policy and standards, 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. As example, MHD, RSNs and CMHA representatives developed a more detailed Service Encounter Reporting Manual this past year. Together they gathered input, explained any policy change that resulted from the input and then prior to its implementation, staff from the MHD provided on-site technical assistance and training.

Although the Division holds its leadership role as extremely important in terms of conveying and overseeing the implementation the Governor's and State Legislature's intentions and initiatives, MHD holds strong beliefs in the need for collaboration with the Mental Health Planning and Advisory Council (MHPAC), allied systems, other state agencies, the Transformation Work Group (TWG), RSNs, the other formal providers of services to children and families, providers, and consumers/families/advocates at large.

In addition to oversight of the mental health system, MHD is responsible for resolution of consumer grievances 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 52 persons at headquarters and nearly 1,700 persons at the state hospitals. With the continued re-alignment this year within HRSA, MHD's headquarters Information Technology staff, Contract staff and Fiscal employees were moved under the direction of other Divisions.

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 amount of funding allocated to each RSN is determined by a capitated formula. The capitation rate is set by actuaries using Medicaid eligible, Medicaid services and trend factors. For our state only funds the MHD uses general population rather than Medicaid eligible.

MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY06, this included community mental health services to 120,527 individuals, with 30% (36,107) of those served being children under the age of 18. During that period, community inpatient psychiatric services were provided to 7,949 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 May 2007, of the Washington Legislature approved budget for FY07-09 biennium State budget over \$19 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 7 percent of the DSHS budget. While this may look like a decrease from the previous budget, it is not. The Special Commitment Center which serves civilly committed sex offenders budget of \$85 million was removed from the MHD's budget into a separate operating budget.

The leadership in the MHD maintains a strong commitment to the need for input of consumers, parents and advocates and invites their participation in all stakeholder work. They also recognize the need to educate the public on mental illness and to reduce the stigma associated with this disease. The growing involvement of the legislature, the many stakeholders involved in both the System Transformation Initiative and the Transformation Grant, is beginning to increase the awareness and understanding of this disease.

Another important area for the leadership of the mental health system is workforce development. Training is occurring throughout the system for workers from Mental Health Division staff through direct care and line staff as evidenced by the Behavioral Health Care conference, presentations and support at a variety of other agency conferences, the employment conference and staff development activities.

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.

Child – Overview of State’s Mental Health System

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.

The planning system and infrastructure for the delivery of children’s mental health services is much the same as the adults. The RSNs must provide a complete array of services to children and youth 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 and youth (age 9-17) have serious emotional disturbances that affect their functioning in family, school or community activities. There are an additional number of children and youth identified by the school system as having a serious behavioral disability. These children and youth are served not only by the mental health and the school systems, but often times by the Children’s Administration (child welfare system), Juvenile Rehabilitation Administration, physical medicine, Division of Alcohol and Substance Abuse, and/or the Department of Health.

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.

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. The systems should assume the responsibility to work together to serve the

child/youth and their family. Additionally, it should 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. MHD has a pilot project using Multidimensional Treatment Foster Care (MTFC) in the Peninsula RSN. The pilot stays true to fidelity standards but parents are not required to place their youth in foster care to meet eligibility.

The Statewide Action for Family Empowerment of Washington (SAFE-WA) a parent organization supported by the Mental Health Division through MHBG funds and the Mental Health Transformation Grant, is in its third year with 501(c) 3 status. SAFE-WA is currently a SAMSHA funded family organization and is awaiting decision on their current application. SAFE-WA is comprised of six family-driven organizations and a youth organization, with pending applications from two other family-driven organizations. SAFE-WA meets every other month and develops monthly reports to bring a united voice to the Mental Health Division's management on prominent children's issues. SAFE-WA also provides training and technical assistance to parents and youth on Evidence Based and Promising Practice.

SAFE-WA is 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 of parents 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 remain involved as coordination and recognition continue to grow.

SAFE-WA parents and youth testified on behalf of Second Substitute House Bill (SSHB) 1088 met with Legislators and their staff on the importance of this legislation and were instrumental in its passage. Specifically, they were very committed to the WrapAround approach created by the Bill. Important pieces of the legislation for parents include:

- increased access to mental health services and requires several service package designs
- increased access points through the physical managed care plan Healthy Options for 20 mental health sessions and
- an emphasis on early intervention and prevention.

Additional information may be found in "Child-Recent Significant Achievements".

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.

The following points were previously identified as areas needing attention in the 2007 MHBG Plan:

- 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.

Please see Child - Recent Significant Achievements for some of they ways in which these challenges were addressed this past year and willcontinue.

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.

As described throughout this plan there continues to be a growing focus on children's mental health and system transformation. New and ongoing issues that continue to affect service delivery are:

- The implementation of SSHB 1088
- The ongoing implementation of Evidence Based Practices and promising practices;
- The ongoing development of the co-occurring disorders programs and the GAIN-SS screening and assessment for youth;
- The ongoing work with STI regarding benefit redesign, involuntary commitment, and housing;
- A beginning discussion of transitional age youth and employment opportunities;
- The continued effort for cross system collaboration as the work within both the MHD and the Transformation Grant continues;
- The planned development of mental health specialist protocols; and,
- The ongoing expansion of parent and youth involvement at policy level.

On August 15, 2007, Pierce County RSN submitted a letter to Governor Gregoire stating that as of October 1, 2007 they would no longer be willing to sign a contract delivering mental health services. At the time of this writing, the MHD is working to select an alternate provider for the service area. As more is understood, this plan will be modified as needed to include updates.

Washington

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

The most significant is the passage of SSHB 1088. The Legislation creates an opportunity for increased access to mental health services and requires several service package designs. There are additional increased access points through the physical managed care plan Healthy Options for 20 mental health sessions (an increase of 8) and 20 fee-for-service visits for mental health with a psychiatrist.

The Legislation places an emphasis on the values of WrapAround and will award up to four pilot sites for new WrapAround services and up to two sites of expanded WrapAround models. A few highlights of this requirement are:

- Treats each child in the context of his or her family,
- Provides services and supports needed to maintain a child with his or her family and community;
- Integrates families into treatment through choice of treatment,
- Integrates educational support services that address students' diverse learning styles;
- Recommends participation in treatment, and provision of peer support;
- Focuses on resiliency and recovery;

Additionally, this legislation calls for:

- A review of the Access to Care Standards of children's mental health;
- An increase provider network;
- For schools and RSNs to collaborate in providing service through the RFP for the pilot sites; and,
- Pilot for psychiatric consultation with Pediatricians for diagnosis and medication evaluations will be established with an overall reduction in psychotropic medications for children under 5-years old and for those children where cognitive therapies are indicated.

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.

This is a joint response. Please see the 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.

This is a joint response. Please see Adult - Description State Agency's Leadership. However, these items are of most interest to children and youth.

MHD provides leadership to the RSN via policy and standards, 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.

Although the Division holds its leadership role as extremely important in terms of conveying and overseeing the implementation the Governor's and State Legislature's intentions and initiatives, MHD holds strong beliefs in the need for collaboration with the Mental Health Planning and Advisory Council (MHPAC), allied systems providing services to children and their families, providers, and consumers/families/advocates at large.

With the additional focus on children's mental health issues, the MHD is working in a collaborative fashion with the Children's Administration, Juvenile Rehabilitation Administration and the Office of Superintendent of Public Instruction. Additionally, MHD is working closely with physical health care to examine the types and amounts of psychotropic drugs prescribed to children.

Thus MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY06, this included community mental health services to 36,107 children under the age of 18.

More information will be found throughout the document.

Washington

Adult - Service System's Strengths and Weaknesses

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

Washington's strengths include:

- A diverse and inclusive community support system;
- A cross-system, legislatively driven, resource for co-occurring disorders including crisis intervention and treatment through the Omnibus Bill;
- Legislation requiring more rapid implementation of mental health parity;
- A steady increase in consumers becoming Peer Counselors.
- A commitment to provide increased support and training for use of evidence based practices across all populations including children, older adults, other vulnerable populations with severe mental illness and serious emotional disturbances;
- MHD, in partnership with Indian Policy Service and Supports (IPSS) has reinstated the Monthly Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between the MHD and the Tribes, address policy issues and concerns and to improve tribal mental health services.
- The implementation of ten PACT teams statewide, 6 full teams and 4 partial teams;
- Training for workforce development;
- The implementation of a cross-system co-occurring disorders screening;
- An intensive chemical dependency case management pilot in two RSNs;
- MHD has hired new staff for the purposes of contract monitoring, fiscal monitoring and quality oversight, and
- A commitment to the transformation of our 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, there are always opportunities for improvement.

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 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.

The legislature funded the implementation of innovative services through pilot projects. Through a RFP process, there was funding awarded to the expansion of five clubhouses, two programs of coordinated care between physical and mental health for low income persons and a final project to create a specific clubhouse and peer support project for the Asian Pacific Islander population.

As a result of participating in the Data Infrastructure Grant, the MHD is moving toward a performance and outcome-based system rather than one that emphasizes process. To continue to improve data quality, the MHD, RSNs, and providers have this past year revised the Service Encounter Reporting Manual. This manual clarifies the responsibility of reporting and clearly identifies CPTs and HCPCS codes to be used by the RSNs. While initial training and testing has occurred the reporting of encounter data will be monitored closely and continued training will be offered.

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 children and youth can improve their resiliency.

While not Washington's challenge alone, the reduction of stigma must continue so 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.

- Housing: Lack of safe and affordable housing
- Benefits: Too many individuals need mental health 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 trainings 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 the mental health system to move toward Transformation.

All of the issues above have been identified through focus groups, 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.

Washington is continuing to experience an unprecedented focus on the mental health system. With everyone involved from consumers and family members, to the Governor's Office, MHD has a grasp on where, in our continuum of care, needs exist.

As with most public mental health systems, Washington State struggles with limited resources to meet the basic needs of its consumers. As we move forward to implement the changes intended to promote consistency and more equitable access to high quality services, we remain aware of potential shortcomings within the system that must be a priority as well.

The MHD has begun implementing a comprehensive package of budget and legislative initiatives in the delivery of Washington State's public mental health services for adults with severe and persistent mental illness and children with serious emotional disorders based on unmet service needs. Strategies include:

1. Statewide implementation of Program of Assertive Community Treatment (PACT) teams.
2. A study of the Medicaid benefits package and Medicaid managed care rates.
3. Preparation of a plan for expanding housing options for individuals with mental illness.
4. A review of Washington State's involuntary commitment statute and system.
5. Development of a utilization review system to assure people receive appropriate levels and durations of state hospital and community psychiatric inpatient care.

A System Transformation Initiative (STI) Task Force has been formed to provide input to the Department of Social and Health Services (DSHS) on implementation of the 2006 legislative and budget initiatives listed above. The STI Task Force began meeting in October 2006 and consists of consumers, family and advocate representatives, 35-40 representatives of various stakeholders including Regional Support Networks (RSN's), allied systems, and providers. The Task Force is a participatory process that seeks to share information regarding STI implementation and gather input to shape implementation activities.

In addition to the STI Task Force, there were three large public forums to solicit input from providers, stakeholders and, most importantly, consumers of mental health services and family members to inform DSHS leaders about how best to implement these legislative and budget initiatives.

Housing: The MHD has contracted with Common Ground, a non-profit consulting firm focused on creating and preserving housing for people with low incomes and special needs, to develop the statewide mental health housing plan. The Housing Action Plan promotes recovery and addresses the increasing demand for beds at Eastern and Western State Hospitals with the goals to:

- Assess the availability of housing for people with severe and persistent mental illnesses and identify key barriers to securing community-based housing;
- Describe evidence-based practices and models for community-based housing;
- Propose models, partnerships, contracting approaches, and financing options for community-based housing that can meet the needs of the diverse populations served by the public mental health system;
- Provide a specific action plan for creating/securing an additional 500 housing units; and
- Provide technical assistance to RSN's, providers, and consumers to build the capacity at the local level to develop housing, design and implement housing programs, and/or partner with landlords to secure housing.

The Housing Action Plan will focus on community-based housing models that have demonstrated success in increasing stability, reducing episodes and length of stays in hospitals and jails, and promoting recovery. Housing options will include permanent supportive housing in a variety of settings with a variety of models. Priority will be placed on developing independent housing and reducing dependence on licensed residential settings such as large congregate care facilities.

One strategy that will be included in the action plan is Housing First. This model has had demonstrated success for people with severe and persistent mental illnesses and those with chronic homelessness. The two hallmarks of Housing First are rapid housing and customer choice regarding services.

The Housing Action Plan will include a description of necessary supports, barriers, and outcomes. Examples of necessary supports include landlord education and incentives or coordination of state housing and service dollars. Examples of barriers to appropriate housing include high rental costs, felony convictions, or cultural and language differences. Examples of appropriate outcomes are:

- 1) Increase in the number of consumers who secure stable permanent housing;
- 2) Increase in the average length of tenancy for consumers in permanent housing; and
- 3) Reduction in the frequency and duration of hospital or jail stays

Benefits: The MHD has contracted with TriWest Group to make recommendations for re-designing its benefit package for publicly-funded managed behavioral health care. The first phase includes compiling a detailed overview comparing Washington's current benefit design with national best practices and benefit designs from comparison states. This will include:

- A review of Washington's Medicaid State Plan and broader mental health benefit design;
- A literature review of national best practices including evidence-based and other culturally relevant and promising practices;
- An analysis of comparison states Medicaid benefit plans; and
- Input and guidance from Washington stakeholders.

The second phase of the project focuses on refining the preliminary recommendations and developing a transition plan that takes into account the statewide system transformation initiative that is taking place. The transition plan will address both the recommended benefits and the financial implications and will include:

- Additional focus groups with a full range of stakeholders, including consumers of the mental health system and their parents, family members, providers, RSNs, Tribal representatives, and allied systems; and
- Working closely with MHD staff and targeted stakeholders to make sure the emerging plan is both administratively and financially feasible and that it reflects the priorities of the department.

All project work culminated in a final report that will include the final recommended benefits and financial implications along with cost projections.

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

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

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

Involuntary Treatment Act (ITA) Project: The MHD has contracted with TriWest Group to assist in the Involuntary Treatment Act (ITA) Project which will review and provide options for improving Washington State's involuntary treatment laws. The project is driven by the MHD's desire to create an efficient, recovery-focused, resiliency-based system of care and will include the following:

- Review of current involuntary treatment statutes in Washington State;
- Comparison of involuntary treatment statutes with approaches in other states; and
- Identification of strengths, challenges, and options for reform.

The activities of the ITA Review will include conducting a literature review, stakeholder focus groups, and key informant interviews. The project will produce a written report

which will identify research results, system strengths and challenges, and options for reform.

In addition to the STI projects the following unmet needs continue to receive attention.

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 the expansion of Peer Counselor certification program and to the development of Clubhouses.

MHD is sponsoring an employment conference with at least one workshop on transitional age employment. Pierce Community College in Tacoma continues to have a strong supported education program for consumers with mental illness wanting to return to school. The SEER program at Spokane Falls Community College in Spokane continues to be active.

Understanding of Recovery and Resiliency: Increased training is expected in early intervention and prevention, cultural competency, and community education, thereby decreasing discrimination and stigmatization. MHD will continue to encourage and solicit expansive involvement of consumers in directing the mental health service delivery system in Washington, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Legislation was passed in 2007 for the MHD to certify Clubhouses. This process is beginning with stakeholder input. Additionally, Washington's Medicaid waiver has required mental health clubhouses as a Medicaid service which has increased the number of clubhouses across the state. This year, MHD will be looking at training and developing both the Compeer program (Compeer is an APA recognized "Best Practice model for recovery") and Person Centered Planning.

The Mental Health Transformation Project is providing assistance with two activities that MHD is watching closely for the possible impact to consumer recovery and resiliency. One of these projects is with the Washington Behavioral Health Care Council where they are developing clinical team training for consumers and clinicians. In this team approach, consumers will sit on clinical teams and provide their input as they work to develop the best plan of care for another consumer. This provides learning opportunity for clinicians in working with consumers and also provides consumers with the support of another consumer and assistance with expressing their strengths, needs and wishes.

The other activity of interest is a prevention policy effort of the Transformation Project. Prevention teams from multiple disciplines are working towards recommendation for the 2009 legislature. The State Board of Health under contract with Transformation is developing a white paper on prevention followed by a Summit in the spring of 2008. The Summit will present 3-5 policies on prevention policies and practices for consideration by lawmakers.

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 legislatively mandated RSN procurement in 2006/2007 continues to result in the MHD's communication of clear expectations including quality care, access to services, and program development. MHD has accomplished this through improved standards and clearer contract expectations. The RSNs are taking these expectations and developing a stronger service delivery system. Not only is this noticed by the MHD but has been validated by an independent review. The RSNs operate a managed care system for Medicaid consumers under a prepaid inpatient health plan (PIHP). Medicaid rule requires an independent review by an annual External Quality Review Organization and the development of a technical report based on their findings. The current year's External Quality Review Organization's report to CMS identifies the following strengths in the state system.
 - PIHPs have maintained a steady level of continuous quality improvement.
 - Evidence of many new and revised policies and procedures demonstrates PIHP efforts to document, standardize, and operationally define processes to effectively manage care throughout the region.
 - PIHPs generally have standardized and improved their authorization and utilization management procedures and mechanisms since separating these functions from the direct service providers.
 - PIHP and provider staff have increased knowledge and understanding of their local grievance systems and are able to articulate pertinent steps to assist Medicaid enrollees in effectively maneuvering through the process.
 - At least 2 Practice Guidelines and/or Evidence Based Practices (EBPs) have been adopted by all PIHPs. The majority of PIHPs have moved beyond locally developed guidelines to nationally validated guidelines and EBPs.
 - The PIHPs have an increased commitment to integrating consumer voice and participation in decision-making throughout all levels of managed care operations and service delivery.
 - Creative service options, based on fundamental values of recovery and normalization, are being developed to meet diverse enrollee needs and to reduce inpatient hospitalizations.

- **Substitute Senate Bill 5533: Chapter 375, Laws of 2007.** This legislation is intended to provide an opportunity for a mental health treatment alternative to arrest for certain individuals. Provisions include:
 - Authorization for police officers to divert individuals with mental illness who have been alleged to have committed misdemeanor crimes, which are not serious crimes, to mental health treatment;
 - Police officers diverting such individuals are provide liability protection;

- Authorizes the licensing and certification of a new type of mental health residential facility, “crisis stabilization unit” to provide an additional mental health treatment resource for these individuals; and
- Authorizes the crisis stabilization units to detain the individual up to 12 hours and requires provision of additional voluntary mental health services.
- **Substitute House Bill 1456: Chapter 360, Laws of 2007.** Known as the “Marty Smith Bill” in honor of a mental health professional killed on the job, this legislation is intended to provide greater personal safety to mental health professionals. Provisions include:
 - Annual training on safety and violence prevention for all community mental health workers who work directly with clients;
 - Policies to ensure that no mental health crisis outreach worker will be required to conduct home visits alone;
 - Employers will equip mental health workers who engage in home visits with a cell phone or other communication device; and
 - Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.
- **Enhanced opportunity for system and community collaboration:** The Mental Health Division (MHD) continues to actively work to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support Networks (RSNs), consumers, families, 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.

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 may 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.

- **Increased efforts to coordinate physical and mental health:** Washington’s Medicaid Integration Project (WMIP) began in January 2005 and continues today, through the collaboration of DSHS with Molina Healthcare of Washington, Inc (Molina). The goal is to manage and provide medical, mental health and chemical dependency services through Molina’s provider network, with an initial requisite enrollment of 6,000 individuals (with option to disenroll) for the residents of Snohomish County. The focus of this project is to make available a

care coordination model through a team approach to 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.
- **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.
 - The job description for the **Manager of the Office of Consumer Affairs (OCA)**; was rewritten with the help of the adult consumer subcommittee of the MHPAC. A national search was conducted to fill the position. There were many strong candidates for the position. Stephanie Lane began work on August 1, 2007. Her first item of business upon hiring was to change the title to Office of Consumer Partnership. One of her first tasks will be to meet with consumers to develop a work plan for the upcoming year. The Office will also create an ongoing relationship with the developing adult consumer network Washington Health Empowerment Network (WHEN) in partnership with the Mental Health Transformation Grant.

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 will provide MHD staff and MHBG contract holders with liaison and consumer-run advocacy and support services.

- **Expansion of Peer Counselor and Recovery training:** Consumer training and employment continue through comprehensive training and certification programs for Peer Counselors. There are now 240 trained Peer Counselors of which, 156 are certified. Another 50 have passed the exams and are awaiting license from the Department of Health. 19 have been trained but have not yet applied for testing and 26 were closed for a variety of reasons. This year there were 2 additional trainings specifically held in eastern Washington to make access to the training easier for approximately 50 trainees.

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 and when they are involved actively in the treatment of the child over age 13.

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) is provided to all certified Peer Counselors as well as others interested in this dynamic, evidence-based program.

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.

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

- **Support of Evidence Based Practices:** In addition to the development of PACT teams, MHBG funds are being used to support development of EBPs specific to Older Adults 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 a budget proviso of \$5 million, the legislature allocated funding over the biennium for the provision of services to persons with mental illness who are incarcerated. The RSNs are required through contract to provide jail coordination services. The following terms are included in the contract.

- Coordinate with local law enforcement and jail personnel including the maintenance or development and execution of Memorandum of Understandings with local county and city jails in the Contractors' service area which detail a referral process for persons who are incarcerated and diagnosed with a mental illness or identified as in need of mental health services.
- Identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- Accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24.
- Conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- Develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs.
- Assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

After providing the services above the RSN may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:

- Daily cross-reference between new bookings and the RSN data base to identify newly booked, persons known to the RSN;

- Development of individual alternative service plans (alternative to the jail) for submission to the courts.
 - Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing);
 - Intensive post-release outreach to ensure there is follow up with the CSO and appointments for mental health and other services (e.g. substance abuse);
 - Inter-local agreements with juvenile detentions facilities;
 - Provision of up to a seven day supply of medications prescribed for the treatment of mental health symptoms following the release from jail.
 - Training to local law enforcement and jail services personnel; and
 - Provision of direct mental health services to individuals who are in jails that have no mental health staff.
- **Improved Tribal Relations and Supports:** The Tribal Liaison position at MHD provides coordination with Washington’s 29 federally recognized tribes in addition to three non-federally recognized tribes as an important part of the mental health and tribal coordination. 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. Currently, MHD and the Suquamish Tribe are about to complete their MOU. Suquamish is also taking the lead for Tribes in working on a Tribal/CLIP MOA.

In 2009, MHD will increase the MHBG funds that are available for the Tribes from the 20% maintained and the RSNs are required to consider the Tribes and Tribal members living in their service area when they submit their spending and service plans.

- **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 are resulting in improvements in accountability and consistency, are followed up with technical assistance from MHD for those RSNs needing help in the development or enhancement of their tracking and monitoring policies, procedures, and accounting practices.

Additionally, the review process of RSN MHBG plans which began in 2007 continues. RSN MHBG plans are 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 then reviews two 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.

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 the President’s New Freedom Commission recommendations.

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 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 published a report that detailed 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.

In February 2005 this group delivered a report to the three DSHS secretaries, providing valuable research on evidenced based practices (EBPs) for children. In turn, five EBPs were selected for broad implementation throughout all three systems. They included:

- 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 described in the Child-Recent Significant Achievements. Treatment outcomes for children, youth and their families should 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.

RCW 71.36.040(3) requires OSPI and DSHS to “jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children.” Further, the RCW requires OSPI and DSHS to “work together to share information about these approaches with other school districts, regional support networks, and state agencies.”

A report was submitted to the legislature in June of 2006 identifying 25 exemplary programs. Interviews and further information gathering took place last fall. Information about the promising practices identified was disseminated through the public schools and public mental health systems.

The MHD and the Mental Health Transformation project are now working together with the Office of the Superintendent of Schools (OSPI) and an advisory group of mental health providers, educators and parents to:

- to strengthen relationships between school districts and publicly funded community mental health providers;
- identify best practices associated with the delivery of mental health services in schools and identify current information about the use of Response to Intervention principles/practices that focus on the mental health/student performance relationship and address student mental health needs; and,
- develop a strategy and implementation plan, using the train the trainers approach, to deliver curriculum developed to share the resource manual, and disseminate information about best practices/promising approaches for the delivery of mental health services in Washington's schools. The curriculum will include a subsection devoted to the use of RTI principles in the delivery of mental health services.

One of the central issues that must be accounted for as this project gets underway is the central role of parents in achieving student success, especially when students are confronted with multiple problems that do not easily fit into either the K -12 or mental health service paradigms. Parents are often in the position of being forced to advocate in both systems on behalf of their children, and it is often the case that the role of "advocate" is seen as "adversary". It was also acknowledged that while this is a difficult and uncomfortable position for parents who have the skill and determination to challenge systems, it is often an impossible task for a large number parents who do not have that requisite skill and competence. Parents say they are often told by both K-12 and mental health personnel who the "professionals" are and that parents should defer to those professional judgments. This issue is complicated by the fact that schools have responsibility for all children irrespective of the issues those children bring into the educational setting, and the publicly funded mental health system is only responsible for that fraction of children who meet short term emergency criteria or meet medical necessity criteria for ongoing treatment.

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.

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

- Early Intervention and Prevention: Increased community education on early intervention and preventions.
- 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.

- **Formal Systems Use:** MHD convened a workgroup to assess the Children's Long-term Inpatient Program (CLIP) and the community acute care resources currently available to children and youth. A second workgroup between MHD and the Tribes occurred to discuss their issues also. A third meeting will occur in late summer or early fall 2007 to discuss the recommendations and develop a plan. Greater collaboration is occurring with JRA and there is a requirement in SSHB1088 to explore Medicaid eligibility for youth when they are in detention to ensure coordinated after care.
- **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 contracts with SAFE-WA, continuing to support the growing Dad's Network, support of parents to attend training and Conferences, and the Parent Community Connectors. Parents who have children in the Long Term Residential Programs often feel isolated and alone. MHD will investigate a parent support activity for these parents while their children are in residence.
- **Understanding of Recovery and Resiliency:** The need for a comprehensive Recovery and Resiliency training and the relationship to children and youth is well understood. MHD has formed a collaborative workgroup with members of the Transformation Work Group to address the need for such a state-wide initiative. The vision of educating consumers, families, providers, administrators, as well as the general public is held in hopes of realizing meaningful outcomes and reducing stigma. MHD will continue to work to ensure that language is consistently used. For instance, parents often wonder how ill their child will have to become to recover and prefer the term resilience. Additionally, parents whose children and youth often are unable to participate in their treatment and there for miss skill development they will need when their children return home. Though our MHBG funds MHD will provide funding to assist parents in visiting their child both to participate in treatment activities but, to also allow them some time as a family unit.
- **Educational/Vocational Activities:** MHD is in strong agreement with RSNs providing more educational and vocational assistance and opportunities for youth. More support to help children and youth stay in school, achieve decent grades, develop meaningful activities, and discover "what they want to be when they grow-up" will only instill hope for the future, which is the core of Resiliency. The employment conference held in July 2007 included a specific topic area on the employment needs of youth in transition.
- **Evidence Based Practice:** 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 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'.

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.

The most significant event of this past year is the passage of Second Substitute House Bill 1088. The Legislation creates an opportunity for increased access to mental health services and requires several service package designs. The additional increased access points through the physical managed care plan Healthy Options for 20 mental health sessions (an increase of 8) and 20 fee-for-service visits for mental health with a psychiatrist.

The Legislation places an emphasis on the values of WrapAround and will award up to four pilot sites for new WrapAround services and up to two sites of expanded WrapAround models. A few highlights of this requirement are:

- Treats each child in the context of his or her family,
- provides services and supports needed to maintain a child with his or her family and community;
- Integrates families into treatment through choice of treatment,
- Integrates educational support services that address students' diverse learning styles;
- recommends participation in treatment, and provision of peer support;
- Focuses on resiliency and recovery;

Additionally, this legislation calls for:

- a review of the Access to Care Standards of children's mental health;
- an increase provider network;
- for schools and RSNs to collaborate in providing service through the RFP for the pilot sites; and,
- Pilot for psychiatric consultation with Pediatricians for diagnosis and medication evaluations will be established with an overall reduction in psyche med under 5-years old and for those who cognitive therapies are indicated.

Another highlight of SSHB1088 is the establishment of an EBP institute at the University of Washington division of public behavioral health and justice policy requires:

"The institute shall closely collaborate with entities currently engaged in evaluating and promoting the use of evidence-based, research-based, promising, or consensus-based practices in children's mental health treatment, including but not limited to the University of Washington department of psychiatry and behavioral sciences, children's hospital and regional medical center, the University of Washington school of nursing, the University of Washington School of Social Work, and the Washington State institute for Public Policy."

Governor Chris Gregoire announced an initiative to cover all children in the state with health insurance by 2010 early in her term of office. As part of the Health Care Services for Children Act, the 2007 Legislature approved new standards for Washington's public health coverage for children who live in families with incomes at up to two and half times the federal poverty level (family of four this is \$51,635) beginning in July 2007. The eligibility standards will increase in January 2009 to three times the Federal Poverty Level. At that point, parents in families with incomes above that ceiling will be able to buy coverage for their children by paying Medicaid's full cost of coverage. The new coverage, which will be consistent with Medicaid's traditional major medical coverage, includes medical, dental, and vision benefits. Families with incomes more than two times the Federal Poverty Level will pay a modest monthly premium (\$15) for the coverage.

The major effort being launched in July is part of Children in public health care will no longer be defined by their health care program but by their age and health status. Doug Porter, assistant secretary of the Health and Recovery Services Administration, which operates the Medicaid program under HRSA stated. "Kids are kids, the idea is to recognize that all uninsured kids represent a problem, no matter what their circumstances, while insured kids are a plus for everyone. The prospect of getting an entire family under the same coverage and with the same primary care provider is a major step toward finding a medical home. "That means they will have a family doctor who is intimately familiar with an entire family's health care needs and concerns. It also means that in an era of patient-centered care, medical homes are a guarantee that the care we receive will be respectful of, and responsive to, individual patient preferences, needs, and values."

DSHS/HRSA will be working with the Office of Superintendent of Public Instruction and local school districts, Community Service Offices and the Health Care Authority to make information available on the new program.

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

The EBP panel of researchers from across the state, originally established as part of the Children's Mental Health Initiative, was reconvened adding parents to the panel. Their task was to update and expand the list of evidence-based, research-based and promising practices prior to a legislatively supported RFP (2006 session) to create a pilot site for the implementation of community selected EBPs. The winner of the RFP is implementing MST and is currently expanding their population using federal block grant funds to include the Tribe in their area.

- EBPs are being implemented for children across the state.
 - Multidimensional Treatment Foster Care (MTFC)- 5 sites (MHD, CA and JRA)
 - Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – 41 sites in 13 RSNs

- Multi-systemic Treatment (MST) 4 sites (MHD, JRA)
- Family Integrated Transitions (FIT) 2 Sites (JRA)
- Functional Family Therapy (FFT) 2 Sites (JRA)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT) (MHD, JRA)
- Aggression Replacement Therapy (ART) (JRA)
- Multi-Family Group Family Psychoeducation (MFG) (MHD- CSTC)

A short-term workgroup was convened to create/discover within its' DSHS partners (MHD, JRA, CA,DDD, DASA) potential solutions or systemic alternatives to deal with hard to serve children/youth who are crossing over multiple systems and are perceived as needing residential services through CA.

There were two forums held regarding children's long term inpatient mental health with one specifically held with Tribes. The Suquamish Tribe and CLIP have an MOA regarding direct access. This first will form a boiler plate for other tribes to follow.

Parents and youth continue to provide a strong voice to the Mental Health Transformation Workgroup and to the Division of Alcohol and Substance Abuse (DASA) Statewide Coordination Grant developing a statewide infrastructure that fosters cross system planning, knowledge and resource sharing to enhance the existing adolescent substance abuse treatment system.

The MHD and the Mental Health Transformation project are working together with the Office of the Superintendent of Schools (OSPI) and an advisory group of mental health providers, educators and parents to develop and conduct statewide train- the- trainer sessions focusing on public education and publicly funded community mental health service coordination. An additional purpose is to begin to develop Response to Intervention strategies and practices specific to the mental well being of students. A significant portion of this Contract will promote the intent of RCW 71.36.040 (3) in an effort to strengthen relationships between school districts and publicly funded community mental health providers.

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.

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 especially considering the new legislation for children and the continued implementation of EBPs. 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's 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.

MHD is a division of the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Assistant Secretary of HRSA and the MHD Director are appointed by the Secretary of DSHS to oversee the MHD.

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 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, MHD implemented a capitated managed care system for community mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks.

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.

In the last three years the system has undergone many changes. 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

In 2006 through direction and support of the state legislature the MHD conducted a RFQ/RFP process for its community services. Involvement of the MHTF continued through oversight of the procurement process.

Completion of the procurement process resulted in there being 13 RSNs. Two small RSNs in rural eastern Washington, Northeastern Washington RSN and North Central RSN are now combined as North Central RSN.

Washington State continues to be proud to be one of the recipients of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant).

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.

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

The RSNs responsibility for services is described in state statute RCW 71.24, 71.34, 71.05. 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 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 is the fact that the RSNs are required to prioritize the expenditure of their state-only funds in covering the costs of crisis and ITA to all citizens of the state, of inpatient care for publically funded consumers, and residential resources.

Once those needs are met, an RSN may use the remaining funds on the other services above. Since inpatient services are some of the most costly to provide for the RSNs, significant effort has been made on the part of MHD to provide technical assistance to the RSNs on ways to improve their Utilization Management and Review tools and processes. RSNs 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 exhausted before they can get to the business of providing the other services listed above.

The mental health system and the RSNs operate the only behavioral health crisis system in the state, resulting in responsibility by default for conditions not normally considered as mental illness. These crisis services are available to anyone in the state, regardless of income.

Crisis services include a 24-hour crisis line and in-person evaluations for individuals requesting 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 prepaid 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 treatment activities (individual, group, family) 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.

- 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.

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 in 2006 approved an MHD request for hospital rate increases 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 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 overarching 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 Snohomish County, though many people opted out of the program. The focus of this new project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through

with prescribed treatment. Coordination of these services is expected to accomplish the following:

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

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

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

Dental services are available to adult consumers. However, it remains difficult to find dentists who accept medical coupons as payment and those that do, have very limited slots. The need to assess consumer's need for dental care is a requirement of the therapist in developing an individual service plan. Several RSNs contract with SeaMar a FQHC to provide mental health services, a few SeaMar clinics have dental services available. Two RSNs are using flex funds for dental services for their clients.

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

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

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

Washington

Adult - Transformation Efforts and Activities in the State in Criteria 1

Adult - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

Transformative efforts related to this criterion and goal number 1 of the NFC are: the active involvement of a mental health task force that included members of the legislative body, informed by providers and stakeholders; the pilot project combining mental health services into the medical home of the person; and the fact that the Governor's Office is actively involved in the mental health transformation project and has moved forward the implementation date of the mental health parity laws.

Transformative efforts related to goal number 2 of the NFC are: the re-establishment and re-design of the Office of Consumer Partnership. The redesign was done with adult consumers and the adult subcommittee of the MHPAC; the promotion of consumer access and choice in safe and affordable housing; supported employment; clubhouse availability; new coordination efforts for co-occurring disorders; and the new jail services legislation.

Transformative efforts with regard to goal numbers 3 and 5 is the use of EBPs and the work that has been done with the Ethnic Minority sub-committee, Tribes, youth and others to determine which EBPs are most culturally appropriate and what changes should be considered in their use. Additionally, with regard specific to Tribes, many cultural-specific events have been sponsored by the Tribes to address mental health issues.

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) of 194,686. 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 2006.

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

Estimated SMI	Total Adults Served	Estimated SMI Served	Quantitative Target
256,030	88,291	59,259	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 FY2006 as well as the projected number served in FY2007. 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 2007 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 2006, the estimated adult population was 4,645,391 and the projected population for 2007 is not yet released.

Projected Service Rates				
Time Period	FY06 Adults Served		FY07 Adults Projected	
SMI Status	SMI	Total	SMI	Total
Adults Served	59,259	88,291	60,500	87,800
WA Adult Population	250,851	4,645,391	Data not available	Data not available
Penetration Rate	23.6% 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		

This table shows that the Mental Health Division serves 23.6% 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.

Washington

Adult - Transformation Efforts and Activities in the State in Criteria 2

Adult - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformative efforts (goals 1, 3, & 4) include partnering with Department of Health, Behavioral Health Risk Surveillance Survey, in both 2006,2007 and plan to do so again in 2008. MHD is currently doing an analysis of the 2006 data for estimates of depression and anxiety disorders and those estimates will be used by the workgroup on early intervention and to guide transformation grant planning and activities.

Washington

Adult - Outreach to Homeless

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

Adult – Outreach to Homeless

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

For the past four (4) 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. Common Ground is also working with the STI to develop the housing plan.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in May 2007 and will be used again in 2008. PATH recipients and others who serve homeless, mentally ill people received financial assistance to support their attendance at the conference.

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. Through a contract with the state Department of Veteran's Affairs SOAR training has been provided to homeless providers and technical assistance to people serving persons who are homeless and mental illness. The training includes assistance on how to help people apply for benefits, disability insurance, Veteran's assistance and related services.

In FFY08, MHD plans of delivering the SOAR training to RSNs and other community providers so they may learn to assist more potentially eligible people to access benefits, speeding up the process and promoting the number of applications approved on first submission. Nationally, it takes close to a year to apply for benefits, and the first application is denied about 60 to 75% of the time. MHD hopes that with training we can reduce this percentage.

The RSNs are required through contract to provide jail coordination services. The following terms are included in the contract.

- Coordinate with local law enforcement and jail personnel including the maintenance or development and execution of Memorandum of Understandings with local county and city jails in the Contractors' service area which detail a referral process for persons who are incarcerated and diagnosed with a mental illness or identified as in need of mental health services.
- Identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- Accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24.
- Conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- Develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs.

- Assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

After providing the services above the RSN may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:

- Daily cross-reference between new bookings and the RSN data base to identify newly booked, persons known to the RSN;
- Development of individual alternative service plans (alternative to the jail) for submission to the courts.
- Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing);
- Intensive post-release outreach to ensure there is follow up with the CSO and appointments for mental health and other services (e.g. substance abuse);
- Inter-local agreements with juvenile detentions facilities;
- Provision of up to a seven day supply of medications prescribed for the treatment of mental health symptoms following the release from jail.
- Training to local law enforcement and jail services personnel; and
- Provision of direct mental health services to individuals who are in jails that have no mental health staff.

RSNs use federal block grant funds to provide homeless outreach, rent subsidies and support services, supported housing and one RSN will provide protective payee services to 150+ consumers

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
across the life span**

RSN	Estimated Number of Homeless Persons	# Homeless		% Homeless SMI to Population	PATH Funding
		SMI Using 35% Estimate	Total Pop (2000 Census)		
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

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 telemedicine sites for the provision of services.

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

- Increased education and training related to the special needs of this population and effect ways in which to engage them in treatment;
- Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security Disability;
- Continued participation in the Rural Mental Health Conferences;
- Workforce development;
- Reducing stigma; and
- 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 the legislation that led to the RFQ/RFP process and required increasing consistency in access to state 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.

Washington

Adult - Older Adults

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

Adult – Older Adult Services

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

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

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

The Older Adults and Family and Treatment subcommittee (OATS) of the MHPAC envisions a system that encompasses cross-system coordination and prioritizes the development and implementation of policies, planning and evidence-based and promising practices that support the specialized needs of older adults.

Washington State is proud to be the founder of the Gatekeeper Program and continues to support this program. This program trains every day workers to recognize signs of isolation, depression and other age-related changes in older adults, as well as co-occurring substance abuse issues. MHD with assistance from OATS will work to reinvigorate this model across the state.

There are many other integrated and cross-system partnerships in the RSNs such as Elder Services, Expanded Community Services, Lockett House and Hope Options. The evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) for late life depression exist in a few CMHAs. MHD will support workforce development through training on these to collaborative care models.

Through the work of the STI benefit design, ITA review and housing plan it is anticipated the needs of older adults will be addressed by:

- Increased education and training related to the special needs of this population and effect ways in which to engage them in treatment;
- Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security;
- Continued workforce development
- Reducing stigma; and

- Increased understanding of designated mental health professionals and crisis workers on the needs of older adults.

Training such as the Caregivers conference and tracks at the Behavioral Health Care conference address the special needs of older adults as they express grief, depression and other age-related symptoms. The training needs to express a different approach to services such as in home care and outreach to those persons who have become isolated. MHD staff will explore the creation of expansion of the peer support program to develop a specialized model that supports the unique needs of this population.

Suicide prevention continues to be an area of focus for the OATS. Older adults continue to have the highest rate of completed suicides as compared to other age groups. They attempt suicide less often but are successful more often. OATS, MHD, and the mental health transformation project will in FFY08 develop a plan to coordinate with the Division of Aging and Disability Services and the Department of Health on a coordinated project for prevention and awareness.

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

In FFY 08, the RSNs will use MHBG funds for older adults in the following manner:

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

Washington

Adult - Transformation Efforts and Activities in the State in Criteria 4

Adult - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

Transformative efforts in this criterion support NFC goals 1, 2, 3, & 4 in the following manner: within the jail coordination services project, persons who are homeless and mentally ill will be screened to develop individual alternative plans of care rather than jail via court. For those consumers who are in jail, transition plans will occur prior to release. The legislatively mandated STI is looking at housing options, employment options and benefit design to assist rural consumers. The mental health system delivers and attends rural mental health conferences to become educated on best practice to create a well trained workforce and implement EBPs. Education on issues facing older adults and the cultural challenges of serving this population is being addressed by the Older Adult Subcommittee. A conference is being planned for education and training related to the special needs of this population. Additional training is being developed to increase the knowledge base of the workforce that is specific to crisis intervention relating to the needs of older adults.

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 MHD.

Funding for the CMHAs is decided at the RSN level. CMHAs collaborate 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 and workforce development. For example, this past year MHD supported trainings at the provider level on such varied topics as:

Co-Occurring Disorders	MHP training on Access to Care 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
PACT training	WRAP

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 victims of this year's weather in western Washington and continued services to Katrina victims located in our state. Washington experienced one declared disaster with flooding however, the impact to individuals was low. As such, MHD did not apply for a crisis counseling grant but the RSNs and the MHD's Disaster Coordinator remained available to offer assistance as needed. The flooding was followed by a tremendous windstorm that while not considered for FEMA, did have a noticeable impact on calls to the crisis clinic and on children in school. The windstorm did an incredible amount of damage including damage to the infrastructure. Governor Gregoire called for a joint report to the response lead by the Emergency Management Department.

DSHS is taking a more proactive role in All Hazards Planning and is requiring each Division to have a viable plan in place. This has resulted in the MHD assigning a portion of time of an additional staff to this area. This will create greater coverage and more awareness in planning.

MHD is developing training materials for disaster mental health counseling based on the SAMHSA model of intervention. Materials will include a power point and appropriate hand outs. One training will be provided to at least 25 individuals to test and evaluate the materials. A statewide training plan including proposed locations, trainers, topics, format/structure for training and strategies for implementation will then be developed for ongoing training.

Another way in which MHD supports mental health training to providers of emergency health services is through the coordination of six (6) 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 of loved ones with mental illness; and Mental health professionals.

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

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

While MHD is currently supporting six (6) 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.

Many of the RSNs provide training to emergency room staff to help specifically identify mental health issues and to coordinate care with designated mental health professionals for community diversion.

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 developmental disability on how to better understand, evaluate, triage, and treat this special population. Training is being provided to both Emergency Room staff as well as employees who would be providing inpatient treatment.

MHD is committed to providing training to the State's emergency and health providers. As the first responders, emergency and health providers 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% 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 followed the list of guiding principals developed in 2007 against which all proposals would be measured. To be funded as part of the 20%, activities must:

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

2007’s “20%” focused on supporting the following, which will remain the spending focuses for 2008.

- 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

The primary ways in which these have been supported include:

- Conferences such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethnic minorities, and youth/parent advocacy.

- Trainings for issues or populations such as disasters, assisting consumers in applying for Medicaid, increasing housing access, implementation of evidence-based practices, targeted trainings for geriatric specialists, ethnic minority specialists, 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.

FFY 2006 (actual)	FFY 2007 (appropriation)	FFY 2008 (estimate)
\$8,379,209	\$8,347,942	\$8,347,942

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 than through contracts with regional support networks; and to distribute such funds through a funding distribution formula other than the one established pursuant to RCW 71.24.035 (13).”

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	97,799
Clark County RSN	372,985
Grays Harbor RSN	65,076
Greater Columbia RSN	603,339
King County RSN	1,696,503

North Central RSN	193,934
North Sound RSN	981,777
Peninsula RSN	313,732
Pierce County RSN	715,003
Southwest RSN	89,479
Spokane RSN	410,237
Thurston Mason RSN	262,707
Timberlands RSN	90,866
Total	5,893,436
Total MHBG Award	8,347,942
5% for MHD Admin.	(417,397)
20% of remaining 95% for MHD initiatives & support of MHPAC	<u>(1,586,109)</u>
80% of remaining 95% for RSNs	6,344,436
Minus Legislatively Mandated MIO CTP	<u>(451,000)</u>
Remaining Available to RSN	5,893,436

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 2008 MHBG funding include, but are not limited to:

- Continuing Education and Employment Services to consumers

- Homeless Outreach
- Outreach to Older Adults
- Consumer advocate positions
- Housing subsidies
- Resource Center for non-Medicaid Consumers
- EBP trainings (e.g.: DBT, WrapAround)
- Community based services to consumers in rural areas
- Cultural competency training
- Development of consumer-run programs/ businesses and drop-in centers
- Creation of new residential and hospital diversion resources
- Support to NAMI
- Expansion of co-occurring disorder treatment
- Tribal Youth Suicide prevention
- Stigma reduction
- Development of Club Houses
- 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

Table 4
FY 2008 – FY 2010 MHBG Transformation Expenditures Reporting Form
State: Washington

Number	State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
1	Improving coordination of care among multiple systems	317,564	8,286,182
2	Support for culturally competent services	640,038	433,996
3	Involving consumers and families fully in orienting the MH system toward recovery	200,837	45,000
4	Support for consumer- and family-operated programs, including Statewide consumer networks	790,205	1,658,023
5	Services for co-occurring mental and substance use disorders	376,036	2,104,636
6	Eliminating disparities in access to and quality of care		40,000
7	Support for integrated electronic health record and personal health information systems	20,000	251,000
8	Improving consumer access to employment and affordable housing	338,157	2,126,253
9	Provision of Evidence Based Practices	141,272	15,756,000
10	Aligning financing for mental health services for maximum benefit		20,000
11	Supporting individualized plans of care for consumers		20,000
12	Supporting use of peer specialist	106,353	418,000
13	Linking mental health care with primary care	120,000	2,548,629
14	Supporting school mental health programs	172,500	650,000
15	Supporting early mental health screening, assessment, and referral to services	60,000	75,000
16	Suicide prevention	5,700	
17	Supporting reduction of the stigma associated with mental illness	49,146	45,000
18	Use of health technology and telehealth to improve access and coordination of mental health care	33,815	188,000
19	Supporting workforce development activities	124,813	4,949,000
20	Other (specify)		

Included in consumer and family operated included clubhouse and clubhouse development. Included in consumers and families orienting the MH system toward recovery includes NAMI and consumer trainings.

MHD has included all proviso line amounts (Innovative Services, PATH, DIG, PACT, DMIO) and 4 of our RSNs have attempted to identify PIHP and state only funds however, they do not contract or pay according to these categories . Therefore, all funds labeled RSN/PIHP are estimates.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	76,309	73,466	73,466	88,025	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** #1: Increase Access to Services for Adults with SMI
- Target:** Adults served through the public mental health system: 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	7.55	7.85	5.90	3.50	N/A	N/A
Numerator	766	769	--	--	--	--
Denominator	10,140	9,793	--	--	--	--

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	4.50	N/A	N/A	N/A	N/A	N/A
Numerator	516	N/A	--	--	--	--
Denominator	11,458	N/A	--	--	--	--

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** #4: Increase the number of evidence-based practices received by adults.
- Target:** Establish a baseline of the number of EBPs received by adults throughout the state.
- Population:** Adults
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** Regional Support Networks (RSNs) and MHD will work to increase the number of adults receiving EBP treatment throughout the state.
- Measure:** Number of EBPs delivered by the adult mental health throughout the state (no numerator or denominator required).
- Sources of Information:** 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:** At this time, MHD is unable to capture EBP data by consumer. How to operationalize this indicator is under discussion by DIG.
- 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

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	59.17	N/A	N/A	N/A	N/A
Numerator	0	1,110	--	--	--	--
Denominator	N/A	1,876	--	--	--	--

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

Transformation Activities:

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	10.82	10.60	10.90	11	N/A	N/A
Numerator	8,626	8,148	--	--	--	--
Denominator	79,729	76,863	--	--	--	--

Table Descriptors:

Goal: 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

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 program.

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

Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	20.23	20	N/A	N/A	N/A
Numerator	N/A	26,300	--	--	--	--
Denominator	N/A	130,000	--	--	--	--

Table Descriptors:

Goal: 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

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

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. Data from administrative data sources will not be available until 2008. However, this indicator will be measured using MHSIP survey beginning in 2007.

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (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. This data will be collected on the MHSIP Survey or on annual basis using the questions and methodology proposed by SAMHSA.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: 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

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

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

Measure: Numerator: Number of adults (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: Beginning in 2007, MHD is using the MHSIP survey for this data.

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

Transformation Activities:

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: : 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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase the number of adults and older adults who report improved level of functioning over a fiscal year.

Measure: Numerator: Number of adults (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: Indicator will be measured using the MHSIP survey starting in 2007.

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	10.80	10.60	10.90	11	N/A	N/A
Numerator	8,626	8,148	--	--	--	--
Denominator	79,729	76,863	--	--	--	--

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 any time 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	20.20	20	N/A	N/A	N/A
Numerator	0	26,300	--	--	--	--
Denominator	0	130,000	--	--	--	--

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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 Washington 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 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 the TELESAGE survey in a fiscal year.

Sources of Information: Beginning in 2007, MHD is using the MHSIP survey for this data.

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 and #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #1 and #5.

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	64.40	63.80	64	65	N/A	N/A
Numerator	56,817	54,003	--	--	--	--
Denominator	88,198	84,625	--	--	--	--

Table Descriptors:

- Goal:** #9: Increase family stabilization as evidenced by consumers maintaining housing.
- Target:** The percentage of adults and older adults who maintain their housing over a fiscal year (92.1%).
- Population:** Adults
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- 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 two 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 Washington. 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 #1 & #3. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #1 & 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 agencies and homelessness reduction efforts.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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 adults (18+) who responded to TELESAGE survey in a fiscal year.
- Sources of Information:** Indicator will be measured using the MHSIP survey starting in 2007.
- 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

Transformation Activities:

Name of Performance Indicator: 5.1 Critical Incident Training

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: To improve First Responders' abilities to identify and interact with mental health consumers.

Target: Washington will complete CIT training program.

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

Criterion: 5:Management Systems

Indicator: Complete the CIT training models and curriculum.

Measure: The CIT Training Program will be used by one pilot site in 2008.

Sources of Information: MHD self report.

Special Issues: This program is accomplished in a variety of ways with a variety of community members. MH Transformation Project is working to develop standardized curriculum. Stakeholder comment could delay implementation.

Significance: MHD is committed to improving the quality of services supported through MHBG funding, and is supportive of standardized programming statewide.

Action Plan: Continue to support ongoing training and monitoring of outcomes; updating training for those first responders who have completed various trainings across the state with the goal of a standardized model by 2010.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: 5.1 Research and Quality Improvement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	80	80	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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

Transformation Activities:

Name of Performance Indicator: 5.2 Workforce Development

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	6	6	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	6	6	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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.

This is a joint response. Please see Adult - Establishment of System of Care

However, it is important to note increased attention to children's mental health and the passage of SSHB1088 will lead to an enhance service package for children, youth and their families. This legislation is described elsewhere in the document.

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.

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

The following EBPs are available in various communities across the state:

- Multidimensional Treatment Foster Care (MTFC)- 5 sites (MHD, CA and JRA)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) - 41 sites in 13 RSNs
- Multi-systemic Treatment (MST) 4 sites (MHD, JRA)
- Family Integrated Transitions (FIT) 2 Sites (JRA)
- Functional Family Therapy (FFT) 2 Sites (JRA)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT) (MHD, JRA)
- Aggression Replacement Therapy (ART) (JRA)
- Multi-Family Group Family Psychoeducation (MFG) (MHD- CSTC)

Washington

Child - Transformation Efforts and Activities in the State in Criteria 1

Child - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

The passage of HB 1088 includes efforts in all six of the transforming goals. Additionally, the use of EPSDT and EBPs support goals 2 through 5. The STI work will look at housing and employment opportunities for families and for transitional age youth. The work that is occurring with the school districts and the mental health system will address goal number 1. As HB 1088 and other EBP pilot sites begin to collect data the MHD will be able to use this technology to better use data to drive mental health care for children, youth and their families. MHD also hopes that some of the data collected by SAFE-WA, the statewide family network, will be coordinated with this data to create a more robust picture of the system of care.

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 **77,426 and 92,911**. 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 2006.

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

Estimated SED	Total Children Served	Estimated SED Served	Quantitative Target
77,426 – 92,911	37,956	25,508	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 FY2006 as well as the projected number served in FY2007. 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. FY2007 & 2008 projected service numbers are not yet available.

Projected Penetration Rates				
Time Period	FY06 Served		FY07 & FY08	
SMI Status	SED	Total	SED	SED
Children Served	34,092	36,124		
WA Child/Youth Population	78,049-93.658	1,522,477		
Penetration Rate		2.4% of all children/youth in Washington State are served by the Mental Health Division		

Washington

Child - Transformation Efforts and Activities in the State in Criteria 2

Child - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformative efforts (goals 1, 3, & 4) include partnering with Department of Health, Behavioral Health Risk Surveillance Survey, in both 2006,2007 and plan to do so again in 2008. MHD is currently doing an analysis of the 2006 data for estimates of depression and anxiety disorders and those estimates will be used by the workgroup on early intervention and to guide transformation grant planning and activities.

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 and youth 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 and youth in their regions. Emphasis is given to the expectation that services for children will be well coordinated on every level. As per SAMHSA requirement, MHBG funds are not expended to provide any services other than comprehensive community mental health services.

Services for children and youth are integrated throughout the mental health system and allied system of care and are available statewide. The RSNs are responsible for coordinating the care of children and youth served by multiple systems such as substance abuse, developmental disabilities, juvenile corrections, child welfare, Medicaid-funded healthcare, and the schools. The RSNs and their providers utilize multidisciplinary teams to coordinate care. A growing percentage of children and youth are receiving wraparound services. Both of 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 public assistance. Washington State also has a Basic Health Care Program to provide insurance coverage to families when there is none from the employer. Children in Basic Health have the same coverage as Medicaid eligible children. Additionally, there are also several community clinics that provide service on a sliding

scale basis for children of families with limited resources and two RSN have in their service area free mental health clinics.

Governor, Christine Gregoire, has embarked on a note-worthy effort to ensure every child in Washington State has healthcare coverage by 2010, 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. Of particular note is that the 2007 Legislature moved the implementation date of mental health parity ahead.

Housing and residential needs persist across all ages and all ethnicities. While it is preferable to serve children in their homes within the structure of their natural supports, sometimes children require the specialized care of inpatient services at the State Hospital's Child Study and Treatment Center (CSTC) or one of the other Children's Long-term Inpatient Program's (CLIP) residential facilities. Screening and referral protocols are in place for these services to improve access.

In addition to the services funded by MHD and other state agencies for the provision of system-wide services to children, the Mental Health Division funds mental health parent programs such as the Community Connector project and SAFE-WA which provides an essential link in the continuum of care that is often overlooked by formal systems. Parents have developed ways to survive the day to day stresses of caring for a special-needs child/youth. The Community Connectors and SAFE-WA allows for parents to help other parents who find themselves in a similar situation. These parents must have children, grandchildren or foster children with complex needs and be willing to network within their community.

Of special note is the forming network of dads providing support to each other. For many years, the MHD parent network had one or two dads. Staff met with dads alone at training to get their input on what they thought the dads might need to come together and support each other. Staff listened and tried to meet the need. A new organization has formed WADADs. They have had three trainings and are planning the fourth. Not only do they learn from each other but they have started to structure these week-end trainings to address the tough issues of raising children and youth with complex needs. To date, they have supported each other with the development of child specific IEPs and have supported and mentored each other in the CLIP application process. One dad has now volunteered to be the leader of the legislative committee of SAFE-WA. The training for the dads is always full; we have had waiting lists, and had to turn dads away. The dads have established a website <https://www.wadads.org> where they post information, training events and have a chat room. In 2008, they are discussing more regional meetings with one or possibly two larger meetings.

Many efforts have been made to improve the continuum of services to children across all social and health 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.

An 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 continues to focus on workforce development. By supporting specialized training and certification for clinicians, significant workforce enhancement can be achieved without disruption to usual funding levels and service priorities. In addition to the workforce development SAFE-WA provided training on the EBPs to parents and youth on implementation from their point of view.

While the Children's Mental Health Initiative has not been as visible over the last year the recommendations continue to move forward.

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 MHD and the Mental Health Transformation project are working together with the Office of the

Superintendent of Schools (OSPI) and an advisory group of mental health providers, educators and parents to develop and conduct statewide train- the- trainer sessions focusing on public education and publicly funded community mental health service coordination.

Individual service plans (WAC 388-865-0435) for children and youth require coordination with a child's IEP whenever it is possible and feasible. For children under three there is a requirement to that the plan must be integrated with the individual family service plan (IFSP) if it exists.

The individual service plan must look at all life domains and plan accordingly. Life domains are:

- Housing;
- Food;
- Income;
- Health and dental;
- Transportation;
- Work, school or other daily activities;
- Social life; and,
- Referral services as appropriate to treatment such as substance abuse.

Children and youth who are Medicaid enrollees also have the added services provided under EPSDT. This allows for a coordinated system of care between primary care, mental health, substance abuse, dental, hearing and vision. HRSA hosts an EPSDT improvement team quarterly to increase the utilization of EPSDT.

An innovative program is the Access to Baby and Child Dentistry. This initiative is to increase access to dental services for Medicaid eligible infants, toddlers and preschoolers.

Co-occurring services are required for youth through RCW 70.96 which was described in the Adult plan. This requires screening and assessment to identify the most common types of co-occurring disorders. Training occurred statewide on the GAIN-SS and use of the tool began in January 2007.

Children and youth have the same services available to them as adults and older adults such as: crisis, ITA, case management, community outpatient and inpatient services. In addition, the RSNs provide many coordinated services supporting resiliency and transformation through their federal block grant funds to children, youth and their families. A few are listed below:

- Tribal youth suicide prevention
- Peer support
- NAMI parent to parent training
- suicide prevention training
- Wrap Around training
- Parent Partner activities

- Psychiatric evaluation and medication management for SED youth not covered by Medicaid
- Children's crisis outreach
- Parent education
- Underinsured school age children with counseling services
- Day support program in the school
- Parent ran organizations
- EBP implementation for the Tribes

Washington

Child - Geographic Area Definition

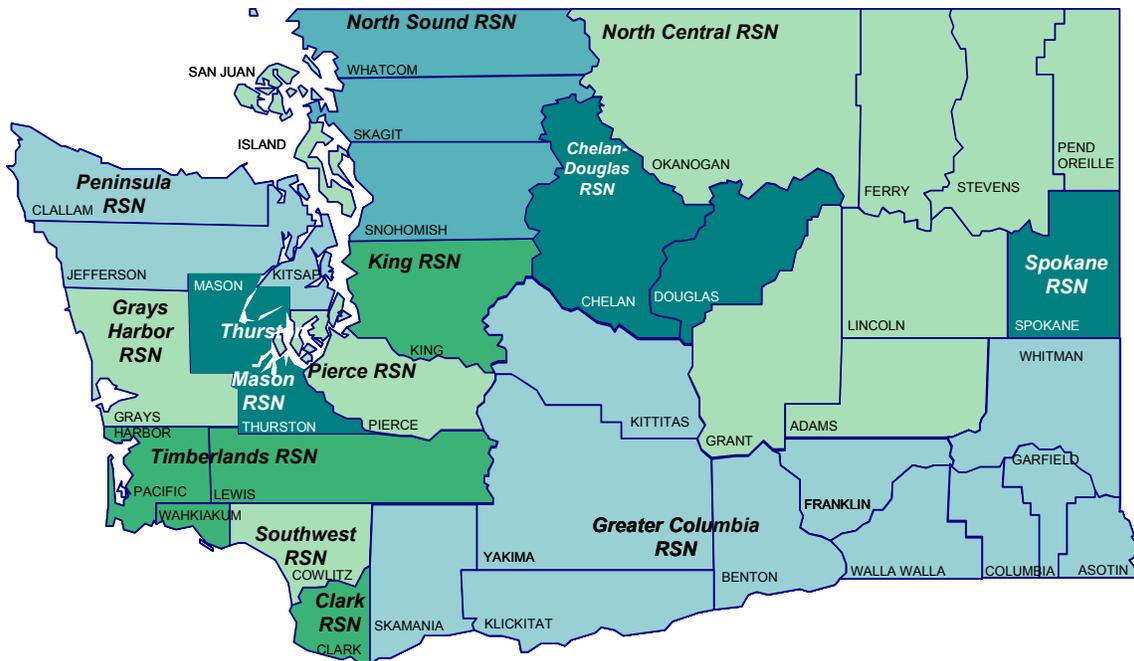
Child - Establishes defined geographic area for the provision of the services of such system.

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.

Washington State Regional Support Networks (RSNs)



Washington

Child - Transformation Efforts and Activities in the State in Criteria 3

Child - Describes mental health transformation efforts and activities in the State in Criteria 3, providing reference to specific goals of the NFC Report to which they relate.

The coordinated efforts with Children's Administration, JRA, the DASA SIG grant and the schools are assisting us to meet the NFC goals 1, 2, and 4. These efforts are increasing the awareness of mental health issues, the importance of consumer voice, and the importance of early intervention. The current co-chair of the children's subcommittee of the MHPAC is an employee of the Department of Health which is strengthening our relationship and making early intervention and disparities in mental health services a part of the larger discussion. New access to physical health and dental health will meet goal number 1 and 2 of the NFC.

Active partnering with the children's mental health staff in the MHD and the MHT-P will meet goals 1-6 as the comprehensive transformation plan is implemented.

Training efforts on EBPs and Promising Practices will increase workforce development and ensure work toward NFC goal 5.

Washington

Child - Outreach to Homeless

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

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

Washington

Child - Transformation Efforts and Activities in the State in Criteria 4

Child - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

please see the adult plan

Washington

Child - Resources for Providers

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

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

Washington

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- Outreach to Homeless

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

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

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	38,927	36,005	37,560	37,580	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: Increase Access to Services for Children and Youth with SED

Target: Number of children and youth served through the public mental health system: 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:

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, Ethnic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping children and youth obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers/families served by multiple agencies. Encourage early prevention and intervention activities through collaboration with schools, foster care system, and juvenile justice.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	8.02	5.89	6.60	5.50	N/A	N/A
Numerator	70	46	--	--	--	--
Denominator	873	781	--	--	--	--

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 – 5.5%

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 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:

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2.80	N/A	N/A	N/A	N/A	N/A
Numerator	29	N/A	--	--	--	--
Denominator	1,036	N/A	--	--	--	--

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #5: 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy
(Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	65.30	N/A	65.40	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

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).

Special Issues: WA has only conducted the Child/Youth MHSIP every other year, with the off years being used to conduct Adult surveys. Beginning in 2007, however, the MHSIP will be conducted on a yearly basis for both populations, per SAMHSA requirements re: yearly reporting on this NOM.

Significance: This is a required National Outcome Measure (NOM). 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

Transformation Activities:

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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) surveyed in the MHSIP survey.
- Sources of Information:** MHD-Consumer Information System (CIS).
- Special Issues:** WA has measured other activities using the MHSIP survey such as school performance in the past. However, with the 2007 MHSIP survey WA state is using the new DIG questions to measure this indication.
- 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	15.90	13.30	15	13	N/A	N/A
Numerator	5,920	4,988	--	--	--	--
Denominator	37,107	37,413	--	--	--	--

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: 13.3%.
- 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:** Data for fiscal year 2007 will not be available until November 2007 from Administrative data sources. However, this indicator will be measured using the 2007 MHSIP survey.
- 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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: MHSIP survey beginning in 2007.

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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	98.20	98.30	98.30	98.50	N/A	N/A
Numerator	24,384	24,885	--	--	--	--
Denominator	24,885	25,354	--	--	--	--

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: 98.3%
- Population:** Children with Significant Emotional Disturbance (SED)
- Criterion:** 3:Children's Services
- Indicator:** RSNs will work with providers to ensure family stabilization and living conditions improve for children and youth as evidenced by decreasing the number of children and youth who become homeless as some point in the past year.
- 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:** 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

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	0	N/A	--	--	--	--

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.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: 5.1 Develop/Enhance skilled workforce

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: To improve First Responders' ability to identify and interact with mental health consumers.

Target: Washington will complete CIT training program.

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

Criterion: 5:Management Systems

Indicator: Complete the CIT training models and curriculum.

Measure: The CIT Training Program will be used by one pilot site in 2008.

Sources of Information: MHD self report.

Special Issues: Thsi program is accomplished in a variety of ways with a variety of community members. MHD Transformation Project is working to develop standardized cirriculum. Stakeholder comment could delay implementation.

Significance: MHD is committed to improving the quality of services supported through MHBG funding and is supportive of standardized programming statewide.

Action Plan: Continue to support ongoing training and monitoring of outcomes; updating training for those first responders who have completed various trainings across the state with the goal of a standardized model by 2010.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: 5.1 Research and Quality Improvement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	80	80	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

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, Children and Youth with Serious Emotional Disturbance.
- Criterion:** 5:Management Systems
- Indicator:** Overall quality of services 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 MHPAC.
- Special Issues:** Current lack of Peer Review policy and procedure to meet requirements called out in funding agreement resulted in State Auditor findings 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: 5.2 Workforce Development

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	6	6	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

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

Population: Adults, 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 provides excellent mental health services that align with the principles of Recovery and Resiliency and that move the system toward Transformation.

Action Plan: Continue to support MHPAC activities including opportunities to attend national conferences. 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: 5.3 Recovery Oriented System of Care

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	6	6	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

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

Target: Support 6 trainings in Recovery and Resiliency.

Population: Adults, 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

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

**Mental Health
Planning &
Advisory
Council**

Vision

Plan, Advocate, Evaluate

Mission

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

Cathii Nash, Chair
3908 East 17th
Spokane, WA 99223
(509) 536-4136

July 21, 2007

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 11, 2007 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 2008.

Council members received the draft application a week before the Council meeting. During the July 11th meeting, Ronda Kenney, MHBG State Planner, reviewed the plan with the members. The Council members recommended several changes which were incorporated by the State Planners, Ronda Kenney and Judy Gosney.

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 four 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 FFY2008 / 2010.

The Council would like to take this opportunity to express our appreciation to the Mental Health Division Planners, who walked the Council through the new SAMHSA's format for the plan and application.

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,



Cathii Nash, Chair

cc: Richard E. Kellogg, Director, Mental Health Division
Judy Gosney and Ronda Kenney, MHBG State Planners

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.