Our Journey of Mental Health Transformation in Washington State: An Assessment of the Washington State Mental Health Transformation Project

September 2010

submitted to

Governor Chris Gregoire

from

The State of Washington

Mental Health Transformation Work Group

TRIWEST GROUP
Seattle, WA

Funding for this report was made possible by the Mental Health Transformation State Incentive Grant Award No. 6 U79 SM57648 from the Substance Abuse and Mental Health Services Administration (SAMHSA). The views expressed in written seminar and/or conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Table of Contents

Executive Summary

Washington State was awarded one of seven initial Mental Health Transformation State Infrastructure Grants in September 2005, beginning a critical five-year stage of Washington State's ongoing journey of mental health system transformation. As of September 2010, that part of the journey draws to a close, and this report seeks to assess its accomplishments. The grant application committed to a bold vision: "The new mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and as a condition from which people can and do recover." From this, the project identified three interrelated statements to define success: (1) **Individuals** recover mental wellness; (2) The **system** transforms itself to that end; and (3) The **community** transforms itself to that end.

This report tells the story of Washington State's journey of mental health transformation from the perspective of the people who led and took part in it. It incorporates the results of the federal government's independent evaluation and centers on interviews with members and key staff of the Transformation Work Group (TWG), as well as analysis of 129 reports related to the Mental Health Transformation Project and over 1,075 recommendations within them.

What We Accomplished. Over 140 contracts and memoranda of understanding yielded:

- **Over 75 substantive policy and organizational changes within state government**, including 44 specific policy changes (33 involving financing policies) and 33 organizational changes;
- **274 specific initiatives, across 15 priority areas,** grounded in the six original goals of the 2003 President's New Freedom Commission, plus two Washington State specific goals;
- **Nearly 9,000 members in consumer, youth and family run networks**; and
- **Nearly 24,000 people trained in the behavioral health system workforce**.

The Process of Change. The primary vehicle for change was the TWG and the multiple iterations of work groups, task forces, and, ultimately, White Space Groups that it coordinated and oversaw. The TWG reported to Governor Gregoire and consisted of 33 member organizations representing the major state departments and sub-agencies responsible for delivering publicly-funded mental health and related support services to publicly eligible individuals. It also included representatives of the Governor's Office, Tribes, local government, consumers, youth, family members, advocacy organizations, RSNs, and provider organizations.

- Instead of following a pre-ordained set of goals and implementation steps, a **principle-based process of change** guided the TWG as it carried out its work. Commitment to these principles was maintained throughout the project and viewed as key by participants.
- TWG members consistently divided the process of the grant activities into **two broad phases**, with the critical pivot point being the April 2008 TWG meeting where the White Space Groups were commissioned. The first phase focused primarily on stakeholder engagement, knowledge accumulation, and prioritization; the second phase centered on the actions of the White Space Groups in advancing their self-defined priorities.

- Nearly every key informant commented on how critical they found the project leadership's **commitment to an open and involving process** for TWG members and the constituencies they represented, backed by the support of DSHS leadership and the Governor's Office.
- Most people interviewed cited how **promotion of shared responsibility** contributed to a broader view of services across publicly-funded programs and the goal of "broadening us."
- A variety of related activities that were not initiated through formal MHTP processes created **important opportunities for synergy** that contributed to change.
- Progress in **relationship-building** was key, both among the TWG members and across state government departments and the broader community. Many underscored transformation in personal attitudes/beliefs through the input of consumers, youth, and family members.
- Grant activities encompassed **public-private partnerships**, including private partners at the payer and provider level, and partnerships with faith-based organizations.
- Many underscored the value of the multiple venues of **cross-agency training** offered.
- Many noted how the MHTP's collaborative processes allowed agencies to **work together more closely despite the serious financial challenges facing the state** and to better coordinate both unavoidable cuts and targeted opportunities to redirect priorities.

Key Results Achieved. All sources highlighted the following results:

- **Establishing recovery, resiliency, and wellness as the core of the system**, as understanding evolved into practices at the heart of day-to-day operations and ongoing planning.
- Transformation of the **behavioral health / criminal justice system interface.**
- Support of a range of activities to help DSHS respond to the opportunities of health care reform and mental health parity and **promote behavioral health / primary care integration**.
- Establishing a broad vision for **transformed children's behavioral health services**.
- Performance management processes, particularly the **Mental Health System Performance Monitoring Dashboard,** to monitor and guide the transformation after the grant.
- **Reduced stigma** by addressing media depictions of persons with mental illness.
- Additional achievements, including promotion of **consumer/family-run organizations**; expansion of **housing resources**; enhanced collaboration to **promote employment;** the shift to **a population-based perspective on mental health**; the **promotion of prevention in school settings**; expansion of **intensive service availability**; many **practice changes at the provider level**; **supports for veterans**; and **enhanced services for Youth in Transition** (YIT).

What We Learned. Knowledge development, synthesis, and incorporation into policy were core activities and an enduring achievement of the MHTP, with 129 reports and over 1,075 recommendations made primarily in the areas of (1) Recovery and Peer Delivered Services for Adults and Older Adults, (2) Children's Health Services, (3) Addressing Health Disparities, and (4) Integrated Care. The TWG members and staff also emphasized their personal journeys of awareness, education, and changed attitudes, including increased **understanding of recovery and resiliency** at a practical level and **appreciation for necessary complexity** in other systems.

What We Will Sustain. While much has been learned and accomplished, key informants unanimously observed that there is still a tremendous amount to do. Organizational change in complex systems is multi-determined and dependent on sustained organizational commitment over a multi-year period. Key informants expressed a cautious, but optimistic sense that the process of cross-training, relationship building, data-driven quality improvement, consumer/youth/family-driven culture change, and provider adoption of evidence-based and promising practices was firmly entrenched, as well as a wide range of specific initiatives. Other priorities for ongoing support (and hope for eventual sustainability) included: **ongoing transformation-related performance and outcome tracking** (such as the dashboard), forums for **multi-agency planning for agency and community leaders**, agency **staff dedicated to the work of coordinating multi-agency planning and implementation efforts,** the opportunity and the necessity of **integrating mental health transformation efforts into health reform**, continuation of efforts to **promote prevention and encourage a population-based perspective**, and concern that the attention of the formal mental health system was at risk of **being diverted away from the needs of their target populations in the absence of ongoing efforts**.

Conclusion. In reference to the interplay of transformation and health reform, one of the leaders interviewed for this report cautiously concluded: "The mental health needs for people with the highest needs, while small in number compared to all people with mental health needs, need special advocacy. It's not just about what we purchase for them; it's about understanding their place in the community and how to build it." In the State of Washington, senior state agency leaders, their key staff, and community leaders representing consumers, youth, families, providers, and counties together have shown that each individual's mission to serve others can be better accomplished by working together. There is utility in transformation, and that is why it has worked and will be sustained. Below are bold statements by the independent federal evaluator that reflect powerfully on the enduring influence of that work.

- *Child Welfare*: Very largely as a result of Transformation Grant activities, the concept of trauma informed care is now deeply rooted in that agency and is certain to be retained . . .
- *Corrections:* The achievement of an ongoing collaboration to address behavioral health reentry issues is widely recognized by diverse parties, and there is a general consensus that this will continue . . .
- *[Child, Youth and Family] Organizations*: . . . increased *inclusion* of these groups having meaningful input into policy decisions, not only in the mental health agency but a majority of other agencies, is a very real achievement . . . that is unlikely to be reversed.
- *Housing*: . . . the Housing Consortium . . . will continue . . . the inter-agency collaborations provide such benefit to all parties with relatively little investment of resources . . .
- *Vocational Rehabilitation*: . . . a profound change, perhaps the most extensive of any agency . . . in the level of awareness of mental health issues and the recognition that . . . [they are] a part of the mission. . .
- *Multi-Agency Youth in Transition:* This working group, consisting of high and mid-level representatives of a comprehensive range of agencies that provide services related to youth (child welfare, juvenile justice, education, mental health, developmental disabilities) appears almost certain to continue . . . due to the effectiveness in using a relatively small commitment of resources to address long-standing problems . . .

Introduction and Background

In September 2005, Governor Chris Gregoire received notice from the federal Department of Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), that Washington State had been awarded one of seven initial Mental Health Transformation State Infrastructure Grants. Washington State was ripe for change thanks to many factors. The State's Joint Legislative and Executive Mental Health Task Force had worked to build awareness and consensus to drive many changes, including the writing of the grant application. 2005's Engrossed Second Substitute Bill 5763 had, among other policy changes, also established the option for counties to levy a 1/10th of one percent sales tax dedicated to new and expanded mental health and chemical dependency treatment services and therapeutic courts. In this context, a critical five-year stage of Washington State's ongoing journey of transformation had begun. Today, in September 2010, that part of the journey draws to a close, and this report seeks to assess its accomplishments.

The grant application itself committed to a bold vision: *"The new mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and as a condition from which people can and do recover."* Stakeholders in Washington State translated this vision into three interrelated statements to define successful transformation:

1. **Individuals** recover mental wellness.

2. The **system** transforms itself to that end.

3. The **community** transforms itself to that end.

This report examines our journey of individual, system, and community level transformation. It does so from the perspective of the people of Washington State who made that journey together, informed by the perspectives of the independent evaluation conducted by the federal government, interviews with Transformation Work Group members, and analysis of 129 reports and over 1,075 recommendations developed during the tenure of the project. The purpose of this report is to document three sets of results:

1. What was accomplished through the project,

2. What was learned by the people who took part in it, and

3. What will be sustained in the years that follow?

Methodology

This report tells the story of the journey of mental health transformation from the perspective of the people of Washington State who led and took part in that journey. More detail on its specific methodology may be found in Appendix Two. While it is informed by and incorporates the results of the independent evaluation carried out by the federal government, its focus is on the experience of transformation, drawing on three primary sets of information:

- Interviews with 23 members and key staff of the Transformation Work Group (TWG), the Governor-appointed body that led this stage of the journey of transformation (see Appendix One for a list of current and past TWG members);
- Reviews of 129 reports by mental health system stakeholders, either initiated by the Mental Health Transformation Project (MHTP) or related to its work, and over 1,075 recommendations included within them; and
- The final draft of the August 2010 summary report of the federal government's independent evaluation of the transformation grant, which provides an external view of the most significant grant activities occurring in the final two years of the grant and key achievements from prior years.

What We Accomplished

The Numbers and the Facts

Given the sheer breadth of the activities and initiatives of Washington State's MHTP, there is a temptation to focus on the numbers. They are certainly impressive, and grew out of over 140 contracts and memoranda of understanding to distribute funding to a wide array of stakeholders, researchers, subject matter experts, and state agencies to promote transformation activities. They are summarized below.

Washington State Mental Health Transformation Accomplishments

- **Over 75 substantive policy and organizational changes within state government**, including 44 specific policy changes (33 of which involved financing policies) and 33 organizational changes
- **274 specific initiatives, across 15 priority areas,** grounded in the six original goals of the 2003 President's New Freedom Commission, plus two additional Washington State specific goals focused on housing and employment
- **Nearly 9,000 members in consumer and family run networks,** including the widely acclaimed Youth 'N Action chapters for youth in transition and multiple consumer- and family-run initiatives, such as Partnerships for Action Voices for Empowerment (PAVE),

National Alliance on Mental Illness (NAMI) chapters, and two consumer-run organizations just awarded federal grants in August 2010 (SAMHSA Statewide Consumer Network Grants) to expand their grassroots consumer organizing efforts to other communities in the state (Consumer Voices are Born [CVAB], and Mental Health Action [MHA])

- **Nearly 24,000 people trained in the behavioral health system workforce** through July 2010 in a wide variety of areas, including crisis intervention training for first responders, training for adult and youth consumers in sharing their stories of recovery with others, training in recovery and resiliency (particularly the initial rounds of recovery and resiliency trainings), training in Tribal communities, Mental Health First Aid training, cross-system training for vocational rehabilitation (in Wellness Recovery Action Plans) and correctional staff with behavioral health system staff, and a variety of specific service delivery methods, including postpartum depression screening, peer counselor training, wraparound service coordination (including adaptations for Tribal communities), trauma-informed care in schools, services for older adults (PEARLS, depression screening), and parent community connectors, among many others

Year One. Also important are the facts of what transpired. Year One (October 2005 through September 2006) began with an initial meeting of what would evolve into the Community Transformation Partnership, a "coalition of coalitions" comprised of 17 consumer, family, youth and advocacy organizations that guided the TWG and, according to many interviewed for this report, held the heart of the transformation process throughout. Year One milestones included:

- **October 2005 –** The grant is awarded and the initial meetings held. The Community Transformation Partnership (CTP) first convenes.

- **November 2005 –** Ken Stark begins his tenure as the initial MHTP Director.

- **December 2005 –** The Transformation Work Group (TWG) holds its first meeting.

- **February and March 2006** – Over 40 public forums and listening sessions (some occurred later in 2006) are held to gather input from hundreds of system stakeholders across the state, yielding over 6,000 pages of written testimony.

- **Early 2006 –** The CTP works with Jill San Jule (and later, Mary Jadwisiak and others) to offer Recovery and Resiliency Trainings that will eventually train over 740 people across the state.

- **April 2006** – 27 initial outcomes based on the input from the public forums are submitted to the TWG for review, and all are approved.

- **April and May 2006** – Six Task Groups are convened and develop strategies based on the initial outcomes.

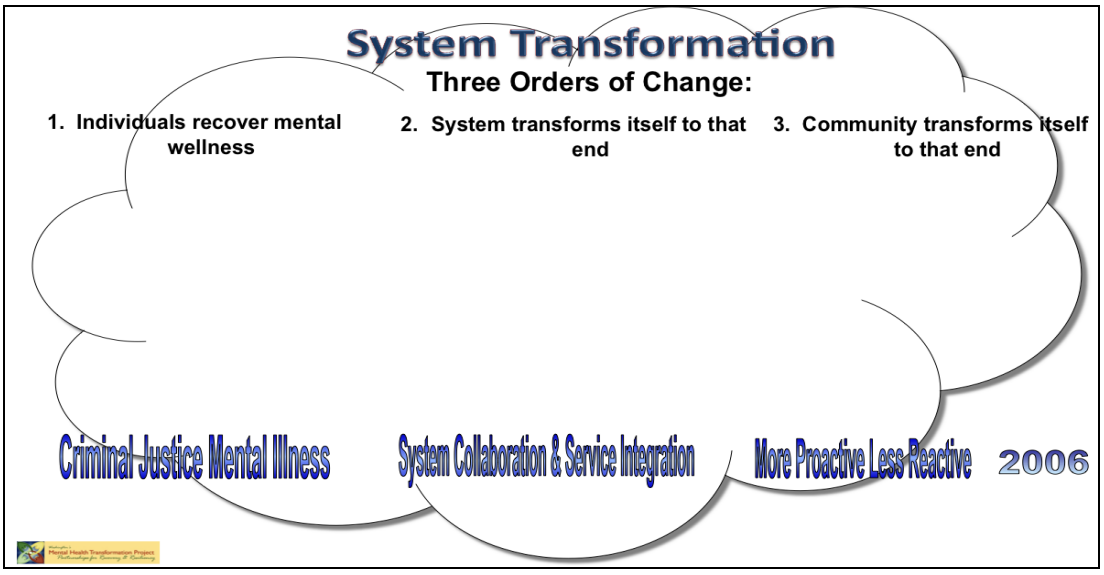
- **June 2006** – The TWG reviewed the Task Group strategies.

- **August 2006** – The TWG developed the initial Comprehensive Mental Health Plan to guide MHTP activities, and this was submitted by Governor Gregoire at the end of Year One.

- **October 2006 –** Governor Gregoire requested that the TWG establish a smaller number of focused priorities, and the TWG prioritized three outcomes: (1) increased system collaboration and service integration, (2) a shift from a reactive to a proactive system, and (3) a decreased number of people with mental illness entering the criminal justice system.

The gap between these three initial outcomes and the ultimate success statements for the project is captured in the figure below.

Figure One: Transformation Progress – End of Year One



Year Two through Middle of Year Three. The next 18 months (October 2006 through September 2007) involved translating the three priority goals into action and continuing the process of input and analysis to shape broader change. Key events included:

- **Winter 2006-07 –** The TWG developed 94 strategies to accomplish the three priority goals. These strategies evolved over early 2007 and came to be known as "white spaces" – the gaps between existing systems that must be knitted together to achieve transformation.

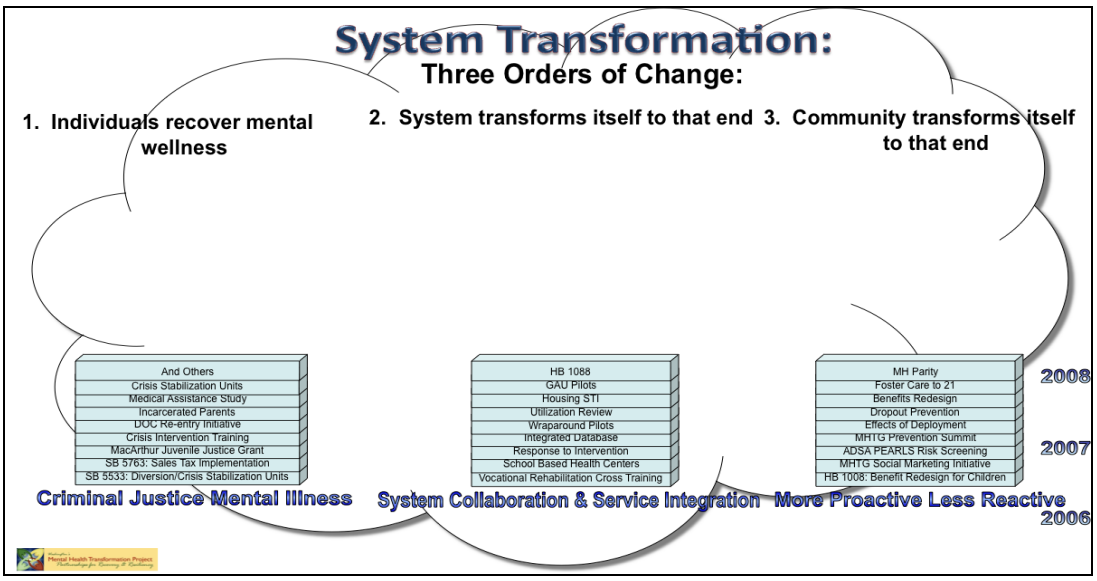
- **2007 Legislative Session –** The legislature passed sixteen (16) pieces of legislation and budget provisos related to mental health transformation, including an expanded mental health parity law, expanded eligibility and benefits for publicly funded behavioral health services, and authority to expand key services (promotion of children's evidence-based practices, clubhouse services for adults, school drop-out prevention, and criminal justice system diversion for adults).

- **Summer/Fall/Winter 2007 –** Dozens of reports, work groups, and studies were carried out to inform the work of transformation. Key accomplishments included the joint vocational / mental health cross-training initiative and the work on social marketing and outreach to media leaders to attempt to change how mental illness is depicted in the media.

- **2008 Legislative Session –** Five new pieces of legislation and budget provisos were passed, addressing promotion of consumer/family-run organizations, funding for Mental Health First Aid, increased accountability for Regional Support Networks (RSNs), and the 1/10th of one percent sales tax funding for mental health, chemical dependency and therapeutic court services.

The figure below shows the progress toward the three success statements achieved through these many initiatives, as well as the significant gap that remained.

Figure Two: Transformation Progress – Year Two Through First Half of Year Three



Second Half of Year Three. Many stakeholders who were interviewed reported that the TWG meeting held in April 2008 was a critical moment of decision for the TWG. Several described it as a turning point for the activities of the grant where the emphasis shifted from what could be done to what will be done. The meeting centered on a critical review of progress to mark the half-way point of the grant period. Progress was assessed, and TWG members were asked what they were willing to "sign up" to accomplish for the last half of the grant. Sixteen priorities were identified, and eight "White Space Groups" were formed to advance the work of transformation: (1) Criminal Justice, (2) Housing, (3) Employment, (4) Older Adults, (5) Integration of Care, (6) Prevention, (7) Youth in Transition, and (8) Role of Peers.

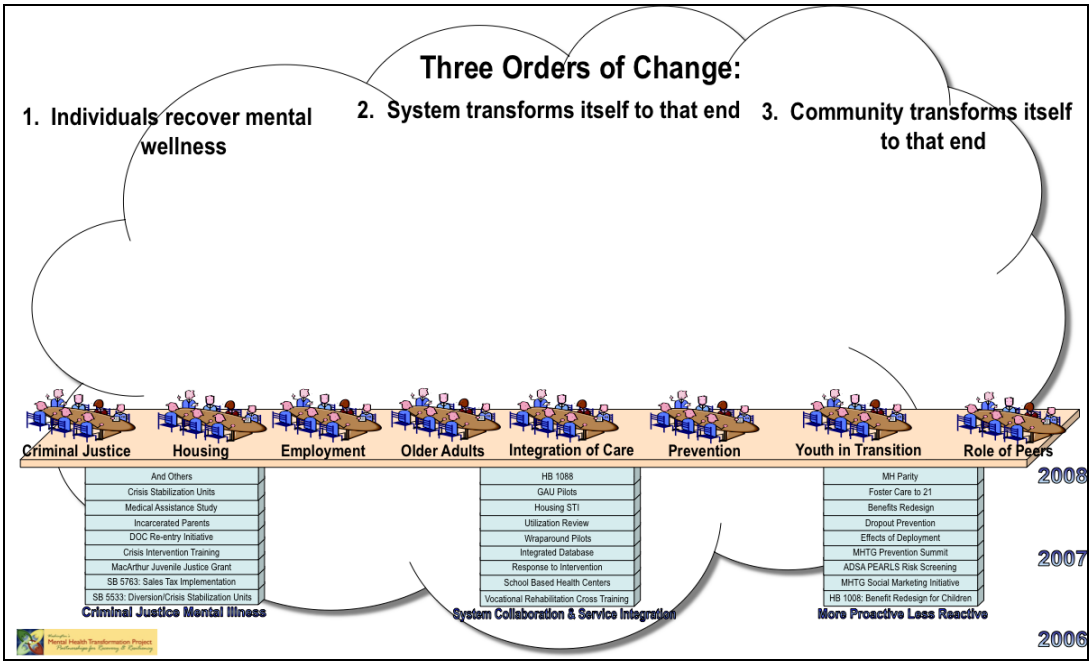
In June 2008, Ron Jemelka was named MHTP Director, succeeding Ken Stark, and the focus of the MHTP was firmly centered on supporting the work of the White Space Groups. The importance of this critical shift to empowering the White Space Groups was emphasized by most people interviewed, and it was noted as key to the project's overall accomplishments. Through the White Space Groups, a framework for success was established, prioritizing three orders of change as the end goals of transformation:

1. Individuals recover mental wellness,

2. The system transforms itself to that end, and

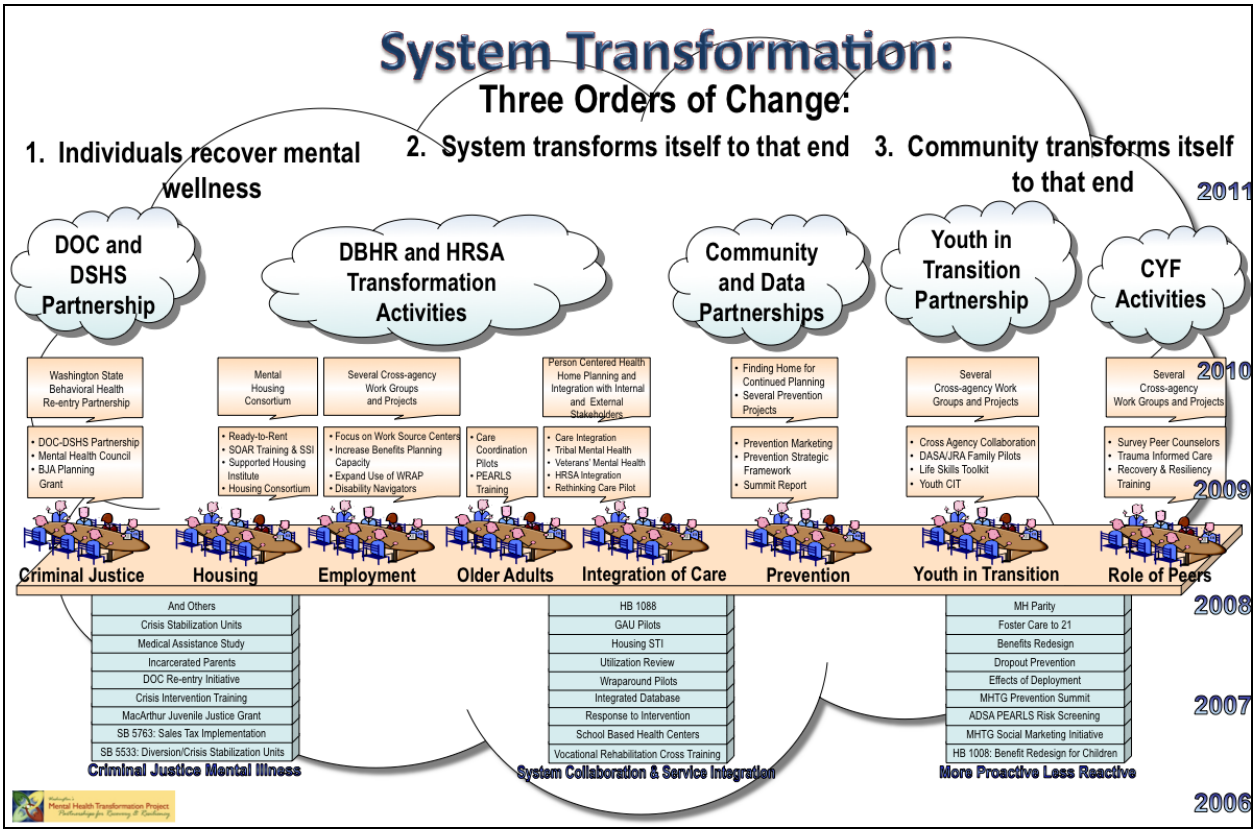
3. The community transforms itself to that end.

Figure Three: Transformation Progress – Second Half of Year Three



Years Four and Five. The White Space Groups advanced 28 priority initiatives across the final two years of the project, summarized in the figure below. The majority of the accomplishments detailed in this report were carried out in that time period. In Year Five, the work of the White Space Groups continued and transitioned into initiatives that will be sustained beyond the grant period. These initiatives include the Washington State Behavioral Health Re-entry Partnership between the Department of Social and Health Services (DSHS) and the Department of Corrections (DOC), the Mental Health Housing Consortium, DSHS Person Centered Health Home Planning and Integration, and various work groups and cross-training in the areas of vocational rehabilitation, youth transitions, services for older adults, veteran's mental health, expansion of efforts to include faith-based partners, and the incorporation of mental health within Washington's broader public health "agenda for change."

Figure Four: Transformation Progress – Years Four and Five



But while the numbers and the facts are impressive, they do not in themselves tell the actual story of transformation. To understand that story, we need to look more closely at the change process and key results that underlie these numbers.

The Process of Change

The primary vehicle for change across the five years of this grant was the Transformation Work Group and the multiple iterations of work groups, task forces, and, ultimately, White Space Groups that it coordinated and oversaw. The TWG reported to Governor Gregoire and consisted of 33 member organizations representing the major state departments and sub-agencies responsible for delivering publicly-funded mental health and related support services to publicly eligible individuals. The TWG also included representatives of the Governor's Office, Tribes, local government, adult consumers, youth, family members, advocacy organizations, RSNs, and provider organizations.

The TWG carried out its work through a principle-based process of change. Many key informants noted how important it was to them that the MHTP was based on a set of principles to guide working together, rather than a pre-ordained set of system goals and associated implementation steps. These principles are defined below.

MHTP Principles to Guide Change

A shift from illness to recovery/resiliency models

Increased consumer, youth and family input

Increased coordination across systems

Increased focus on outcomes

Opportunistic management of the transformation process that sought to leverage related initiatives across state government to build synergy for system change:

- Creating awareness, momentum, and expectations for change,
- Identifying collaborative priorities,
- Building and supporting coalitions,
- Seeding innovation and opportunity,
- Helping involved persons become change agents and problem solvers, and
- Using data to build knowledge and drive change.

Stakeholders consistently reported that the commitment to these principles was maintained across the entire five-year grant period. They also described several key dynamics in how those principles were realized.

A commitment to an open and involving process. Nearly every key informant noted how critical it was that the project's leadership was committed to maintaining an open and involving process for TWG members and the constituencies they represented. Many also noted the importance of having this commitment backed up by the evident support of DSHS leadership and the Governor's Office. It is clearly noteworthy that many of those interviewed described the Community Transformation Partnership – 17 consumer, family, youth and advocacy organizations that guided the TWG – as a main driver of the transformation achieved and one of the project's most important enduring achievements.

Key informants repeated themes such as "transparency", shared control, a "rare opportunity for collaboration," an opportunity to "think differently," and a "safe place where people have a sense of trust." Others noted how the process was centered on "facilitation and convening," emphasizing that the change flowed from both the process of bringing people together and the fact that people were willing to come to the table. Many observed that the direct involvement and evident commitment of senior leaders in each agency and sub-agency involved in the TWG was critical to this process, as much as the commitment of the MHTP leadership to the principles of open involvement. One person described the process as "artfully inclusive and realistic." The independent federal evaluation reinforced the input of people interviewed for this report, focusing its process findings on the importance of involving "champions," those "persons who are already committed to the process of change in the area of mental health services or who have the potential to become such" with the appropriate supports. The MHTP clearly seemed to facilitate that process.

Promoting shared responsibility. Nearly all of the people interviewed reported a shift in how they viewed the populations they served. Most noted that they began with a more limited focus on the particular subgroup their agency was chartered to serve. Then, through the process of the grant, they reported movement toward a broader view of trying to promote effective services across publicly-funded programs. One leader described the goal of system change as "broadening us."

> I was there to represent youth; I wanted to speak from my own experiences as a young person and definitely hope that what was said helped youth of all ages.

Building synergy with emerging opportunities. A variety of related activities that were not initiated through formal MHTP processes created important opportunities that contributed to change. For example, the 2005 passage of HB 1290, which authorized expedited restoration of

Medicaid benefits for incarcerated and hospitalized individuals, helped promote many efforts to improve services for adults in the criminal justice system. Also, the 2006 legislation in response to the Pierce County state hospital lawsuit funded the projects of the System Transformation Initiative on housing, assertive community treatment, and several others.

Work across phases. Key informants tended, with marked consistency, to divide the process of the grant activities into two broad phases, with the key pivot point being the April 2008 TWG meeting where the White Space Groups were first commissioned. The first phase of the grant, which preceded the April 2008 meeting, focused primarily on stakeholder engagement and accumulation of knowledge and information, as well as sifting through multiple iterations of priorities. The second phase centered on the actions of the White Space Groups in advancing their self-defined priorities. While some key informants noted the wish that implementation had begun sooner in many areas, without exception they all also underscored the necessity of immersing the process in the complexity of the systems they sought to change. One key informant described the initial phase of the grant as "lots of paper; not a lot of implementation, . . . [but a process that] laid a foundation that allowed people to move forward."

Developing relationships. Key informants were also very consistent in noting the progress of relationship-building throughout the time of the grant, both among the TWG members and across state government departments and staff. One TWG member observed that "initial conversations were about the money, but [after] a couple of years it shifted to being about policy, partnership and working together." Many key informants highlighted that the relationships built between TWG members and across the broader system have an ongoing effect on day-to-day policy making and implementation. They saw these relationships as among the factors having the most potential to promote sustainability of transformation efforts. The independent federal evaluation observed "the importance of incorporating in the Transformation leadership a store of *knowledge about the entire social support system* in the State and the operations and functions of at least the major agencies," noting that the Washington MHTP had done this well, particularly by "recognizing leverage points for engaging other agencies based on their felt needs." Most importantly, many key informants underscored that the transformation of their own personal attitudes and beliefs resulted, more than any other factor, from the stories shared by consumers, youth, and family members and the input they provided in person at every TWG meeting, as well as more broadly through trainings and video.

> The partnerships will endure, and I will be able to work with the partners I have developed. I know who to call now.

Public-private partnerships. Grant activities encompassed more than just government programs, though this was understandably their primary focus. Behavioral health integration and health home efforts involved private partners at the payer and provider level, and 2010

activities have incorporated partnerships with faith-based organizations to support individuals with mental illness within their communities.

Cross-agency training opportunities. Many key informants underscored the value of the multiple venues of cross-agency training that were offered. Most of these trainings focused on some level of integration, for example, consumer/provider, criminal justice/behavioral health, youth-in-transition supports across agencies, vocational rehabilitation/behavioral health, and primary care/behavioral health. One agency leader noted: "The best thing the grant did for my agency was to support the integration discussion in a much more meaningful way than what we had the capacity and resources to do ourselves."

Turning challenges into opportunities. Many key informants noted the importance of the process, particularly given the serious financial challenges facing the nation as a whole and Washington State in particular from late 2008 through the present. Nearly everyone that was interviewed pointed out areas in which progress was limited due to a lack of funding and, in some cases, funding cuts. Nonetheless, many key informants also reflected on how the relationships and collaborative processes built through the MHTP allowed agencies to work together more closely and to better coordinate both unavoidable cuts and targeted opportunities in order to redirect spending and programs. Several even expressed the sense that the financial challenges themselves pushed interagency collaboration forward further than might otherwise have been the case. People also emphasized the project's willingness to learn from unsuccessful efforts, noting the success of the consumer regional organizing initiatives (ROIs) that grew out of initial efforts to develop a statewide consumer network.

Key Results Achieved

Both the key informant interviews and the independent federal evaluation highlighted the following primary results achieved through the MHTP.

Establishing recovery, resiliency, and wellness promotion as the core of the system. Nearly every key informant reported a shift to adopt the framework of recovery, resiliency and wellness as the bedrock of mental health. Even those that came to the table with this perspective at the heart of their activities reported that their awareness of its potential broadened over the five years. People interviewed reported such transformation at multiple levels within themselves, the agencies in which they work, and the broader framework of policy development. These individuals described a range of initial views of recovery and resilience. Those in the formal mental health system described them as more or less endorsed within the prior system, but often as little more than concepts toward which to aspire. Some in other systems related their views to long-standing models in their systems, like

> Recovery became real and not just a word.

person-centered planning for people with developmental disabilities or rehabilitation supports for youth served by the Juvenile Rehabilitation Administration (JRA). Still others working in criminal justice, vocational, housing and other settings described their views as outright novel concepts not encountered before this project. Yet all of these informants noted that today, across all of their involved agencies, the concepts of recovery and resiliency have evolved to practices at the heart of day-to-day operations and ongoing planning.

> A house, a job and a friend.

This evolution was seen as progressing hand-in-hand with the development and expansion of grassroots consumer and family organizations such as CVAB, MHA, WA-DADs, and Youth 'N Action, as well as the formalization of regulations for clubhouses and emerging regulations for consumer-run organizations supported through SHB 2654. The lessons learned about the critical role of grassroots organizing in support of such organizations through early, failed attempts to develop a statewide consumer network led to the ROIs, which did succeed over the last two years in supporting development of a wide array of consumer-run efforts statewide. Several informants noted the importance of the MHTP establishing forums (particularly the Community Transformation Partnership, as well as those of the White Space Group process) and a broader culture to promote genuine opportunities for input from consumers, youth, and family members. Key informants (including most agency representatives) cited this accomplishment, more than any other, as the most important achievement of the MHTP. The initial Recovery and Resiliency trainings and the ROIs were viewed as key interim steps toward this achievement.

Transformation of the behavioral health / criminal justice system interface. Building on the early momentum of HB 1290, efforts to align the delivery of mental health services and to prevent repeated use of the criminal justice system evolved into one of the most robust and multi-leveled partnerships built through the grant. The joint DSHS/DOC-led Washington State Behavioral Health Re-entry Partnership will continue to promote coordination, cross-training, and policy development after the grant ends. Key achievements between the formal mental health service delivery system and state/local criminal justice systems during the tenure of the grant included the following laws that have been passed to improve services for individuals during and following involvement in the criminal justice system:

- **SSB 6024 Addressing Applications for Public Assistance from Persons Currently Ineligible to Receive Assistance** allowed incarcerated individuals to re-apply for public assistance while still in jail, even without a release date or far in advance of release.

- **SHB 1201 Offender Reentry Community Safety Program** refocused the existing Dangerous Mentally Ill Offender program to become the Community Integration Assistance program. It supported progressive treatment options for people involved in the criminal justice system,

including mental health advance directives.

- **HB 6610 Independent Public Safety Review Panel** established an advisory panel to DSHS and the courts to support more treatment-responsive options for individuals determined to be not guilty by reason of insanity.

Behavioral health / physical health integration. The MHTP has supported a range of activities to help DSHS respond to the opportunities of health care reform and mental health parity. Building on a series of public forums conducted in the Fall of 2009 and broader efforts within DSHS and the Washington State Medical Purchasing Authority (formerly the Health Care Authority), the MHTP helped DSHS build its capacity to develop an integrated delivery system for behavioral and physical health care. DSHS has instituted a learning collaborative to promote enhanced understanding and policy development in the area of behavioral health / physical health integration, supported by an array of related initiatives and legislation, including:

- **Person-centered health homes.** Within DSHS, the Health and Recovery Services Administration (HRSA) has integrated with the Medical Purchasing Authority, and both agencies are now promoting integrated behavioral health and physical health care services through person-centered health homes.

- **HB 2025 Sharing Health Care Information.** This bill allowed mental health and primary care providers to share health records about a person they both serve, in order to improve coordination of care for people with co-morbid mental and physical illnesses.

Children's behavioral health. Many of those interviewed observed that the state's financial challenges have hampered the realization of the broad vision of transformed children's behavioral health services set by 2007's HB 1088. However, they also emphasized that the promotion of evidence-based care and integrated services for children, youth, and youth in transition has nevertheless continued to progress. Some informants pointed out that at the least the challenges inherent in the present system are now better understood and widely acknowledged. These interviewees underscored that, if funding were to be enhanced or redirected in the future, the path to transformation is now clearer. Accomplishments include **SHB 1373 Concerning Children's Mental Health Services,** which made permanent the 2007 increase in the number of allowed outpatient mental health visits and the 2007 expansion of professionals eligible to provide outpatient mental health therapy for children in managed care and fee-for-service Medicaid and CHIP programs.

Performance management. An array of projects that focused on performance management were implemented, ranging from an integrated decision support infrastructure across state agencies to customer-focused information portals, such as the Security Lifeline established under **HB 2782**, which provides an online benefits portal where individuals can apply for services, including public benefits and education and training support. Most importantly, both key informants and the independent federal evaluation underscored the importance of the **Mental Health System Performance Monitoring Dashboard**. This set of performance indicators was developed by the TWG specifically to monitor and continue to guide the transformation of the mental health system in Washington State going forward after the formal grant period ends. Nine overall sets of indicators (three related to each of the three overall levels of success defined by the TWG: individual, system, and community levels) were identified, defined and recommended, and are now being considered for integration within the base engine for system accountability within DSHS, including potential monitoring of partnership agreements with other agencies. Several stakeholders underscored the importance of building measurement of such progress into the core metrics of the agencies involved. They argued that the institutionalization of metrics related to recovery, resiliency, wellness, and system / community transformation was among the areas with the greatest potential for continued transformation over time.

> These goals and measures are intended to be broader than any one system of care. . . . The indicators of success represent a commitment to monitoring our collective, cross-agency performance, sharing information, and continually improving what we do. The leadership team hopes that they will continue to be used to assess the recovery orientation of the entire system of care in Washington State. (Excerpt from *Washington State Mental Health Transformation Project measures of statewide performance for Washington State,* Mental Health Transformation Work Group, June 2010.)

Reducing stigma. Many stakeholders and the federal evaluation emphasized the very successful initiative to address media depictions of people with mental illness. In addition to complimenting the trainings carried out in this area for their quality and effectiveness, stakeholders also reported that they have observed changes in how key media outlets write their stories about people with mental illnesses. Many expected the effects of this initiative to be among the most enduring and important.

Other accomplishments. A range of additional achievements were also observed by key informants, though with less frequency. Most of these related to specific achievements within the informants' own agencies. They included:

- DBHR allocation of block grant funds to begin providing technical assistance to **develop consumer/family-run organizations** (as recommended by the consumers and family members of the SHB 2654 Work Group and building on the success of the ROIs), as well the incorporation of consumer/family-run organizations as supplementary providers in discussions of person-centered health homes;

- Expansion of a wide range of **housing resources** through the Housing Consortium;

- Enhanced collaboration between the Division of Behavioral Health and Recovery (DBHR) and the Division of Vocational Rehabilitation (DVR) to **promote employment** (including establishment of joint fidelity standards for supported employment) and broader awareness of the importance of employment to mental wellness (influenced to a large degree initially by cross-training of DVR staff in Wellness Recovery Action Plans – WRAP);

- The shift to **a population-based perspective on mental health**, related in large part to the work of the Prevention Advisory Group and the involvement of public health in both promoting mental health within the public health setting and a population-based perspective within mental health settings, including the awareness of concepts such as adverse child experiences (ACEs) across mental health, education, and broader child-serving systems (one person summed it up as having achieved "a shared sense of ownership for mental health prevention");

- Related to this, the **promotion of prevention in school settings** through the Compassionate Schools Initiative through the Office of the Superintendent of Public Instruction (OSPI), including *The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success*, a guide to childhood emotional and mental health needs, as well as the impact of ACEs and concrete steps to support healthy emotional development;

- Expansion of **intensive service availability** through initiatives such as the Programs for Assertive Community Treatment (PACT) and Wraparound Service Coordination pilots;

- Many **practice changes at the provider level** promoted by the training, activities, and culture of the MHTP, in full partnership with the Washington Community Mental Health Council, including broader consumer and family involvement, incorporation of consumer/family-delivered services, and adoption of multiple evidence-based practices addressing trauma, cognitive behavioral therapy, early childhood mental health, use of data in clinical decision-making (for example, real-time access to data from multiple systems through PRISM), partnerships with faith-based organizations, and a variety of other practices;

- A wide array of **supports for veterans** made more visible within the broader public mental health system and supported in its growth, ranging from prevention and education initiatives (for example, curriculum for children of deployed veterans, navigators on college campuses, and support of the "Veteran Friendly Campus Program" that promotes college campus best practices for adjusting to war veteran students), to expansion of awareness of and skills to carry out trauma-informed care and veteran-trauma-informed care, to data linkages for improved continuity of care between veteran-serving agencies and the broader public mental health system, to trainings for providers in veteran issues and development of veteran peer support through approaches such as the "Veterans Conservation Corp"; and

- **Enhanced services for Youth in Transition** (YIT), including the work of the YIT White Space Group to develop the YIT Tool Kit and enhanced data sharing across child-serving agencies (including establishment of outcome indicators), led by parents, caregivers, and youth, and building on the interagency work of JRA, chemical dependency and mental health service leads within DBHR, Children's Administration (CA), and many others.

Keep in mind that this is just a sampling of the dozens of specific initiatives summarized in the "numbers and facts" above. However, these were the ones most salient and on the minds of the TWG members interviewed, as well as reflected in the independent federal evaluation. What is more, the people interviewed agreed widely that this set of accomplishments related directly to the tremendous array of stakeholder guidance, knowledge production, and recommendation synthesis described in the next section of the report.

What We Learned

Knowledge development, synthesis, and incorporation into policy were both core activities and an enduring achievement of the MHTP. It was noted earlier that one of the key process principles of the MHTP was using data to build knowledge and drive change. Central to that was the synergy between two sets of input that are often in tension with one another – input gathered directly from consumers, youth, family members, providers, allied service agencies, and other stakeholders, and input generated through more formal studies and assessments by subject matter experts. Through the MHTP, each set of data often mutually supported and informed the other, according to the stakeholders we interviewed. Two sets of learning are therefore highlighted in this section – those formally presented through reports either commissioned by or related to the efforts of the MHTP, as well as those more personal lessons learned as reported by individual key informants interviewed.

> We will be able to use the publications and curricula and reports and tools developed, as well as so much that was generated in terms of statewide conversations, documenting what people wanted, what issues still exist.

Review of Related Reports

As noted previously, the MHTP began with a tremendous amount of input from over 40 public forums. Many of the 129 reports and studies reviewed by TriWest for this report drew upon that initial stakeholder input, and others added in additional rounds of stakeholder input and deliberation in determining their key findings. TriWest reviewed over 1,075 recommendations from these reports and categorized them across four primary domains and seven additional areas:

- Primary Domain 1: Recovery and Peer Delivered Services for Adults and Older Adults,
- Primary Domain 2: Children's Health Services,
- Primary Domain 3: Addressing Health Disparities,
- Primary Domain 4: Integrated Care, and
- Other Areas, including:
    1. Hospital Transitions,
    2. Improved Contracting/Procurement for Behavioral Health,
    3. Performance/Outcome Measurement,
    4. Systematic Promotion of Evidence-Based and Promising Practices,
    5. Enhanced Care Management for People with Complex, High Risk Conditions,
    6. Information Technology, and
    7. Promotion of a Public Health-Oriented Mental Health System.

The reports incorporated input from a variety of stakeholder groups, including consumers, youth, family members, providers, local/state/Tribal government representatives, and subject matter experts; a full listing is provided in Appendix Three. The main findings are summarized below, and it is interesting to note how closely they mirror the achievements described in the previous section. It appears that the MHTP process principle of using data to build knowledge and drive change had some level of utility.

Recovery and Peer Delivered Services for Adults and Older Adults (464 recommendations across 50 reports). The most studied and reported upon domain of recommendations centered on the development of a recovery and peer-delivered system of care for adults and older adults. The recommendations fell into eight broad categories: (1) embracing recovery to ensure that care is recovery-oriented and peer-delivered to the fullest extent possible, (2) improving behavioral health services in the criminal justice system, (3) expanding housing supports and reduce homelessness, (4) expanding employment supports, (5) improving behavioral health services for older adults, (6) improving behavioral health services and supports for youth in transition, (7) reducing stigma, and (8) partnering with consumers and families in evaluation.

Children's Health Services (333 recommendations across 50 reports). The next most studied and reported upon domain of recommendations centered on children's health services, both

behavioral health and the integration of behavioral health within the broader physical health delivery system. Recommendations fell into three broad categories: (1) improving access to care, (2) increasing use of evidence-based and promising practices, and (3) expanding involvement of youth and families. Collectively, these recommendations envision a system that offers easy access to the most effective services and actively engages youth and families as participants in decision-making.

Addressing Health Disparities (137 recommendations across 39 reports). Recommendations concerning health disparities were identified in many of the reports reviewed. Concerns most often were voiced in relationship to culture-based disparities for ethnic/racial groups and rural-urban disparities, as well as disparities in services to people without insurance coverage, people with physical disabilities and people who are gay, lesbian, bisexual and transgendered (GLBT).

Integrated Care (111 recommendations across 38 reports). Many report recommendations focused on better integrating care across service systems. Specific recommendations fell into three broad categories of (1) integrating chemical dependency (CD) and mental health (MH) care, (2) integrating behavioral health (CD and MH) with primary care, and (3) integrating behavioral health service delivery across departments for people involved in multiple agencies.

Other Areas of Recommendations (136 recommendations across 35 reports). Most of the remaining recommendations fell into seven additional areas:

1. **Improving transitions in services from and to psychiatric hospital settings** by improving utilization management practices, expanding the continuum of care, improving data systems, reforming payment approaches, implementing targeted quality improvement processes, and increasing involvement of consumers.

2. **Changing the contract and procurement process for behavioral health (BH)** to increase accountability and state/local partnerships overall and in the area of enhanced utilization management.

3. **Improving performance and outcome measurement** at the state, managed care organization, and RSN levels, focusing on both improved data reporting/monitoring processes and increased use of electronic medical records.

4. **Implementing systematic efforts to increase use of evidence-based and promising practices** by improving encounter coding and actuarial processes, developing Centers of Excellence and an evidence-based culture to support implementation of priorities, and being mindful of the limitations inherent in such practices in order to use them wisely.

5. **Improving care management for people with complex, high risk conditions**.

6. **Leveraging information technology** more innovatively through approaches such as a Global Consumer Information Center, related data hubs for both state agencies and consumers, centralized encounter records, Smart ID Card, consumer websites, and enhanced data tracking of service needs, use and supply over time.

7. **Promotion of a public health-oriented mental health system** by creating a statewide system/entity that would institutionalize a coordinated approach to prevention and promotion that is supportive of recovery, resiliency, mental wellness, effective clinical practice, and decreased stigma.

Personal Lessons Learned

The TWG members and MHTP leaders interviewed for this report repeatedly emphasized the importance of both the formal reporting process of knowledge creation and learning just described, as well as the more personal journey of awareness, education, and changed attitudes. Key informants reported the following personal lessons learned.

Understanding of recovery and resilience. Many observed that, while they had been to some level familiar with these concepts prior to the MHTP, they now understood at a practical level what these concepts entail. As discussed previously, most attributed that shift in perspective to the stories and input of consumers, youth and family members, particularly through the influence of the Community Transformation Partnership. One informant summed it up bluntly: "Consumers are people." Another noted the result that "consumers were very effective partners and are now at the table – it's a healthy process." Yet another noted that the concept of "A house, a job and a friend" was key to her understanding of what recovery meant, going on to observe that the health care delivery system too often makes things complicated, and we focus instead on the complexity of the delivery system. She concluded: "Instead we need to step back and look at what people need."

Appreciation for system complexity. Many key informants noted that they had always known the system was complex, but prior to the MHTP process they had assumed that much of the complexity in systems other than their own was unnecessary. These same informants noted that now they understood better why the system overall was so complex. They also emphasized appreciation of the need to both reduce complexity where possible, but also to put in place processes to continuously educate

> I know that me, and a lot of people in the community, would have never found out about all that goes on if it wasn't for the Mental Health Transformation Project.

stakeholders across the system, including consumers, agency staff, and executive and legislative decision-makers, regarding the necessary complexity of systems addressing people's complex needs. One leader captured the notion by stating that "wraparound needs to be viewed as an orientation, not as a discrete service," underscoring that the principles of successful wraparound support across complex services systems need to be understood and incorporated at the system level as well as individual level. Another informant noted that understanding the complexity of each other's responsibilities and the limits of each other's resources was key to achieving mutual respect. As one informant summed it up: "I know way more about the mental health system than when I walked in."

What We Will Sustain

> The most important thing to me through this entire process? The most important thing to me was youth, consumer and family involvement.

While much has been learned and accomplished, key informants were unanimous in their opinion that there is still a tremendous amount to do. Some expressed a measure of disappointment that more structural change had not come about in the way that mental health services are purchased and delivered across agencies. However, most acknowledged that the complexity of the system defied simple solutions through restructuring. In fact, several key informants (all of them from outside of DBHR) observed that the many rounds of restructuring behavioral health oversight at the state agency level over the last two years had actually hampered the more organic transformation process that is needed in complex systems.

Research over the last decade has begun to point a clear path toward sustainable system performance improvement, and Fixsen and his colleagues summarized the lessons learned through that research in their seminal 2005 work.[1] This research argues persuasively that organizational change is multi-determined and dependent on sustained organizational commitment over a multi-year period. Fixsen and his colleagues describe a multi-year, six stage process involving (1) exploration and adoption, (2) program installation, (3) initial implementation, (4) full operation, (5) innovation, and (6) sustainability. Furthermore, the process of moving from one stage to the next involves a complex interplay of organizational capacities, technical expertise, and quality improvement activities over time.

Applying these six stages to the array of MHTP achievements over the last five years shows a range of developmental progress across the Project's many initiatives:

[1] Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida. Downloaded at: http://www.fpg.unc.edu/~nirn/resources/publications/Monograph/pdf/Monograph_full.pdf.

- Some seem to be quite mature at the **innovation/sustainability level**, for example, PACT implementation, housing resource development, JRA evidence-based practices, and supported employment fidelity.

- Others appear to be approaching the level of **full implementation**, for example the wide range of criminal justice / behavioral health integration efforts and efforts at many provider agencies to shift toward recovery/resiliency-based perspectives.

- Still others are at the level of **initial implementation** with readiness to move to full operation should resources be available, for example Wraparound Service Coordination implementation, the Compassionate Schools Initiative and consumer/family-run organizations in the process of expanding to other areas of the state.

- Yet others appear to be at the program **installation/exploration/adoption** levels, such as primary care / behavioral health integration and a range of prevention initiatives.

> There wasn't enough time to transform the entire system, but there were lots of seeds planted to make a lot of little changes now and potential future changes – the seeds of a culture change . . .

We asked key informants about sustainability and overall they expressed a cautious, but optimistic sense that the process of cross-training, relationship building, data-driven quality improvement, consumer/youth/family-driven culture change, and provider adoption of evidence-based and promising practices was firmly entrenched. They expressed hope that these trends were likely to continue for at least a period of time and potentially over the longer term, given an adequate level of ongoing leadership and resource commitment. However, informants were also realistic, pointing out that in a time of increasing budget pressure and increased demand, there was also the risk that system decision-makers would prioritize scarce resources toward other more immediately experienced needs. Most also expressed the hope that leadership would continue to demonstrate a commitment to ongoing transformation, noting that they viewed senior governmental leaders' commitment to transformation as the only viable strategy to achieving high quality service delivery in a time of dwindling or at best static resources.

The interviews revealed confidence that a wide range of specific activities would continue at least at their present levels and potentially at a broader level. The CTP; the consumer-run organizations that just received new SAMHSA grants; the Compassionate Schools Initiative and broader efforts to prevent or address adverse childhood experiences; expanded training for DVR staff in motivational interviewing; a continuing home for the Prevention Advisory Group through the DSHS Office of Planning, Performance and Accountability; and continued work to

improve coordination and supports for youth in transition through JRA, CA, and DBHR were among the many specific initiatives that informants expressed confidence in sustaining.

Informants also underscored a range of discrete priorities that, in their view, were particularly critical to the overall continuity of transformation and that they hoped would continue to receive support and find a sustainable home:

- Many emphasized the importance of **ongoing transformation-related performance and outcome tracking** via the dashboard and related projects. There was optimism that the robust performance tracking and reporting capacity of the DSHS Research and Data Analysis (RDA) Division would be able to carry that process forward, with collaboration from other key agencies such as DOC.

- Many also noted the gap that will come about with the end of the TWG process and its **multi-agency planning forum for agency and community leadership**. In the words of one informant who seemed to speak for many, the end of the TWG would entail the loss of "a rare opportunity for collaboration" and "an opportunity to think differently." While the ongoing demands of state and community agency leadership put a premium on the time of senior leaders, many informants emphasized the need to have some level of ongoing review and planning at the senior agency leadership level (perhaps even only annually at the least). Many also shared that they trusted that the White Space Group process would continue through the various work groups and specific initiatives it had spawned.

> . . . transformation, at least in the case of Washington involves what amounts to a *culture change* in how agencies consider their mission with regard to the mental health of their clients. In essence, this represents a shift from a compartmentalized perspective in which agencies other than mental health consider themselves to have a primary mission, such as vocational rehabilitation or corrections, leaving mental health care to the purview of specialty treatment programs. Instead, these agencies now share a recognition that mental health is an important consideration for the well being of their clients. . . . of course this varies in degree among agencies, but it was a very widespread observation, and for many informants it was clearly the most stimulating aspect of the transformation process, with a number commenting that they could not imagine the system returning to its previous state in this respect. (Final Federal Evaluation Finding)

- Others noted the critical role of the MHTP **staff dedicated to the work of coordinating multi-agency planning and implementation efforts.** These interviewees wondered how

that work would continue in the absence of such staffing, particularly in the case of efforts at the exploration/adoption or installation levels of development, such as primary care / behavioral health integration. Informants expressed faith that the agencies primarily responsible for the outcomes in each area would continue to provide staff support to these efforts. Several expressed the hope that DSHS in general, and DBHR in particular, would serve as the point of accountability for the ongoing mental health transformation process. These interviewees underscored that the relationships that have been developed will not be sustained on their own without at least a minimum investment in ongoing facilitation and resources to serve as the independent advocate that MHTP staff and consultants have provided for the past five years.

- Many highlighted both **the opportunity and the necessity to integrate mental health transformation efforts into health care reform**, arguing that "successful health care reform depends on alignment with the broader human service system" for serving people with the most complex and severe needs. Many expressed a comparable level of concern that those with complex needs could, in the absence of concerted effort, be left out of or lost within the flurry of federally-mandated efforts to implement health care reform more broadly. Most of these articulated some variation on the theme that system evolution to tap the promise of health care reform will require behavioral health transformation as an essential concept. Cost curves cannot be bent if co-morbid behavioral health concerns are not addressed or if efforts to support housing, employment and other human services are not coordinated. Key points made by these informants were that approaches such as accountable health care organizations will require collaboration between health care funders and government human services more broadly in order to avoid shifting costs to correctional, juvenile justice, child welfare, homelessness, and broader county and state governmental safety net programs. In order to ensure that health care reform "works for the entire community," planners will have to extend the population-based management approaches identified through the MHTP. Some of the leaders interviewed for this report expressed the opinion that a policy statement by senior leadership within state government was needed to underscore the state's commitment to addressing long term, complex needs within the greater context of health care reform.

- Most of the informants from child-serving agencies, as well as agencies serving people with developmental disabilities and other long-term needs, expressed a greater level of **concern that the attention of the formal mental health system was at risk of reverting away from the needs of their target populations in the absence of ongoing efforts to promote system transformation**. Several specifically attributed this concern to the ongoing limitations of the 1915(b) waiver program's Access to Care Standards (ACS), which essentially every report and recommendation related to children's services has identified as a barrier needing removal, and which also limits potential services for adults with co-occurring behavioral

health and developmental needs, traumatic brain injury, and dementia. All also noted the fiscal realities that continue to stymie planning to address the ACS.

So what, in the end, will be the legacy of the MHTP? One key informant in particular seemed to sum up the thoughts of many with the image of the inevitable silos of state government depicted as rocks and the efforts to fill the white space between as sand: ". . . like sand poured in among rocks – the rocks are still there, but now there is sand among the rocks; it supports the rocks better and stabilizes the rocks."

Conclusion

In reference to the interplay of transformation and health care reform, one of the leaders interviewed for this report cautiously concluded: "The mental health needs for people with the highest needs, while small in number compared to all people with mental health needs, need special advocacy. It's not just about what we purchase for them; it's about understanding their place in the community and how to build it."

The independent evaluation carried out by the federal government concludes with a concise summary of the external view of what will be sustained as a result of the last five years of journeying toward mental health system transformation in Washington. This summary is excerpted in abbreviated form in the box below.

The changes in attitudes, beliefs and actions regarding mental health issues . . . were widespread and in a number of cases, substantial and likely to be lasting. The following, though not a complete list, briefly describes some of these.

Child Welfare: Very largely as a result of Transformation Grant activities, the concept of trauma informed care is now deeply rooted in that agency and is certain to be retained . . .

Corrections: The achievement of an ongoing collaboration to address behavioral health reentry issues is widely recognized by diverse parties, and there is a general consensus that this will continue, given the utility for all concerned.

[Child, Youth and Family – CYF] Organizations: Although strengthening of CYF organizations has been one of the goals of the Transformation Grant, there have been many challenges in this area. . . . Informants suggested that further progress in this area will depend on the extent of commitment by the state mental health agency in the face of multiple competing priorities. While the future of CYF organizations may be uncertain, the increased *inclusion* of these groups having meaningful input into policy decisions, not only in

the mental health agency but a majority of other agencies, is a very real achievement . . . that is unlikely to be reversed.

Housing: . . . the Housing Consortium . . . will continue . . . As with other areas such as corrections, the inter-agency collaborations provide such benefit to all parties with relatively little investment of resources, that they are highly likely to be sustained.

Vocational Rehabilitation: . . . a profound change, perhaps the most extensive of any agency, had occurred in the level of awareness of mental health issues and the recognition that dealing with these issues, either directly or through collaboration, was a part of the mission. . . The impression of this change was so strong it is difficult to imagine that it would not continue, barring some major alteration such a change in high-level leadership with a very different orientation.

Multi-Agency Youth in Transition: This working group, consisting of high and mid-level representatives of a comprehensive range of agencies that provide services related to youth (child welfare, juvenile justice, education, mental health, developmental disabilities) appears almost certain to continue . . . due to the effectiveness in using a relatively small commitment of resources to address long-standing problems that had previously resisted efforts to resolve.

These are bold and for the most part unequivocal statements by the independent federal evaluator, and they reflect powerfully on the many specific examples and findings throughout this report. People sometimes claim that true collaboration, integration, and transformation occur because people set their own interests aside in favor of the goals of others. In the State of Washington, that truism has been turned on its head, as senior state agency leaders, their key staff, and community leaders representing consumers, youth, families, providers, and counties together have shown that each individual's mission to serve others can be better accomplished by working together. There is utility in transformation, and that is why it has worked and why it will be sustained. By embracing the broader mission of each participant to help children, youth, adults, and families recover mental wellness and by truly understanding each agency's role in that complex mission, Washington State has indeed moved farther down the path to true transformation.

Appendices

Appendix One: Current and Past Transformation Work Group Members and Staff

Current Transformation Work Group (TWG) Members	Organization
Joanna Arlow	Washington Association of Sheriffs and Police Chiefs (WASPC)
Barbara Bate	National Alliance on Mental Illness (NAMI)
Kari Burrell	Governor's Office
Carlos Carreon	Regional Support Network (RSN) Representative (West Side) – Cowlitz County Health and Human Services
Ann Christian	Washington Community Mental Health Council (WCMHC)
Chris Clark	Youth Representative
Lynn Davison	Common Ground
Jocie Devries	Washington Partnerships for Action Voices for Empowerment (PAVE)
David Dickinson / Andy Toulon / Frank Jose	Division of Behavioral Health and Recovery (DBHR) – Mental Health
Susan Dreyfus	Department of Social and Health Services (DSHS) Secretary
Peg Evans-Brown / Andres Aguirre	Division of Vocational Rehabilitation (DVR)
Melanie Green	Adult Consumer Representative
Rashi Gupta	Washington State Association of Counties (WSAC)
Ron Jemelka	MHTP Director
Tamara Johnson	Youth Representative
Steve Kutz	Tribal Representative – Cowlitz Tribe
Kathy Leitch / Traci Adair	Aging and Disability Services Administration (ADSA)
MaryAnne Lindeblad / Doug Porter	Health and Recovery Services Administration (HRSA)
Sheryl Lowe	Tribal Representative – American Indian Health Commission for Washington State
Suzie McDaniel	RSN Representative (East Side) – Spokane County Community Services
Martin Mueller	Office of the Superintendent of Public Instruction (OSPI)
Don Nichols	Mental Health Planning and Advisory Council (MHPAC) – Older Adult Advocate
Helen Nilon	MHPAC
Toby Olson	Governor's Council on Disability Issues and Employment
Denise Revels-Robinson / Barb Putnam	Children's Administration
Victoria Roberts / David Dickinson	DBHR – Substance Abuse
Tom Schumacher / John Lee	Department of Veterans Affairs (DVA)
Cheryl Strange / Eldon Vail / Ken Taylor	Department of Corrections (DOC)

Current Transformation Work Group (TWG) Members	Organization
Cheryl Sullivan-Colglazier / John Clayton	Juvenile Rehabilitation Administration (JRA)
Nancy Vernon	Department of Early Learning (DEL)
Mary Wendt / Mary Selecky	Department of Health (DOH)

Past TWG Members	Organization
Doug Allen	Division of Alcohol and Substance Abuse (DASA – predecessor to DBHR)
Robin Arnold-Williams	Past DSHS Secretary
Cardell Ashford	Youth Member
Christine Barada	Spokane County
Gordon Bopp	NAMI
Shirley Charley	Tribal Delegate
Cheri Dolezal	RSN Representative – Clark County
Kelly Eagan	DOC
Jan Flemming	DOC
Joanne Freimund	MHPAC
Rick Godderz	Spokane County
Dawn Grosz	Parent Advocate
Patty Hayes	DOH
Tory Henderson	DOH
Larry Horne	DEL
Danette Ives	Tribal Delegate
Gaye Jensen	JRA
Julie Jensen	Older Adult Advocate
Sue Just	Parent Advocate / Statewide Action for Family Empowerment (SAFE)
Gary Kamimura	Department of Employment Security (DES)
Richard Kellogg	Mental Health Division (MHD – predecessor to DBHR)
Rebecca Kelly	JRA
Nathan King	Youth Delegate
Patty King	SAFE
Jim LaMunyon	WASPC
Jennifer LaPointe	Tribal Delegate
Cathii Nash	MHPAC
Michael Paulson	HRSA
Monique Perry	Youth Advocate
Riley Peters	DOH
Marcia Riggers	OSPI

Past TWG Members	Organization
Lynnae Ruttledge	DVR
Tom Saltrup	DOC
Sekou Shabaka	JRA
Mark Snowden	Older Adult Advocate
Ken Stark	MHTP
Rick Weaver	Central WA Comprehensive Mental Health
Jean Wessman	WSAC
Rita Whigham	Older Adult Advocate
JoEllen Woodrow	MHPAC

MHTP Staff (Past and Present)	Title
Ron Jemelka	Director (2008 to present)
Ken Stark	Past Director (2005 to 2008)
Jeanette Barnes	Family Liaison (Present)
David Brenna	Senior Policy Analyst (Past)
Darci Ebinger	Administrative Assistant 5 (Present)
Angela French	WebMaster (Past)
Judy Gosney	Program Manager (Present)
Amy Jeppesen	Social and Health Program Consultant (Present)
Joyce Lane Jordon	Project Manager (Past)
Jill San Jule	Consumer Liaison (Past)
Stephanie Lane	Project Manager (Past)
Erin Peterschick	Project Coordinator (Past)
Jeff Pike	Communication/Social Marketing (Past)
Rena Shawver	Communication/Social Marketing (Present)
Ginger Stewart	Fiscal and Contracts Manager (Past)
Bianca Stoner	Project Coordinator (Past)
Roxanne Waldron	UW Consultant (Past)
Kathy Zimmerman	Fiscal and Contracts Manager (Present)

Appendix Two: Final Report Methodology

This report tells the story of the journey of mental health transformation from the perspective of the people of Washington State who led and took part in that journey. While it is informed by and incorporates the results of the independent evaluation carried out by the federal government, its focus is on the experience of transformation, drawing on three primary sets of information:

- Interviews with 23 members and key staff of the Transformation Work Group (TWG), the Governor-appointed body that led this stage of the journey of transformation;
- Reviews of 129 reports by mental health system stakeholders, either initiated by the Mental Health Transformation Project (MHTP) or related to its work, and the over 1,075 recommendations included within them; and
- The final draft of the August 2010 summary report of the federal government's independent evaluation of the transformation grant, which provides an external view of the most significant grant activities occurring in the final two years of the grant and key achievements from prior years.

The interviews with TWG members, their staff, and MHTP senior staff focused on the following key questions:

- What were the most important changes in the behavioral health system and other related human services systems over the five years of MHTP activities?
- Which activities of the MHTP were most important in contributing to these changes?
- What was learned through the process and how does that affect your work going forward?
- What will you and others do to sustain and continue the process of transformation?

The review of the 129 reports focused on their recommendations for services and systems improvements, with over 1,075 specific recommendations identified. For most reports, only formally identified recommendations were included. Some reports did not formally identify recommendations, and in these cases only clearly identified recommendations were included. Recommendations were prioritized primarily based on the number of times that they were made across reports, and secondarily by the importance attributed to them by stakeholders in the report, when known. These reports incorporated input from a variety of stakeholder groups, including direct consumer of mental health services (both youth in transition and adults); family members of adults who receive mental health services; parents, caregivers, or family members of children and youth who receive mental health services; mental health services providers; chemical dependency services providers; regional support networks (RSNs); local, state, and Tribal government representatives; and subject matter experts. The reports addressed a wide variety of populations and issues in health and human services, and a full listing of the reports is provided in Appendix Three. Predominant themes in four primary domains and seven additional areas emerged from this review:

- Primary Domain 1: Children's Health Services,
- Primary Domain 2: Recovery and Peer Delivered Services for Adults and Older Adults,
- Primary Domain 3: Integrated Care,
- Primary Domain 4: Health Disparities, and
- Other Areas, including: (1) Hospital Transitions, (2) Improved Contracting/Procurement for Behavioral Health, (3) Performance/Outcome Measurement, (4) Systematic Promotion of Evidence-Based and Promising Practices, (5) Care Management, (6) Information Technology, and (7) Promotion of a Public Health-Oriented Mental Health System.

The August 2010 summary report of the federal government's independent evaluation of the transformation grant documented an external view of the most significant grant activities occurring in the final two years of the grant, as well as several key achievements from prior years. Content from this report was used to validate the findings from the Washington State interviews and the reviews of reports. The summary report addressed the following areas:

- Achievements, including legislation and policy/organizational changes, web-based resources, and trainings;
- Lessons learned regarding leadership, staff continuity, resources, inter-agency collaboration, and consumer, youth and family involvement; and
- Sustainability.

Appendix Three: List of Reports Reviewed

Number	Report Citation
1.	Acumentra Health. (2008). 2008 external quality review annual report – Washington State Healthy Options, State Children's Health Insurance Program, Mental Health Division Program, Washington Medicaid Integration Partnership, Medicare/Medicaid Integration Project. The State of Washington, Department of Social and Health Services, Health and Recovery Services Administration.
2.	Acumentra Health. (2008). 2008 performance measure comparative analysis report - Washington State Healthy Options, State Children's Health Insurance Program, Washington Medicaid Integration Partnership. The State of Washington, Department of Social and Health Services, Health and Recovery Services Administration.
3.	Acumentra Health. (2006). 2006 external quality review annual report – Washington State Healthy Options and State Children's Health Insurance Program and Washington Medicaid Integration Partnership. The State of Washington, Department of Social and Health Services, Health and Recovery Services Administration.
4.	Adult Consumers and Families Subcommittee. (2006). Priority Outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
5.	Adult Consumers and Family Members Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
6.	Advocates for Human Potential, Inc., and TriWest Group. (2007). Statewide transformation initiative involuntary treatment act (ITA) review. The State of Washington, Department of Social and Human Services, Health and Recovery Services Administration, Mental Health Division. Downloaded from: http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_ita_final_report_2008_01_17_final.pdf.
7.	Barnhart, L. and Shaw, P. (November 2, 2006). Financing strategies for care coordination within the medical home. The State of Washington, Department of Health, Children with Special Health Care Needs Program. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
8.	Bogart, M. and Wilson, M. (November 2, 2006). Centers for foster care health. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
9.	Cavens, P. and Tolby, B. (2007). Community medical home for child psychiatry. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.

Number	Report Citation
10.	Children's Health Care Work Group. (November, 2007). Report to the Legislature, SSB 5093, Children's Healthcare Improvement System, Chapter 5, Laws of 2007 Second Substitute Bill 5093, Child Health Care Act, Section 4, Identify explicit performance measures, establish targets for performance measures and submit a report to the Legislature. The State of Washington, Department of Social and Health Services, Health and Recovery Services Administration, Division of Health Care Services.
11.	Children, Youth and Families Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
12.	Children, Youth, and Parents, Families Subcommittee. (2006). Priority outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
13.	Common Ground. (2007). Mental health housing action plan. Downloaded from: http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_final_mh_housing_action_plan.pdf.
14.	Community Health Plan of Washington. (2008). GA-U mental health pilot interim evaluation. The State of Washington, Department of Social and Health Services.
15.	Co Occurring Disorders Interagency Advisory Committee (March 2005). Action Plan for Co-Occurring Disorders for Washington State 2005-2007. Downloaded from: http://coce.samhsa.gov/cod_resources/pdf/WashingtonStateActionPlan2005-2007.pdf.
16.	Co-Occurring Disorders Subcommittee. (2006). Priority outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
17.	Co-Occurring Disorders Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
18.	Criminal Justice Subcommittee. (2006). Priority outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
19.	Criminal Justice Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.

Number	Report Citation
20.	Cross-System Crisis Response Task Force. (2004). Recommendations for improvements to crisis response. Cross-System Crisis Response Project. The State of Washington, Department of Social and Health Services, Association of County Human Services.
21.	Cuddeback, G., Morrissey, J. and Mancuso, D. (2008). Expedited Medicaid restoration for persons with mental illness released from jails, prisons and hospitals. GAINS Center Meeting, Washington, DC. Downloaded from: http://mhtransformation.wa.gov/MHTG/crimjustice.shtml.
22.	Cultural Competency Task Group. (no date – n.d.). Cultural competency definition. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
23.	Cultural Competency Task Group. (n.d.). Cultural competency task group strategies, overarching recommendation of the group. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
24.	Cultural Competency Task Group. (n.d.). Mental health transformation project (Powerpoint presentation). Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
25.	Cultural Competency Task Group. (n.d.). Strategies. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
26.	Department of Health, Children with Special Health Care Needs Program. (2006). Medical homes for children and youth with special health care needs – Making it happen in Washington State. (2006). Washington State Medical Home Leadership Network. Downloaded from: http://www.medicalhome.org/4Download/strategicplan.pdf.
27.	Department of Health, Office of Health Promotion. (March 2009). Elements of recovery for people experiencing mental illness. Washington State Mental Health Transformation Project Social Marketing Initiative. Downloaded from: http://www.dshs.wa.gov/pdf/Publications/22-1316.pdf.
28.	Department of Health, Office of Health Promotion. (March 2009). Feeling better: A guide to the mental health system and getting the help you need. Washington State Mental Health Transformation Project Social Marketing Initiative. Downloaded from: http://www.dshs.wa.gov/pdf/Publications/22-1315.pdf.

Number	Report Citation
29.	Department of Health, Office of Health Promotion. (March 2009). Promoting recovery in organizations. Washington State Mental Health Transformation Project Social Marketing Initiative. Downloaded from: http://www.dshs.wa.gov/pdf/Publications/22-1318.pdf.
30.	Department of Health, Office of Health Promotion. (March 2009). Supporting Recovery – an overview. Washington State Mental Health Transformation Project Social Marketing Initiative. Downloaded from: http://www.dshs.wa.gov/pdf/Publications/22-1317.pdf.
31.	Department of Health, Office of Health Promotion. (2007). Social marketing anti-stigma initiative progress report. Downloaded from: http://mhtransformation.wa.gov/MHTG/smresources.shtml.
32.	Department of Health, Office of Health Promotion. (2006). Plan for mental health social marketing anti-stigma initiative. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/SocialMarketingPlan.pdf
33.	Department of Social and Health Services. (2010). *One Department, One Mission, One Core Set of Values*.
34.	Department of Social and Health Services. (2008). 2008 fact sheet: 2SHB1088: children's mental health. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_1088ChilrensMH.pdf.
35.	Department of Social and Health Services, Division of Alcohol and Substance Abuse. (2008). Improving the statewide adolescent treatment system of care: Strategic Plan, Adolescent Treatment Coordination Grant 2005-2008. Downloaded from: http://www.theteenline.org/csatsite/Adolescent%20Strategic%20Plan%20Final.pdf.
36.	Department of Social and Health Services, Division of Research and Data Analysis. (2006). The voices: 2006 Washington State mental health resources & needs assessment study. Funded by the Mental Health Transformation Grant (SAMHSA) for Washington State's Mental Health Transformation Project. Report Number 3.31. Downloaded from: http://www.dshs.wa.gov/pdf/ms/rda/research/3/31.pdf.
37.	Department of Social and Health Services, Health and Recovery Services Administration, Division of Healthcare Services. (2007). Report to the Legislature – Prevention and Health Promotion in Washington State Government Health Programs – A Five Year Plan, Chapter 259, Laws of 2007, Engrossed Second Substitute Bill 5930 (39).
38.	Department of Social and Health Services, Health Care Authority. (2007). Report to the Legislature – Reducing Unnecessary Emergency Department Use, As Required by Engrossed Substitute Senate Bill 5930.

Number	Report Citation
39.	Department of Social and Health Services, Health Care Authority, Department of Health. (2008). Final Report to the Legislature – Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes, as Required by Engrossed Second Substitute House Bill 2549. (2008).
40.	Department of Social and Health Services, Medical Assistance Administration. (2003). Washington State ABCD evaluation report - A report of the findings from the assuring better child health and development initiative. Funded by the Commonwealth Fund in collaboration with the National Academy for State Health Policy.
41.	DMA Health Strategies. (2009). Improving care: Options for redesign of Washington's mental health system. The State of Washington, Department of Social and Health Services, Health and Recovery Administration, Mental Health Division. Downloaded from: http://fortress.wa.gov/dshs/maa/news/legbrief/wastatefinalrev.pdf.
42.	Evaluation Task Group. (n.d.). Powerpoint presentation. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
43.	Evans, A. (n.d.). Building sustainable consumer run organizations. University of Washington and Self Help Empowerment and Evaluation Alliance (SHEEA). Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/SustainableCROs.pdf.
44.	Evans, A. (n.d.). Funding the consumer run organizations. University of Washington and Self Help Empowerment and Evaluation Alliance (SHEEA). Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FundingCROs.pdf.
45.	Evidence Based Practice Institute. (March 18, 2009). SAFE-WA Partners Meeting (Powerpoint presentation). Tacoma, Washington: University of Washington, Division of Public Behavioral Health and Justice Policy.
46.	Evidence/Consensus-Based/Promising/Emerging Practices Task Group. (2006). Group report. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
47.	Evidence/Consensus-Based/Promising/Emerging Practices Task Group. (2006). Group report, Table 1. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
48.	Evidence/Consensus-Based/Promising/Emerging Practices Task Group. (n.d.). Mental health transformation project; evidence, consensus-based, emerging, and promising practices. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.

Number	Report Citation
49.	Fiscal Systems Task Group. (n.d.). Fiscal systems task group financing principles. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
50.	Foley, C. (2002). Well-child focus groups, report of findings. Olalla, Washington: OMPRO. For the State of Washington, Medical Assistance Administration.
51.	Folz, B., Watson, J., Jaffe, D., Krupski, A. and Roy-Byrne, P. (2007). Washington inpatient utilization management report. University of Washington at Harborview Medical Center, Department of Psychiatry and Behavioral Sciences, Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP). For the Washington State Division of Mental Health, Systems Transformation Initiative. Downloaded from: http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_um_project_10_24_07_bf_final.pdf.
52.	GAINS Mental Health Coalition. (2007). Dealing with mentally ill and chemically dependent offenders in Washington State, the business plan. Washington Association of Sheriffs and Police Chiefs and the National Alliance on Mental Illness. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/CDOffendersWA.pdf.
53.	Grevstad, L., Froelicher, S. and Kurtz, G. (November 2, 2006). Kids Matter: Improving outcomes for children in Washington State, a framework for building an early childhood system. The State of Washington, Department of Health, Head Start Collaboration Office, Foundation for Early Learning-The Build Initiative. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
54.	Harrington, A. and Blodgett, C. (2008). Publicly funded mental health and school coordination resource manual (Including Exhibit 7: “Examples of Activities that Promote Promising Practices”). Area Health Education Center, Washington State University, Spokane. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/SchoolCoordinationManual.pdf.
55.	Homelessness Subcommittee. (2006). Priority outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
56.	Homelessness Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
57.	IT Task Group. (n.d.). Presentation to the TWG from the IT task group. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.

Number	Report Citation
58.	Jemelka, R. (June 2010). The journey of transformation. Presentation at the Washington Behavioral Health Care Conference, June 24, 2010. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/Journey%20of%20Transformation%20Behavioral%20Health%20Care%20Conference.pdf.
59.	Jemelka, R. (September 9, 2009). The path of transformation: Where we've been; where we're going. Washington State Mental Health Transformation Project. Presentation at the Washington Behavioral Health Care Conference. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/PathofTransformation.pdf.
60.	Joesch, J., Krupski, T., Rosenberger, E., and Roy-Byrne, P. (2008). GA-U mental health pilot project implementation status report. University of Washington at Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP).
61.	Knowlton, S. (2009). Projected Cost of House Bill 1088 – Revised; letter to S. Breen, Chief of Mental Health Finance, Division of Rates and Finance, Health and Recovery Services Administration. Seattle, Washington: Milliman.
62.	Longhi, D. (2006). Research based prevention outcomes (Report 4.58a). Olympia, Washington: The State of Washington, Department of Social and Health Services, Research and Data Analysis Division.
63.	Lovell, D. (2007). A report to the Governor: Promoting public safety and reducing incarceration of persons with mental illness. The State of Washington, Department of Corrections, on behalf of the Statewide Council on Mentally Ill Offenders. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/MHCouncilReport.pdf.
64.	Lovell, D. and Mayfield, J. (2007). Washington's dangerous mentally ill offender law: Program costs and developments (Document No. 07-03-1901). Olympia, Washington: Washington State Institute for Public Policy. Downloaded from: http://www.wsipp.wa.gov/rptfiles/07-03-1901.pdf.
65.	Mancuso, D., Nordland, D. and Felver, B. (September 2007). Arrests among working-age disabled clients, the role of mental illness and substance abuse. The State of Washington, Department of Social and Health Services, Research and Data Analysis Division, in collaboration with the Health and Recovery Services Administration, Division of Alcohol and Substance Abuse. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_ArrestsWorkingAgeDisabled.pdf.
66.	Mauer, B. (2010). Substance use disorders and the person-centered healthcare home. MCPP Healthcare Consulting, National Council for Community Behavioral Healthcare. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/Substance%20Use%20Disorders%20and%20the%20Person-Centered%20Healthcare%20Home%20Report.pdf.

Number	Report Citation
67.	Mauer, B. and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care, mental health and substance use services in primary care settings and primary care services in specialty mental health and substance abuse settings. MCPP Healthcare Consulting. Downloaded from: http://www.cimh.org/LinkClick.aspx?fileticket=FBCYbhoBeg8%3d&tabid=489.
68.	McBride, D., Voss, W., Mertz, H., Villanueva, T., and Smith, G. (2007). DSHS service providers identify their use of mental health evidence-base practices (EBPs). Washington Institute for Mental Health Research & Training - West, University of Washington, Department of Psychiatry and Behavioral Sciences. From: McBride, D., Voss, W., Mertz, H., Villanueva, T. and Smith, G. (2007). Mental health evidence-based practices (EBP) in Washington State. Tacoma, WA.
69.	McBride, D., Voss, W., Mertz, H., Villanueva, T., and Smith, G. (2007). Mental health evidence-based practices (EBPs) in Washington State, the 2007 evidence-based practices (EBP) survey. Washington Institute for Mental Illness Research and Training-Western Branch. University of Washington School of Medicine Department of Psychiatry and Behavioral Science. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/EBPs_in_WA_with_Appendices.pdf.
70.	McBride, D., Voss, W., Waldron, R., Villanueva, T., & Smith, G. (2006). Consumers speak out about the recovery orientation of the mental health system in Washington State. Washington Institute for Mental Health Research & Training – West, University of Washington, Department of Psychiatry and Behavioral Sciences. From McBride, D., Voss, W., Waldron, R., Villanueva, T., & Smith, G. (2006). Mental health consumers speak. Tacoma, WA. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_ConsumersSpeakRecovery.pdf.
71.	McLaughlin, C. and Janis, W. (2008). Public health: Always working for a safer and healthier Washington - a public health model for mental health. Washington State Board of Health, Washington State Mental Health Transformation Project, Olympia, Washington. Downloaded from: http://mhtransformation.wa.gov/ppt/MHTG/PubHealthModelMH.pps.
72.	Mental Health Transformation Workgroup. (2010). System transformation: Three orders of change.
73.	Mental Health Transformation Workgroup. (June 2010). Washington State Mental Health Transformation Project measures of statewide performance for Washington State. Olympia, Washington.
74.	Monroe-DeVita, M. and Wiley, C. (n.d.). Consumer and family evaluation mini-grant program toolkit. University of Washington and Washington Institute for Mental Health Research and Training. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/Mini-GrantToolkit.pdf.

Number	Report Citation
75.	Morrissey, J. and Cuddeback, G. (2008). Overlapping caseloads in DOC and DSHS highlight need for greater inter-agency collaboration and information sharing. From: Morrissey, J. and Cuddeback, G. (2008). Using DSHS's integrated database to examine criminal justice-mental health issues. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_OverlappingCaseloads.pdf.
76.	Morrissey, J. and Cuddeback, G. (2008). Using DSHS's integrated database to examine criminal justice-mental health issues. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/IntegratedDBCriminalJustice.pdf.
77.	Morrissey, J., Thomas, K., Ellis, A. and Konrad, T. (2007). Geographic disparities contribute to Washington State's mental health workforce challenges. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_GeographicWorkforceChallenges.pdf.
78.	Morrissey, J., Thomas, K., Ellis, A. and Konrad, T. (2007). Geographic disparities in Washington State's mental health workforce. Cecil B. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/WorkforceFullReport.pdf.
79.	Office of Superintendent of Public Instruction, Department of Health, Board of Health, and Department of Social and Health Services. (2003). Report on the well child exam pilot project.
80.	Older Adults and Families Subcommittee. (2006). Priority outcomes. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
81.	Older Adults and Families Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
82.	Older Adults Subcommittee for Mental Health Transformation. (n.d.). Answers to four questions. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
83.	Olson, C. (November 2, 2006). The medical home and quality improvement. Washington Chapter of Pediatrics. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.

Number	Report Citation
84.	OMPRO. (2005). 2005 final report: Healthy options focused review, early and periodic screening, diagnosis, and treatment. The State of Washington, Department of Social and Health Services, Health and Recovery Services Administration.
85.	OMPRO. (2004). Children's preventive healthcare initiative, final report. The State of Washington, Medical Assistance Administration.
86.	Onizuka, R. (June 28, 2010). Multi-payer medical home reimbursement pilot update, DSHS integrative collaborative. Washington State Health Care Authority. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/Multi-Payer%20Medical%20Home%20Reimbursement%20Pilot%20Update.pdf.
87.	Onizuka, R. (May 27, 2010). Decisions – multi-payer medical home reimbursement pilot design. Multi-Payer Medical Home Reimbursement Pilot, Washington State Health Care Authority. Downloaded from: http://www.hca.wa.gov/documents/decision_multi-payer_medical_home_reimbursement_pilot_052710.pdf.
88.	Puget Sound Health Alliance. (July 2010). 2009 healthcare payment reform summit, October 29, 2009 – High level overview and summary discussion. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
89.	Qualis Health. (2008). Evaluation of Washington State Medicaid chronic care management projects. The State of Washington, Health and Recovery Services Administration and Aging and Disability Services Administration.
90.	Qualis Health. (2008). Evaluation of Washington State Medicaid chronic care management projects - qualitative report. The State of Washington, Department of Social and Health Services.
91.	Reshaping Governmental Public Health in Washington State Workgroup. (2010). An agenda for change. The State of Washington, Department of Health.
92.	SHB2654 Work Group. (2008). Report to the legislature on substitute house bill (SHB) 2654: Strategies for developing consumer and family run services. The State of Washington, Department of Social and Human Services, Health and Recovery Services Administration, Mental Health Division. Downloaded from: http://www.dshs.wa.gov/pdf/hrsa/mh/consumerdirectedmentalhealthcare.pdf.
93.	Social Marketing Task Group. (n.d.). Mental health transformation project. Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
94.	Sorensen, J. (2006). Washington's outpatient services extended rate study (Version 4.2, December 4, 2006). The State of Washington, Department of Social and Health Services, Division of Alcohol and Substance Abuse.

Number	Report Citation
95.	Stout, J. (November 2, 2006). Children's Health Improvement Collaborative (CHIC). University of Washington. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
96.	Strode, A. (2009). Final updated report, implementing E2SSB-5763 in Washington counties. Washington Institute for Mental Health Research and Training, Washington State University, Spokane. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FinalReport042009E2SSB_5763.pdf.
97.	Strode, A. (2008). Final report implementing E2SSB-5763 in Washington State counties. Washington Institute for Mental Health Research and Training, Washington State University, Spokane. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FinalReport042009E2SSB_5763.pdf
98.	Strode, A. and Roll, J. (2007). Disparities in mental health services between urban and rural communities in Washington State. Washington Institute for Mental Illness Research and Training, Washington State University, Spokane. Downloaded from: http://mhtransformation.wa.gov/MHTG/powerpoints.shtml.
99.	Task Group on Fiscal Systems. (n.d.). Mental health transformation project (Powerpoint presentation). Washington State Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/strategies.shtml.
100.	The Washington Institute for Mental Health Research & Training. (2008). Children's mental health access & services in Washington State: Stakeholder input & recommendations. The State of Washington, Department of Social and Health Services, Health and Recovery Administration, Mental Health Division.
101.	Thompson, J. (June 14, 2008). A big unknown: Mental health medication in Washington. State Medicaid, Community Mental Health Meeting, Yakima, Washington. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/MedicationWA.pdf.
102.	Torres, J. (n.d.). Kids' potential, our purpose. Washington State Department of Early Learning. Downloaded from: http://mhtransformation.wa.gov/ppt/mhtg/MIHv2Presentation.ppsx.
103.	Transformation Evaluation Team. (June 4, 2010). Using data to transform practice: Measuring impact of Washington's MH transformation. Olympia, Washington.
104.	TriWest Group. (2010). Addressing behavioral health service disparities: Current and potential strategies within Washington State and the national context. Submitted to the State of Washington, Department of Social and Health Services, Health Recovery and Services Administration, Division of Behavioral Health and Recovery.

Number	Report Citation
105.	TriWest Group. (2009). Options for consumer self-directed care implementation in Washington State: Models and recommendations. Submitted to the State of Washington Mental Health Transformation Project.
106.	TriWest Group. (2008). Intensive children's mental health services workgroup summary. The State of Washington, Mental Health Division.
107.	TriWest Group. (2007). Report: Comparison with other states: Arizona, Colorado, New Mexico and Pennsylvania. Appendix K from: Folz, B., Watson, J., Jaffe, D., Krupski, A. and Roy-Byrne, P. (2007). Washington inpatient utilization management report. University of Washington at Harborview Medical Center, Department of Psychiatry and Behavioral Sciences, Center for Healthcare Improvement for Addictions, Mental Illness, and Medically Vulnerable Populations (CHAMMP). For the Washington State Division of Mental Health, Systems Transformation Initiative. Downloaded from: http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_um_project_10_24_07_bf_final.pdf.
108.	TriWest Group (2007). Statewide transformation initiative mental health benefit package design, final report (including the chapter: "Analysis and recommendations for Tribal Governments and their members"). The State of Washington, Department of Social and Human Services, Health and Recovery Services Administration, Mental Health Division. Downloaded from: http://www.dshs.wa.gov/pdf/hrsa/mh/sti_benefit_design_final_report_2008_01_23_final.pdf.
109.	Vela, E. (2004). Residential treatment services rate study. The State of Washington, Department of Social and Health Services, Division of Alcohol and Substance Abuse.
110.	Vollan, T. (November 2, 2006). Medical home for children in Washington State, Washington State data from the 2003 national survey of children's health. The State of Washington, Department of Health. Downloaded from: http://www.medicalhome.org/about/medhomeplan.cfm.
111.	Washington External Quality Review Organization. (2007). 2006 external quality review statewide technical report for prepaid inpatient health plans. Olympia, Washington: The State of Washington, Department of Social and Health Services, Mental Health Division. Downloaded from: http://www.dshs.wa.gov/pdf/hrsa/mh/EQRO_Statewide_Report_Full_Set_2006.pdf.

Number	Report Citation
112.	Washington Institute for Mental Health Research and Training. (n.d.). Washington State's mini-grant program successfully engages more consumers & families in program evaluation. University of Washington Division of Public Behavioral Health and Justice Policy, Department of Psychiatry and Behavioral Science. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/FS_MiniGrants.pdf.
113.	Washington Mental Health Transformation Plan. (2006). Chapter 3: Mental health transformation in collaboration with Indian Country.
114.	Washington Patient-Centered Medical Home Collaborative. (n.d.). 2009-2011 mission, goals and change package. The State of Washington, Department of Health, Washington Academy of Family Physicians. Downloaded from: http://www.mhtransformation.wa.gov/pdf/mhtg/Patient%20Centered%20Medical%20Home%20Collaborative%20Change%20Package,%20Mission%20and%20Goals.pdf.
115.	Washington State Board of Health. (2007). Mental health - A public health approach, developing a prevention-oriented mental health system in Washington State. (2007). Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/PublicHealthModelMH.pdf.
116.	Washington State Mental Health Transformation Project. (2010). Mental Health Transformation Project GPRA totals. Olympia, Washington.
117.	Washington State Mental Health Transformation Project. (June 2009). Transformation efforts related to the employment of individuals with mental illness in Washington State. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/WashingtonDNPfinal.pdf.
118.	Washington State Mental Health Transformation Project. (September 2009). Washington State comprehensive mental health plan update for 2010. Olympia, Washington. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/PlanUpdate_09.pdf.
119.	Washington State Mental Health Transformation Project. (2007). Transformation Workgroup action strategies for 2007. Downloaded from: http://mhtransformation.wa.gov/MHTG/priorityreport.shtml.
120.	Washington State Mental Health Transformation Project. (September 2007). Washington State comprehensive mental health plan update for 2007. Olympia, Washington. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/PlanUpdateFull.pdf.
121.	Washington State Mental Health Transformation Project. (2006). Washington state mental health transformation grant public testimony summary and analysis - Public input. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.

Number	Report Citation
122.	Washington State Mental Health Transformation Project. (2006). Washington state mental health transformation grant public testimony summary and analysis – Regional support network input. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
123.	Washington State Mental Health Transformation Project. (n.d.). Making recovery real: Improving employment outcomes using peer support services. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/MakingRecovery.pdf.
124.	Washington State Policy Summit Team. (July 20, 2009). Action Plan: Washington. National Policy Summit on the Elimination of Disparities in Mental Health Care.
125.	Workforce Training and Education Coordinating Board. (2010). Workforce development directory 2010. Downloaded from: http://www.wtb.wa.gov/Documents/WorkforceDevelopmentDirectory2010.pdf.
126.	Youth 'N Action. (2007). Youth guide to the Washington mental health system. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/YouthResourceGuide.pdf.
127.	Youth 'N Action East. (2008). Youth 'N Action East, top accomplishments 2008. Downloaded from: http://mhtransformation.wa.gov/pdf/mhtg/2008youthactionReport.pdf.
128.	Youth Transitioning into Adulthood Subcommittee. (2006). Priority outcomes. The State of Washington Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.
129.	Youth Transitioning into Adulthood Subcommittee. (2006). Washington state mental health transformation grant public testimony summary and analysis. The State of Washington Mental Health Transformation Project. Downloaded from: http://mhtransformation.wa.gov/MHTG/subsummaries.shtml.