Appendix D

Children's Mental Health Access & Services in Washington State: Stakeholder Input & Recommendations

Children's Mental Health Access & Services in Washington State:

Stakeholder Input & Recommendations

Prepared for the
Department of Social and Health Services
Health and Recovery Administration
Mental Health Division

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The Washington Institute for
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The University of Washington
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Table of Contents

Acknowledgements 2

Executive Summary 3

Introduction 8

Methods 9

Findings 10

Barriers to Access 10

Priority Services and Supports 14

Potential Strategies to Improve Access & Services 16

Recommendations 18

Access Recommendations 18

Service and Support Recommendations 20

System Design Recommendations 27

Appendices

- **Appendix 1:** Results from the November 2007 Children's Community Forum
- **Appendix 2:** Results from RSN Interviews and Questionnaires
- **Appendix 3:** Results of the 2008 Washington Children's Mental Health Survey
- **Appendix 4:** Gaps & Recommendations Related to SSHB 1088 Identified by DSHS Assistant Secretaries & Administrators
- **Appendix 5:** Results from the September 2008 Children's Community Forum
- **Appendix 6:** Issues Identified by Tribal and Recognized American Indian Organization Representatives

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Executive Summary

In September 2007, the Washington State Mental Health Division (MHD) contracted with the Washington Institute for Mental Health Research and Training (WIMHRT) at the University of Washington to provide support in fulfilling legislative initiatives related to SSHB 1088, a Children's Mental Health Bill. The focus of the Institute's work over the past year and the primary areas of focus within this report are on the legislatively mandated areas of: (1) access to care and (2) services and supports.

This report was shaped based on input using five methods of data collection to solicit feedback about access and services from children's mental health system stakeholders in Washington State, including:

1. Two Community Forums
    a. November 2007 Forum (N=170)
    b. September 2008 Forum (N=180)
2. Interviews and questionnaires completed by Regional Support Network (RSN) representatives (N = 8);
3. Input from DSHS Assistant Secretaries and Administrators (N = 4);
4. One statewide Children's Mental Health Survey (N = 1,065); and
5. Two Tribal Roundtables
    a. Western Washington (N=23)
    b. Eastern Washington (N=22)

Based on the findings from this stakeholder input process, the following recommendations are divided into the following three areas:

- Access Recommendations
- Service and Support Recommendations
- System Design Recommendations

Access Recommendations

Access Recommendation #1: Support provider organizations to increase youth and family access to, and engagement in, services:

Access Recommendation #1a: Increase rates to community mental health agencies to provide services out of the office, after hours, and during weekends (e.g., New York's Clinic Plus model). Further, as noted in the 2007 STI Benefit Design Report, it is critical to tie the differential rates to the delivery of the desired services, rather than simply increase rates across the board.

Access Recommendation #1b: Train providers, parents, and youth on evidence based and promising family and youth engagement and empowerment strategies (e.g., the REACH Institute's Parent Empowerment Program). Similarly, there should be more development of Family Navigators to help families get information about options and make choices.

Access Recommendation #2: Address limits to access to services posed by current Access to Care Standards (ACS). Confirming data collected for previous reports (see [1] below), the data across multiple sources for this report indicate that Washington State stakeholders are concerned about the limitations within the current ACS.

Consistent with previous recommendations in the Mental Health Benefit Design Report, one possible strategy for addressing these limits would be to increase the CGAS minimum scores for all covered diagnoses, allowing for more children with higher levels of functioning to access routine outpatient services. More specifically, it is recommended that the State increase the minimum score to 70 if it is economically feasible. The current actuarial analysis of the financial impact of revising the CGAS minimum scores for outpatient services will help to better define the viability of this approach at this time.

While likely to be less feasible, a second possible strategy recommended by multiple stakeholders is the expansion of current diagnostic categories (e.g., including autism-spectrum disorders, severe behavioral challenges) so that they now qualify for services under ACS.

Access Recommendation #3: Shift RSN utilization management away from front-end restrictions across all enrollees to proactive care management for the most intensive and costly services. This recommendation was initially made within the System Transformation Initiative (STI) Mental Health Benefit Design report[1] and is further recommended here based on stakeholder input. As described in this previous report this type of shift will require the development of statewide medical necessity standards and both initial and concurrent reviews for all levels of care.

Access Recommendation #4: Increase access to child psychiatrists by expanding the current Partnership Access Line (PAL). ***PAL*** is a telephone-based child mental health consultation system funded by the state legislature and currently being implemented in Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services.

It is recommended that the PAL program both be expanded statewide and adapted to support primary care practitioners in providing medication management to children and youth currently on waiting lists for programs in communities with limited access to child psychiatrists.

[1] TriWest Group (2007). *Statewide Transformation Initiative Mental Health Benefit Package Design Final Report.*

Service & Support Recommendations

Service and Support Recommendation #1: More actively promote Family Advocacy, Peer-to-Peer Support, and Youth Support.

Service and Support Recommendation #1a. Promote Family Support and Advocacy Organizations (FSAOs) to be more self-sustaining and more capable of providing reimbursable services, such as by:

a. Promoting development of contractual relationships between FSAOs and RSNs and/or community mental health agencies (CMHAs); and
b. Establishing a new category of provider type modeled after Arizona's Community Service Agencies (CSAs) that can provide a range of appropriate "non-clinical" services (e.g., respite, family support, youth support, family navigation, Wraparound family partners and care coordination, and other reimbursable services). This recommendation was initially provided in the Mental Health Benefit Package Design Report (see reference [1]).

Service and Support Recommendation #1b. Further, expand current technical assistance and other supports to FSAOs (e.g., through Center(s) of Excellence) to implement evidence based and promising family support models. Consistent with this, the funding of technical assistance to develop parent- and youth-run organizations across the state at multiple levels of development, including dedicated funding for both the start-up of new organizations and the enhancement of existing organizations, was prioritized by the HB 2654 Work Group. Technical assistance should also support RSNs and CMHAs to integrate their services with those of consumer and family run organizations. This should be funded from multiple sources. Actively include representatives of effective state and local youth- and family-run organizations.

Service and Support Recommendation #1c. Enhance the current peer-to-peer and family/youth support worker certification process, including revisions to current knowledge assessments. Conduct a study of certified family- and youth-support workers about their experiences with the certification process, with providing care to youth and families, and barriers to their effectiveness in providing this covered service.

Service and Support Recommendation #2: Implement evidence-based practices (EBPs) for youth at risk of out-of-home placement or transitioning home from out-of-home placement settings. The data suggest that this population is a high priority for Washington State stakeholders. Benton, Clark, Franklin, King, Mason, Skagit, Snohomish, Thurston, Whatcom, and Yakima County's have already implemented EBPs that address the service needs of this population, while also engaging families in the treatment process, including ***Multidimensional Treatment Foster Care (MTFC), Functional Family Therapy (FFT), Multisystemic Therapy (MST),*** and ***Family Integrated Transitions (FIT).***

Service and Support Recommendation #3: Implement EBPs for youth exposed to past trauma. While a high priority across participants in the September 2008 Forum, providers and DSHS representatives were most likely to endorse EBPs for youth exposed to trauma. Several efforts are currently underway to implement ***Trauma Focused Cognitive Behavioral Therapy (TF-CBT)*** in various parts of the state. Both Children's Administration and the Mental Health Division have allocated resources to expand the number of clinicians trained in this approach. The Evidence Based Practice Institute has identified the expansion of therapists skilled in TF-CBT as a major target for its workforce improvement activities.

Service and Support Recommendation #4: Implement EBPs for youth with co-occurring mental health and substance abuse disorders. In addition to ***MST*** and ***FIT***, ***Multidimensional Family Therapy (MDFT)*** is another evidence-based model that may be implemented to address the needs of youth with co-occurring disorders.

Service and Support Recommendation #5: Implement evidence based models that target early signs of behavioral problems and assist parents in working with oppositional and defiant behaviors. Specifically recommended models include ***Parent-Child Interaction Therapy (PCIT)*** and ***The Incredible Years.***

Service and Support Recommendations #6: Implement prevention and early intervention programs with evidence for effectiveness that align with stakeholder priorities. Recommended prevention and early intervention programs that span from birth to age 12 include: ***Nurse-Family Partnership, Positive Parenting Program (Triple-P), Good Behavior Game,*** and ***School Development Project (Seattle Social Development Project).***

Service and Support Recommendation #7: Increase availability of Wraparound care coordination statewide. In addition to increasing overall Wraparound capacity, develop more specific provider codes to allow oversight of Wraparound-specific activities by providers and family support workers and encourage local or state fiscal partnerships that can support use of case rates with accountability. Further, ensure availability of some slots to non-Medicaid youth. Finally, support an existing or new Center of Excellence (COE) to oversee training, professional development, and fidelity and quality monitoring specific to Wraparound.

Service and Support Recommendation #8: Build infrastructure to support implementation of prioritized EBPs. In particular, support community and tribal decision-making and oversight of EBP implementation using innovative community mobilization models. Such models may include: ***Partnerships for Success***, ***Communities that Care,*** and ***Getting to Outcomes.***

In addition to using a community mobilization model, implement methods to more accurately track EBP implementation (e.g., more specific reimbursement codes) and use enhanced reimbursement rates or other methods to offset costs of evidence-based/family-based interventions as well as reimbursement for training and supervision.

Finally, a key element of infrastructure to support EBP implementation and sustainability is the development and support of Centers of Excellence (COEs) such as the Children's EBP Institute

to promote wider and more sustainable implementation of EBPs through training, ongoing consultation and support, fidelity assessment, and outcome monitoring. Such COEs should include dedicated staff with expertise in each type of EBP, as well as full partnerships with family members and youth and an emphasis on adaptations for specific cultural groups.

System Design Recommendations

System Design Recommendation #1: Increase leadership roles of families and youth in system design and accountability monitoring by promoting and supporting cross-system community collaborative teams.

Specific roles include:

a. Oversight of local system functioning (i.e., review quality, outcomes and cost data, availability of services, and comprehensiveness of the local service array; propose solutions; and develop annual plans to overcome gaps and needs) and
b. Monitoring and problem-solving for individual families (e.g., review access to intensive services, oversee progress of families enrolled in the most intensive services)

System Design Recommendation #2: Increase leadership roles of families and youth in system design and accountability monitoring by building greater capacity at the DSHS level to use cross-system teams with youth and family leadership.

Specific recommended roles include:

a. Review of state data on outcomes, costs, and quality;
b. Evaluation of the success of state policies and service initiatives and implementation of mid-course corrections; and
c. Review of local plans and local data.

Further, consider methods to improve support to local communities and providers as well as "bust barriers" that exist at the state level. Develop quality assurance standards and indicators based on principles of evidence based practice as well as family-driven, youth-guided care and implement a process for overseeing quality review (e.g., Hawaii). Implement a public awareness campaign targeting providers and allied systems regarding methods for achieving family centered care and effectiveness of specific methods to achieve it (e.g., Arizona)

Introduction

In September 2007, the Washington State Mental Health Division (MHD) contracted with the Washington Institute for Mental Health Research and Training (WIMHRT) at the University of Washington to provide support in fulfilling legislative initiatives related to improvement of children's mental health throughout the State of Washington. In 2007, the State Legislature passed SSHB 1088, a Children's Mental Health Bill (see Table 1). The focus of the Institute's work over the past year and the primary areas of focus within this report are on the legislatively mandated areas of: (1) access to care and (2) services and supports.

Table 1: Section 1 of Second Substitute House Bill (SSHB) 1088

The legislature intends to substantially improve the delivery of children's mental health services in Washington state through the development and implementation of a children's mental health system that:

1. Values early identification, intervention , and prevention;
2. Coordinates existing categorical children's mental health programs and funding, through efforts that include the elimination of duplicative care plans and case management;
3. Treats each child in the context of his or her family, and provides services and supports needed to maintain a child with his or her family and community;
4. Integrates families into treatment through choice of treatment, participation in treatment and peer support;
5. Focuses on resiliency and recovery;
6. Relies on a greater extent on evidence-based practices;
7. Is sensitive to the unique cultural circumstances of children of color and children in families whose primary language is not English; and
8. Integrates educational support services that address students' diverse learning styles; and
9. To the greatest extent possible, blends categorical funding to offer more service and support options to each child.

MHD has spearheaded several initiatives related to improving the system of mental health for children and families in recent years (see Table 2). Among these efforts include the work by the Colorado-based consulting firm, TriWest Group, with whom MHD contracted to evaluate and provide recommendations regarding several areas of overlap for this project. These projects include the following and their findings will be integrated into relevant parts of this report:

- The System Transformation Initiative's Mental Health Benefit Package Design Report;[2]
- Report to the Legislature on Substitute House Bill (SBH) 2654: Strategies for Developing Consumer and Family Run Services; [3] and
- The Intensive Children's Mental Health Services Workgroup Recommendations.[4]

[2] TriWest Group. (July, 2007). *Statewide Transformation Initiative Mental Health Benefit Package Design Final Report.* Olympia, WA: Department of Social and Health Services, Health and Recovery Services Administration, Mental Health Division. Available at: http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_benefit_design_final_report_2008_01_23_final.pdf.

[3] SHB2654 Work Group. (September, 2008). DSHS Review Draft: Report to the Legislature on Substitute House Bill (SHB) 2654: Strategies for Developing Consumer and Family Run Services. Edited and compiled by TriWest Group. Washington State Department of Social and Health Services, Mental Health Division: Olympia, WA.

Table 2: Recent Washington State Mental Health System Improvement Efforts

The Washington State Joint Legislative Audit and Review Committee (JLARC) reported recommendations to the state legislature on improving the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for children's mental health in 2002 and for serving at risk youth in 2004.

The Children's Mental Health Initiative, a 2005 collaborative effort between Child Welfare, Mental Health and Juvenile Rehabilitation, produced strategies to move the system toward more coordinated, effective treatments for children with complex needs served by multiple systems.

The Washington State Mental Health Division System Transformation Initiative (STI) was initiated by MHD in September 2006. STI included a comprehensive package of budget and legislative initiatives to promote Washington State's public mental health services for adults with severe and persistent mental illness and children with serious emotional disorders. Specific projects under STI included (1) statewide implementation of ten Program of Assertive Community Treatment (PACT) teams: (2) an evaluation of the state Medicaid benefits package; (3) development of a plan for expanding mental health housing options; (4) a review of Washington State's involuntary commitment statute; (5) development of a utilization review system in state hospitals and community inpatient facilities; and (6) preparation of a plan for expanding employment for adults with mental illness.

Mental Health Transformation State Incentive Grant was awarded to Washington State in October 2005. This 5-year federally-funded project defined a transformed mental health system as one centered on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections.

Intensive Children's Mental Health Services Workgroup convened in April 2008 to craft recommendations to the MHD for expansion of services for the children with most intensive needs. Recommendations included increasing parent involvement when children transition out of CLIP facilities, developing more parent support organizations, and expanded availability of Wraparound, crisis supports, and expanded access to empirically-supported family-based treatments.

Methods

This report was shaped via a robust stakeholder advisory process. Five methods of data collection were used to solicit feedback about access and services from children's mental health system stakeholders in Washington State, including:

1. Two Community Forums
    a. November 2007 Forum (N=170)
    b. September 2008 Forum (N=180)
2. Interviews and questionnaires completed by Regional Support Network (RSN) representatives (N = 8);
3. Input from DSHS Assistant Secretaries and Administrators (N = 4);
4. One statewide Children's Mental Health Survey (N = 1,065); and
5. Two Tribal Roundtables

[4] TriWest Group. (June, 2008). Intensive Children's Mental Health Services Work Group Recommendations. Washington State Department of Social and Health Services, Mental Health Division: Olympia, WA.

a. Western Washington (N=23)
b. Eastern Washington (N=22)

Findings

The following provides an integrated summary of the findings from the first four data sources. Refer to ***Appendices 1-5*** for more details regarding the specific breakdown of results from each data source. These Appendices are arranged as follows:

- Appendix 1: Results from the November 2007 Children's Community Forum
- Appendix 2: Results from RSN Interviews and Questionnaires
- Appendix 3: Results of the 2008 Washington Children's Mental Health Survey
- Appendix 4: Gaps & Recommendations Related to SSHB 1088 Identified by DSHS Assistant Secretaries & Administrators
- Appendix 5: Results from the September 2008 Children's Community Forum

A separate set of recommendations entitled *Issues Identified by Tribal and Recognized American Indian Organization (RAIO) Representatives* is included in Appendix 6. In the following summary of findings, relevant results from the September 2008 Community Forum are typically presented after summaries from the other four data sources. This is because the September 2008 Forum presented preliminary results from the other data sources to participants, and then gathered additional information from participants using an Electronic Audience Response System (EARS).

Barriers to Access

Restrictive Access to Care Standards

There was a clear indication across data sources that stakeholders perceive the Access to Care Standards (ACS) employed in Washington State to be overly restrictive, primarily through (1) **omission of specific diagnostic categories** and (2) **narrow and restrictive functioning requirements**. This general opinion was expressed across all data sources. In the September 2008 Forum, 96% of participants agreed (66% strongly) that they had concerns about the current ACS. For respondents to the Children's Mental Health Survey, the most commonly endorsed concern pertaining to access was "children who are not eligible for services because their diagnosis or functional impairment is not serious enough." Data from the RSN interviews and input from the DSHS partner agencies specifically reference several diagnostic categories for which ACS were perceived to be too restrictive, including autism spectrum disorders, severe behavioral challenges, and children and youth with development disabilities. Results from the 2007 mental health forum also indicate that stakeholders believe there is inconsistent application of ACS across RSNs. At the 2008 Forum, when asked directly to rate their level of concern about different issues regarding ACS, respondents voiced high, but relatively equal levels of concern that the ACS (1) requires **too low a level of functioning** (i.e., the maximum Children's Global Assessment of Functioning or CGAS score is too low); (2) **do not include enough specific diagnoses**; and (3) allow **little or no access to services for non-Medicaid children, youth and families**. Respondents rated their concern about inconsistent application of ACS standards much lower than these other three concerns. This also reflected concerns previously

documented by MHD through stakeholder focus groups and forums involving parents and caregivers for the 2007 STI Benefit Design report. [5]

Insurance Limitations

In addition to concerns about ACS, data from all sources (except DSHS input) indicated perceived inequities in access due to insurance status, specifically **children and youth without Medicaid or with no insurance**. This was the second most-frequently cited barrier to access from the Children's Mental Health Survey, just behind eligibility restrictions due to ACS. As cited above, this was also rated as a significant concern by participants in the 2008 Forum.

Inadequate Capacity

Stakeholders expressed concerns about the impact of inadequate mental health service capacity in several ways. First, there was a consistent theme across 2007 Forum participants, RSNs and DSHS (particularly Children's Administration) that **delays in completing intake and getting therapy appointments** are major barriers to effective service. Second, stakeholder perspectives suggest specific age groups and types of children and youth for whom there is not adequate capacity. These results were, however, somewhat inconsistent across data sources. For example, 2007 Forum participants prioritized the need for **prevention and early intervention**, but data from the Children's Mental Health Survey indicate the primary age groups for which increased capacity is needed is **adolescents (12-16 years old)** and **transition age youth (17-25 years old)**. These two groups were endorsed by Survey respondents nearly twice as often as that of young children (0-4 years old) and school-aged children (5-11 years old). Similarly, RSNs identified the need for **crisis services for families**, which was not prioritized by either 2007 Forum participants or survey respondents.

When 2008 Forum participants were asked to provide ratings of capacity building needs**,** 90% of respondents agreed that **evidence-based prevention and early intervention programs** were a priority, with 71% strongly agreeing. When asked to provide ratings of importance, prevention and early intervention was rated slightly higher as a priority than other options, including **EBPs for children with serious behavior problems** (89%), **EBPs for youth exposed to trauma** (87%), **EBPs for youth with co-occurring mental health and substance abuse disorders** (79%), and **EBPs for youth at risk of out of home placement** (76%). However, when participants were asked to rank order their priorities in these areas, prevention and early intervention was rated as a lower priority than implementing EBPs for parents with youth with serious behavioral problems, and at approximately the same priority level as EBPs for youth exposed to trauma and youth at risk of out of home placement. As might be expected, different types of Forum attendees tended to have different top priorities. Youth and RSN representatives were most likely to voice support for prevention and early intervention, while parents of children with mental health problems were most likely to rate EBPs for youth with serious behavior problems as the highest priority. Providers and DSHS representatives were most likely to endorse EBPs for youth exposed to trauma.

[5] TriWest Group. (July, 2007). Previously cited.

This diversity in perspectives was also reflected in the findings of the Intensive Children's Mental Health Services Work Group convened in April 2008. This Work Group included representatives from SAFE-WA and parent advocates who work closely with parents and caregivers of children served by Washington's Children's Long-term Inpatient Program (CLIP) facilities, as well as representatives from Children's Administration, the Juvenile Rehabilitation Administration, the CLIP programs, RSNs, and MHD. These stakeholders work very closely with children and youth with the most severe behavioral health needs, and the service array they prioritized differed somewhat from that prioritized by the broader stakeholder groups. Because very few children and youth from the overall population of children with mental health needs have needs requiring the level of intensive and restrictive services provided by the CLIP programs, the views of this group would be hard to discern from the aggregate analyses just described. It is important to keep the perspectives of these stakeholders in mind, given the vulnerabilities of the children and families served, as well as the significant, multi-system service use and costs experienced by this group. The work group identified a set of key service elements necessary to effectively address the intensive mental health needs of children and youth. While all of these elements were not equally endorsed by all members of the work group, they included:

- **Transition Services** – Services to support children, youth and their families in successful transitions stepping down from CLIP facilities were identified, including **consultation** from CLIP facilities to community agencies for children and youth stepping down from CLIP services, supports for ongoing **family involvement** during CLIP admissions, and **aftercare** to support maintenance and generalization of treatment gains.
- **Crisis Continuum** – A comprehensive crisis services continuum was prioritized, including a **mobile crisis team** in major communities across the State able to offer 24/7 in-home response connected to an array of immediately available **crisis beds** (including placements in family-like settings) to support children and youth in community placements over a short (1 to 7 days) to medium (14 to 30 days) term.
- **High Fidelity Wraparound** – Family driven planning and coordination to identify service needs and plan and coordinate access to services was identified, in accord with the standards of the National Wraparound Initiative.
- **Parent Organizations** – Active local Parent Organizations were seen as important to support family engagement in services and help families navigate the service system, advocate for their needs, and cope with the stresses of supporting their children.
- **Out-of-Home Program Capacity** – Increasing the capacity for effective residential services was discussed in terms of three components: **increasing reimbursement rates for CLIP** facilities to be more in line with the Child Study and Treatment Center (CSTC) level of care; adding an **additional 16 bed CLIP facility** in the center of the State, and building statewide capacity for **Multidimensional Treatment Foster Care** and other small, family-based out-of-home placement models that are empirically-supported. This lack of capacity was also noted in previous studies, including the 2004 report by the Public Consulting Group.[6]
- **Community Based Treatment** – The work group also prioritized increasing capacity for empirically-based treatments to support children, youth and their families in the

[6] Public Consulting Group. (November, 2004). Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds: Adults and Children. State of Washington DSHS MHD: Olympia, WA.

community (e.g., Multisystemic Therapy, Functional Family Therapy, Family Integrated Transitions, Multidimensional Family Therapy). These treatments would include models addressing co-occurring disorders.

- **Centers of Excellence** – The work group noted the need for local centers within Washington to provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices.

Lack of Specific Provider Types

The findings about inadequate overall capacity a variety of service modalities, cited in the previous section, was reinforced by data indicating a lack of qualified and adequately trained mental health providers in several specific areas. First, a need for access to more **child psychiatrists** was expressed across all data sources. Child psychiatry was the most oft-cited provider gap from the Children's Mental Health Survey (along with "child mental health therapists," both of which received 23% of all responses). More specifically, RSN and DSHS informants also cited a need for more **consultation by child psychiatrists to primary care providers** and more **consistent medication management**. Child psychiatrists also emerged as the top need at the 2008 Forum. Second, as indicated above, there was also a need expressed across all data sources for **qualified children's mental health providers**. This option was the second most oft-cited provider type at the 2008 Forum. Finally, the RSN interview results pointed to a need to recruit and retain **bilingual providers** and data from the Children's Mental Health Survey supported this need, with 14% of all responses endorsing a need for "providers with diverse racial and cultural backgrounds;" however, it should be pointed out that this option was the fifth most often expressed need across professional types, behind child psychiatrists, qualified mental health providers, mental health specialists, and **family/peer-to-peer support workers**.

System Fragmentation and Lack of Continuity of Care across Systems and Services

Data from the 2007 Forum, RSN interviews, and DSHS partners all referenced a need for **greater collaboration and better integration of policies and funding across child/youth-serving agencies and systems**. With respect to access to services, this was supported by Survey data showing that schools (55% of all respondents), primary care settings (48%), and early childhood settings (46%) are the three settings in which capacity is needed to more effectively identify and intervene with children with emerging mental health needs.

Barriers to Engagement and Completion of Treatment

Data across sources highlighted additional barriers to access and full engagement in services and pointed to potential solutions. First, all data sources (except DSHS) cited **lack of information to families** as a barrier to effective access to services. **Peer-to-peer and family navigator services** were cited by 2007 Forum participants and RSN interviews as a mechanism to help overcome this barrier, while Survey data indicated strong support for **family** and peer-to-peer support workers as well as family navigators. Second, logistical barriers were cited across all sources, most prominently **transportation and child care**. However, it should be noted that parents who responded to the Children's Mental Health Survey prioritized logistical supports such as transportation vouchers and child care much lower than the need to develop more effective services and capacity to provide family support. On the other hand, Survey respondents,

particularly parents, prioritized the need for **services in the family home and during off hours** (evenings and weekends) very highly as a way to ensure better access to and engagement in services.

This finding was reinforced by EARS results from the 2008 Mental Health forum, which found that 94% of respondents agreed (57% strongly) that youth and families could be better engaged if there were **incentives for providers to deliver services out of the office, during off-hours, and during weekends**. This was the most oft-supported strategy to better engage parents, just ahead of "**training providers on evidence based and promising family and youth engagement/empowerment strategies**" (91%) and ahead of "**developing Family Navigator services"** (78%).

Age of Consent

Finally, though it was not revealed through data from other sources, it should be noted that in the Children's Mental Health Survey, the greatest barrier to involvement in services cited specifically by parents are perceived **confidentiality issues** that arise because of age of consent laws in the state. When presented specifically at the 2008 Forum, 59% of respondents strongly agreed and 25% agreed that the **age of consent in Washington** is an area of concern. It should be noted that this concern also emerged as a major stakeholder-identified need in the 2007 study of involuntary treatment in Washington State.[7] These concerns relate to §71.34.500 and §71.34.530, which permit minors over 13 years to seek and receive mental health inpatient and outpatient treatment without the consent of their parents. Many States have similar laws permitting minors to access mental health and/or substance abuse treatment without the consent of their parents, but in Washington concerns about the age of consent are linked most directly to minors' ability to *refuse* treatment even when their parents and mental health professionals believe it is in their best interests. While a law designed to accomplish this exists at RCW §71.34.600, stakeholders report that it is seldom used. In the 2007 report, parents and providers suggested that this law is not used for a number of reasons, including that most parents are unaware of the law and providers are not clear about the rights of minors under the law and how minors can access the legal system if they object to treatment.

Priority Services and Supports

Overall Service and Support Priorities

As mentioned in the previous section, it is difficult to make a summary statement about overall priorities for development of enhanced service capacity. On the one hand, 2007 Forum participants highly prioritized a need for **enhanced prevention and early intervention services**, including **services for infants**. On the other hand, the specific services cited by RSN and DSHS respondents tend to be high intensity services such as the **Wraparound process** (also prioritized highly in the 2007 Forum), **Family Integrated Transitions (FIT)**, **Multidimensional Treatment Foster Care (MTFC)**, and – more generically – "high-intensity services," "evidence

[7] TriWest Group and Advocates for Human Potential. (July, 2007). *Statewide Transformation Initiative Involuntary Treatment Act (ITA) Review: Final Report.* Olympia, WA: Department of Social and Health Services, Health and Recovery Services Administration, Mental Health Division. Available at: http://www1.dshs.wa.gov/mentalhealth/sti_involuntary_treatment_act.shtml.

based practices for children with SED," and "services for youth transitioning from CLIP and juvenile justice facilities." Moreover, as mentioned above, the Children's Mental Health Survey data indicate more support for prioritizing services for older children, youth, and young adults (aged 12-25) than young and school-age children. Survey data also revealed "**increasing availability of community based care for youth with serious behavioral problems**," and "**investing in Wraparound**," as the two top overall priorities for the mental health system. The April 2008 Intensive Children's Mental Health Services Work Group prioritized a mix of expanded **crisis supports**, targeted expansion of **empirically-supported out-of-home capacity**, and **family driven supports** such as Wraparound, Parent Organizations, and transition supports. Results from the 2008 Forum did not clarify such priority areas well, with respondents providing high ratings of priority for all these types of services. As mentioned above, however, **EBPs for parents with children and youth with serious behavior problems** did emerge as the highest priority among five broad categories presented.

Use of Services with Evidence for Effectiveness

Across data sources, support for use of **evidence based practices (EBPs)** was robust and expressed in different ways. RSN and DSHS interviewees were explicit in their support for "expanding" or making "widely available" EBPs for children and families, as well as ensuring availability of "a continuum of EBPs." Children's Mental Health Survey results showed that the highest training priority was for "services proven to be effective" (closely followed by "training on how to engage families in services"). Moreover, only 3% of Survey respondents voiced that they believed "we don't need more evidence based or promising practices," which may be considered surprising given the dialog that sometimes accompanies the discussion of EBPs. At the same time, it should be noted that when asked to express their overall priority, Survey respondents prioritized EBPs fourth, after investing in services for high-risk children, reducing barriers to care posed by ACS, and Wraparound.

Specific Treatments

Several service modalities and target populations emerged as having broad-based support from across stakeholder perspectives.

- As mentioned above, there is clear support for **intensive community-based treatments** that have the ability to maintain or transition children and youth to community settings. Specific services of this modality that were identified include MST, FIT, FFT, and MTFC.
- The **Wraparound service model** was prioritized consistently by 2007 Forum participants and RSN informants, and was prioritized highly in several items from the Children's Mental Health Survey and by the Intensive Children's Mental Health Services Work Group.
- Survey data as well as results from EARS data collection at the 2008 Forum revealed that children and youth with mental health problems stemming from **past trauma** are a high priority for intervention, endorsed by 46% of all respondents. This aligns with the perspective of DSHS partner agency representatives who specifically identified Trauma Focused Cognitive Behavioral Therapy (TF-CBT) as a priority service need.
- The need for additional capacity to serve **youth with co-occurring disorders**, particularly co-occurring mental health and substance abuse problems, was identified as a

priority across RSN and DSHS interviews, and was the second highest priority among Survey respondents (endorsed by 44% of all respondents). This area was relatively less highly prioritized, however, by 2008 Forum participants.

- **Respite care services** were identified as a needed service across all sources of data. Respite was endorsed as a specific service need by 38% of Survey respondents, placing it behind services such as intensive community based services, Wraparound, and day treatment among priorities.
- The Intensive Children's Mental Health Services Work Group prioritized a mix of expanded **crisis supports**, targeted expansion of **empirically-supported out-of-home supports** such as crisis beds, Multidimensional Treatment Foster Care, and the Child Study and Treatment Center, and **family driven supports** such as Wraparound, Parent Organizations, and transition supports.

Preventive and School-Based Services

As referenced previously, developing enhanced capacity to implement preventive and early intervention services was an overwhelmingly endorsed priority among attendees at the November 2007 Children's Mental Health Forum. **Infant and early intervention** was also a theme among DSHS partners, particularly Children's Administration. Developing **school-based mental health services** also was endorsed as a priority at the 2007 Forum. This was supported by several results from the Children's Mental Health Survey, which pointed to the need to develop capacity in schools (just ahead of primary care and early childhood settings) to identify and intervene with children with mental health needs. Both were also priorities identified in the 2007 STI Benefit Design stakeholder focus groups.

Potential Strategies to Improve Access and Services

Though the focus of the current report was not intended to be system-level strategies, a number of recommendations for specific strategies emerged from data analysis. These strategies fell into three main areas: Family engagement approaches, training infrastructure, and potential funding strategies.

Family Engagement Approaches

Stakeholders nationally are increasingly recognizing the importance of family support services as a means of improving family engagement and empowerment, improving likelihood of treatment completion, and potentially improving outcomes through bolstering social support and parent self-efficacy. Across all data sources, stakeholders endorsed the need to more **actively partner with parents and youth in system design and accountability monitoring**. With respect to specific services and supports, participants in all the different types of data collection prioritized services such as **peer-to-peer, family, and youth support partners** (provided by family members and youth) as well as individuals who can serve as **family navigators** and thus help negotiate the multiple systems with which many families must interact. Respondents to the Children's Mental Health Survey also prioritized **training for providers on methods to enhance family engagement** at about the same level of priority as training for providers on effective services.

As mentioned above, specific methods to engage families were presented at the 2008 Mental Health Forum for prioritization by participants. **Incentivizing providers to deliver services out of the office and during off-hours and weekends** and **training providers in evidence based and promising strategies to engage parents and youth** were nearly universally supported.

Family- and Youth-Run Organizations

In addition to the above priorities, participants in the 2008 Children's Mental Health Forum were asked three questions related to the development and support of family- and youth-run organizations in Washington State. As shown in Figures 7-9 of Appendix 5 of this report, 97% of Forum participants were in overall agreement with the idea of **enhancing existing family- and youth-run organizations**, while 88% were also in support of **development of more family- and youth-run organizations** in Washington State. The Intensive Children's Mental Health Services Work Group prioritized the expansion and development of **parent organizations** to support family engagement in services and help families navigate the service system, advocate for their needs, and cope with the stresses of supporting their children. The parents, youth consumers, adult consumers, and other members of the HB2654 Work Group recommended multiple approaches for supporting both the enhancement and expansion of family run and youth run support organizations, including a pilot to support development, technical assistance funding, and the development of certification standards for mature organizations seeking to expand their delivery of state-funded and Medicaid-funded support services. Training and technical assistance for both RSNs and providers to support their collaboration with parent and youth run organizations was a critical component of the HB2654 recommendations.

Training Infrastructure and Centers of Excellence/Evidence Based Practice Institute

As previously recommended in the 2007 STI Benefit Design Report, there was a consistent recommendation to improve the level of knowledge and skill of the children's mental health workforce by supporting entities that can provide training, ongoing technical assistance and support, fidelity data collection, outcome monitoring, and human resource development. DSHS and RSN informants in particular voiced a need for a consistent source of **training and professional development for implementing EBPs**, while Survey respondents prioritized both **training for providers on effective practices** as well as **training for providers on methods to better engage youth, parents, and families**. The Intensive Children's Mental Health Services Work Group highlighted the need for Centers of Excellence to support both community-based EBP implementation and parent support. The HB2654 Work Group highlighted the need for centralized Technical Assistance Centers run by parents and youth to support the implementation of parent and youth run organizations.

Funding Strategies

Though far from specific, several funding strategies were proposed by stakeholders. The need to better blend and coordinate funding to serve youth with intensive, multi-system needs was presented by participants in the 2007 Forum as well as in multiple RSN interviews. Other RSN interviewees also specified some of their own creative financing strategies such as setting aside funds to offset costs for developing infrastructure to implement EBPs. As described above, survey respondents and 2008 Forum participants voiced strong support for providing agencies with incentives to provide services in families' homes and during evenings and weekends, to

increase likelihood of engagement and completion of treatment. The 2007 STI Benefit Design Report noted the need to developing encounter coding approaches to more clearly track the delivery of EBPs, as well as financing approaches that take into account the differential cost of delivering these services.

Recommendations

The following recommendations were driven by the findings identified above and based on input from community stakeholders regarding the status of children's mental health services and access in Washington State. These recommendations are divided into three sections below:

- Access Recommendations
- Service and Support Recommendations
- System Design Recommendations

Access Recommendations

Access Recommendation #1: Support provider organizations to increase youth and family access to, and engagement in, services:

Access Recommendation #1a: Increase rates to community mental health agencies to provide services out of the office, after hours, and during weekends.

For example, ***New York's Clinic Plus*** model is an early intervention program is designed to screen for early signs of social or emotional difficulty. Free screenings are provided in schools and health care facilities, and if a problem is identified, the family is put in touch with mental health providers who will deliver evidence-based treatments in the home at no cost. As noted in the 2007 STI Benefit Design Report, it is critical to tie the differential rates to the delivery of the desired services, rather than simply increase rates across the board.

Access Recommendation #1b: Train providers, parents and youth on evidence based and promising family and youth engagement and empowerment strategies.

The ***Parent Empowerment Program*** at the REACH Institute, for example, trains "professional parents," (often parents of children with mental illness) to become advocates for other parents in similar situations. These advocates help parents who are new to the mental health system to understand these various resources, and find treatment from providers in a way that builds trust and eases confusion and stress. Programs like this have been developed to provide these services in various settings, including mental health clinics, primary care clinics, in schools, and in the juvenile justice system.

Similarly, there should be more development of ***Family Navigators*** to help families get information about options and make choices. A family navigator is a parent partner trained professionally to help other parents of children with mental illnesses understand their child's issues and access appropriate treatment solutions. Often having had first hand experience, navigators are trained to maintain up-to-date knowledge of types of treatment in their local

area, and what channels a family must go through to obtain treatment. Generally, their major responsibilities are to educate the parents about their child's mental illness, and facilitate access to the most appropriate treatment.

Often the development of parent- and youth-run organizations is the best strategy for increasing community capacity for family and youth engagement and empowerment. The family and consumer-led HB 2654 Work Group prioritized training and support for parents, youth, and other consumers to encourage development of such organizations. Washington State currently has several exemplar parent- and youth-run networks and organizations that may be the best poised to continue to develop their capacity to provide this type of training to providers, parents, and youth. These networks include Statewide Action for Family Empowerment of Washington (SAFE-WA), which provides support to parents and caregivers and their network organizations, and Youth 'N Action, a statewide youth advocacy organization.

Access Recommendation #2: Address limits to access to services posed by current Access to Care Standards (ACS). Confirming data collected for previous reports (see [8] below), the data across multiple sources for this report indicate that Washington State stakeholders are concerned about the limitations within the current ACS.

Consistent with previous recommendations in the 2007 Mental Health Benefit Design Report, one possible strategy for addressing these limits would be to increase the CGAS minimum scores for all covered diagnoses, allowing for more children with higher levels of functioning to access routine outpatient services. More specifically, it is recommended that the State increase the minimum score to 70 if it is economically feasible. The current actuarial analysis of the financial impact of revising the CGAS minimum scores for outpatient services will help to better define the viability of this approach at this time.

While likely to be less fiscally feasible, a second possible strategy recommended by multiple stakeholders is the expansion of current diagnostic categories (e.g., including autism-spectrum disorders, severe behavioral challenges) so that they now qualify for services under ACS.

Access Recommendation #3: Shift RSN utilization management away from front-end restrictions across all enrollees to proactive care management for the most intensive and costly services. This recommendation was initially made within the System Transformation Initiative (STI) Mental Health Benefit Design report[8] and is further recommended here based on stakeholder input. Stakeholders giving input to this report clearly said that if a family or child presents for mental health treatment, they should be assumed to be in need of some type of response. Too often, current RSN efforts to manage service use focus too much on controlling who gets in the door to receive services, rather than determining how best to serve children in need. As described in this previous report this type of shift will require the development of statewide medical necessity standards to guide both initial and concurrent reviews processes for

[8] TriWest Group (July, 2007). Previously cited.

all levels of care, with increased emphasis of care management for those most in need and less reliance on front-end limitations to care delivery.

Access Recommendation #4: Increase access to child psychiatrists by expanding the current Partnership Access Line (PAL). ***PAL*** is a telephone-based child mental health consultation system funded by the state legislature and currently being implemented in Washington State. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services.

It is recommended that the PAL program both be expanded statewide and adapted to support primary care practitioners in providing medication management to children and youth currently on waiting lists for programs in communities with limited access to child psychiatrists.

Service & Support Recommendations

Service and Support Recommendation #1: More actively promote Family Advocacy, Peer-to-Peer Support, and Youth Support.

Service and Support Recommendation #1a. Promote Family Support and Advocacy Organizations (FSAOs) to be more self-sustaining and more capable of providing reimbursable services, such as by:

a. Promoting development of contractual relationships between FSAOs and RSNs and/or community mental health agencies (CMHAs); and
b. Establishing certification standards for parent and youth-run organizations seeking to provide state and Medicaid-funded "non-clinical" services (e.g., respite, family support, youth support, family navigation, Wraparound family partners and care coordination, and other reimbursable services). This recommendation was initially provided in the Mental Health Benefit Package Design Report (see reference [8]), was prioritized through legislation under HB 2654, and was addressed comprehensively in the recommendations of the HB 2654 Work Group.

To support such implementation, the HB 2654 Work Group concluded that "Washington State needs a broader and diverse array of consumer and family run organizations to develop and provide an ever-expanding array of services and supports grounded in the priorities of the consumers and family members that live in the communities where those programs operate." The Work Group articulated a developmental framework to guide development and certification standards for mature organizations seeking to access expanded state and Medicaid funding to support delivery of such supports.

Service and Support Recommendation #1b. Further, expand current technical assistance and other supports to FSAOs (e.g., through Center(s) of Excellence) to implement evidence based and promising family support models. Consistent with this, the funding of technical assistance to develop parent and youth run organizations across the state at multiple levels of development, including dedicated funding for both the start-up of new organizations and the

enhancement of existing organizations, was prioritized by the HB 2654 Work Group. Technical assistance should also support RSNs and CMHAs to integrate their services with those of consumer and family run organizations. This should be funded from multiple sources. Actively include representatives of effective state and local youth- and family-run organizations. Examples include King County's A Village Project II and SAFE-WA's network organizations, including A Common Voice for Pierce County, BRIDGES to Parent Voice (Clallam, Kitsap, and Jefferson Counties), Changes Parent Support Network (King and Snohomish Counties), Spokane's Passages program, and Training Resources in Partnership (Island, San Juan, Skagit, Snohomish, and Whatcom Counties), as well as the Mockingbird Society. Youth 'N Action, a youth-run statewide organization, should also be included.

Service and Support Recommendation #1c. Enhance the current peer-to-peer and family/youth support worker certification process, including revisions to current knowledge assessments to tailor them to the delivery of parent and youth supports. To support these enhancements, conduct a study of certified family- and youth-support workers about their experiences with the certification process, with providing care to youth and families, and barriers to their effectiveness in providing this covered service.

Service and Support Recommendation #2: Implement evidence-based practices (EBPs) for youth at risk of out-of-home placement or transitioning home from out-of-home placement settings. The data suggest that this population is a high priority for Washington State stakeholders, as documented in this report as well as through the 2007 STI process. Benton, Clark, Franklin, King, Mason, Skagit, Snohomish, Thurston, Whatcom, and Yakima County's have already implemented EBPs that address the service needs of this population, while also engaging families in the treatment process, including:

- ***Multidimensional Treatment Foster Care (MTFC)*** [9]**:** MTFC is a program for youth ages 3-17 in foster care homes that emphasizes creating a positive and predictable environment through close supervision and supportive relationships with caregivers. Foster parents are trained in behavioral methods for creating this environment, and provided with 24/7 support from a treatment team that develops a structured, individualized program for each child. In addition, biological families are given family therapy to maintain and support appropriate behaviors and relationships upon the child's return to his biological home.

- ***Functional Family Therapy (FFT)*** [10]**:** FFT can be used as a short term (8-12 session) preventative or interventional program for supporting and enhancing the abilities of high-

[9] Chamberlain, P., & Reid, J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology, 19,* 266-276.
Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52 (9),* 1179-1189.
Weisz, J.R., Doss, J.R., Jensen, A., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology, 56,* 337-363.
[10] Sexton, T.L, Alexander, J.F. (December, 2000). Functional family therapy. *Office of Juvenile Justice & Delinquency Prevention, Juvenile Justice Bulletin*, 3-7.

risk youth ages 11-18 and their families to improve their situations in natural settings. It relies on a systematic approach, using three phases to target specific goals of engagement and motivation, behavior change, and generalization so that the entire family can utilize community resources to maintain these changes. FFT provides a flexibly structured and culturally sensitive framework for establishing self-sufficiency within families and reducing recidivism in youth receiving treatment.

- ***Multisystemic Therapy (MST)[11 12]:*** MST provides a comprehensive approach to correcting antisocial behaviors in youth by providing intensive cognitive behavioral, behavioral, and pragmatic family therapies in the home, community, and at school. Emphasis is placed on considering and correcting the social factors that contribute to the antisocial behaviors, which is accomplished by removing youths from deviant peer groups and creating a strong network of family, friends, and community members to support and maintain positive change. MST is currently being implemented in four sites across Washington State.

- ***Family Integrated Transitions (FIT)[13]:*** The FIT program integrates Multisystemic Therapy (MST), Dialectical Behavioral Therapy (DBT), and Motivational Enhancement Therapy (MET) to provide individual and family therapy to juvenile offenders under 17 ½ with comorbid Axis I mental illnesses and chemical dependency. Beginning 2 months prior to the youth's release, therapists are available 24/7 to coach parents and help them find natural community supports and services to ease the youth's transition during the first 4 to 6 months out of detention. The goals of the FIT program include lowering the risk of recidivism, achieving youth abstinence from alcohol and other drugs, improving the mental health of the youth, and increasing prosocial behavior.

Service and Support Recommendation #3: Implement EBPs for youth exposed to past trauma. While a high priority across participants in the September 2008 Forum, providers and DSHS representatives were most likely to endorse EBPs for youth exposed to trauma. The 2007 STI process also highlighted this priority. Several efforts are currently underway to implement ***Trauma Focused Cognitive Behavioral Therapy (TF-CBT)[14]*** [15]in various parts of the state.

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[11] Huey, S.J. Jr., Henggeler, S.W., Brondino, M.J., & Pickrel, S.G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology, 68 (3),* 451-467.

[12] Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. E. (1998). Multisystemic treatment of antisocial behavior in children and adolescents. New York: Guilford.

[13] Aos, S. (2006). *Washington State's Family Integrated Transitions program for juvenile offenders: Outcome evaluation and benefit-cost analysis.* Document No. 04-12-1201. Olympia: Washington State Institute for Public Policy.

[14] Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2006). Trauma-Focused Cognitive-Behavioral Therapy for Sexually Abused Children. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice (2nd ed.)* (pp. 743-765). Washington, DC: American Psychological Association.

[15] Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents: A Clinician's Guide*: The Guilford Press.

Both Children's Administration and the Mental Health Division have allocated resources to expand the number of clinicians trained in this approach. The Evidence Based Practice Institute has identified the expansion of therapists skilled in TF-CBT as a major target for its workforce improvement activities. TF-CBT is a treatment provided to children between the ages of 4 and 18 who are experiencing symptoms of Post Traumatic Stress Disorder (PTSD) after a traumatic event. Even if the child has not been clinically diagnosed with PTSD, this model of psychotherapy provides an effective combination of CBT and trauma-sensitive interventions to improve the emotional and social well being of any child with significant behavioral or emotional problems related to traumatic life events. Individualized sessions are provided to both the child and parent, and occasionally both at the same time, to teach ways of managing distressing thoughts and feelings, increasing family communication, and improving parenting skills.

Service and Support Recommendation #4: Implement EBPs for youth with co-occurring mental health and substance abuse disorders. In addition to ***MST*** and ***FIT***, ***Multidimensional Family Therapy (MDFT[16])*** is another evidence-based model that may be implemented to address the needs of youth with co-occurring disorders. MDFT is an intervention aimed at improving the relationships between substance abusing youth with behavioral issues and their family members. Treatment is administered in several phases, first targeting functional areas to create a developmentally normative lifestyle for the adolescent, and continuing to expand to parent interventions, interactions between the parent and adolescent, and finally including systems external to the family. This approach is particularly flexible has been successful in highly diverse populations.

Service and Support Recommendation #5: Implement evidence based models that target early signs of behavioral problems and assist parents in working with oppositional and defiant behaviors. Specifically recommended models include:

- ***Parent-Child Interaction Therapy (PCIT[17])***: PCIT uses principles from attachment and social learning theory to help the parent effectively correct problem behavior and develop a nurturing relationship with his or her preschool-aged child. Parents are observed by therapists while interacting with their children, and coached on methods for becoming an authoritative parent including limit setting, problem solving, and consistency.

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[16] Liddle, H. A. (2002a). *Multidimensional Family Therapy for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 5*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

[17] Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., et al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting & Clinical Psychology, 72 (3),* 500-510.

- ***The Incredible Years[18]:*** The two main areas of focus for the Incredible Years program are to prevent conduct problems from developing and to intervene at the early onset of these behaviors in children from infancy to school-age. These goals are accomplished by the interaction of three programs aimed at improving the skills of the child (academic and social achievement), parent (increase communication and nurturing approaches), and teacher (effective classroom management and teaching of social skills). This curriculum effectively targets risk factors for conduct disorder, and creates a positive environment for the child both at home and at school.

Service and Support Recommendations #6: Implement prevention and early intervention programs with evidence for effectiveness that align with stakeholder priorities.

Recommended prevention and early intervention programs that span from birth to age 12 include the following:

- ***Nurse-Family Partnership[19]:*** This program provides at-home nurse visits to low-income and high risk first-time parents and their children. Visits begin during the prenatal period and continue until the child is two years of age, and are designed to help mothers have healthier pregnancies, and be self-sufficient in ensuring the healthy development of their children.

- ***Positive Parenting Program (Triple-P)[20]:*** This program is aimed at teaching parents of children from birth to age 12 better ways of preventing emotional, behavioral, and developmental problems. It is structured to include five levels of varying intensity, from the dissemination of information through printed materials, to 8-10 session parenting programs and more enhanced interventions for families experiencing additional relational stress. Using social learning, cognitive behavioral, and developmental theory in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues. Triple-P is currently being implemented in two sites in Seattle (Odessa Brown, Harborview Sexual Assault and Trauma Center), Pierce County Public Health, various agencies in Thurston-Mason, and with at least 20 provider agencies in Children's Administration.

- ***Good Behavior Game[21]:*** This program is designed to reduce aggressive and disruptive behavior in 1st and 2nd grade classrooms. The teacher divides the class into three teams

[18] Webster-Stratton, C. (1984). A randomized trial of two parent-training programs for families with conduct-disordered children, *Journal of Consulting and Clinical Psychology, 52(4),* 666-678.
[19] Olds et al. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial, *Pediatrics, 120 (4),* e832-e845.
[20] Sanders, M.R., Markie-Dadds, C. & Turner, K.M.T. (2003). Theoretical, scientific and clinical foundations of the Triple P-Positive Parenting Program: A population approach to the promotion of parenting competence. *Parenting Research and Practice Monograph No.1.* pp1-24.
[21] Kellam, S.G., Ling, X., Merisca, R., Hendricks Brown, C., & Ialongo, N. (1998). The effect of the level of aggression in the first grade classroom on the course and malleability of aggressive behavior into middle school, *Development & Psychopathology, 10 (2),* 165-185.

with equal proportions of boys and girls, and well-behaved versus disruptive children. The teacher then outlines examples of good and bad behaviors, and each team is given a sheet where a check is placed each time a member of that team misbehaves. The game is played in short periods at first, and then longer ones, with the team with the least check marks at the end of a period receiving rewards that are first tangible, and then become more abstract.

- ***School Development Project (Seattle Social Development Project)***[22]**:** This program uses an intervention designed to improve the skills of teachers, parents, and children toward developing prosocial behaviors and avoiding risk factors associated with antisocial behavior and drug abuse. This program teaches children better interpersonal and refusal skills, and emphasizes behavior management for parents and cooperative learning for teachers.

Service and Support Recommendation #7: Increase availability of Wraparound care coordination statewide.

Wraparound[23][24] is collaborative system designed to focus on family voice and team planning to develop a community-based system of care for children with emotional and behavioral disorders and their families. A team of professionals who provide care to the child meet regularly with the family, and create a plan to manage care and crises that is based on the individual strengths and needs of the family. This plan is continually evaluated to ensure that it provides appropriate, culturally competent care that results in observable and measurable improvements.

In addition to increasing overall Wraparound capacity, develop more specific provider codes to allow oversight of Wraparound-specific activities by providers and family support workers and encourage local or state fiscal partnerships that can support use of case rates with accountability. Further, ensure availability of some slots to non-Medicaid youth.

Finally, support an existing or new Center of Excellence (COE) to oversee training, professional development, and fidelity and quality monitoring specific to Wraparound.

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[22] Hawkins, JD, Smith, BH, Hill, KG, Kosterman, R, Catalano, RF, & Abbott, RD (2007). Promoting social development and preventing health and behavior problems during the elementary grades: Results from the Seattle Social Development Project. Victims & Offenders, 2 161-181.

[23] Suter, J., & Bruns, E. J. (2008). A narrative review of wraparound outcome studies. In E. J. Bruns & J. S. Walker (Eds.), *Resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

[24] Walker, J.S., Bruns, E.J., & Penn, M. (2008). Individualized services in systems of care: The wraparound process. In B. Stroul & G. Blau (Eds.). *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families.* Baltimore: Brookes.

Service and Support Recommendation #8: Build infrastructure to support implementation of prioritized EBPs. In particular, support community and tribal decision-making and oversight of EBP implementation using innovative community mobilization models. Such models may include:

- ***Partnerships for Success***[25]***:*** This model provides a community planning infrastructure designed to strategically identify service needs and gaps for children's mental and behavioral healthcare in communities and map those needs onto evidence based practices in a manner that promotes sustainability and community engagement. Due to being a community-driven process, the Partnerships for Success model is inherently flexible and able to be implemented within a range of different community contexts and structures.

- ***Communities that Care***[26]***:*** This is a prevention-oriented system that evaluates the strengths and issues of each school community to develop a plan for implementing appropriate evidence-based programs. This approach integrates social development theories from prevention science to address issues such as substance abuse, positive social development, unplanned pregnancy, and academic issues in a way that has greater flexibility than a step-by-step program.

- ***Getting to Outcomes***[27]***:*** This is a system that emphasizes accountability and outlines the planning, implementation, and evaluation of programs devised to improve a particular set of issues. By following a process of logical assessment of risk factors and needs assessment, Getting to Outcomes helps to ensure the development of a useful, sustainable program within a particular community.

In addition to using a community mobilization model, implement methods to more accurately track EBP implementation (e.g., more specific reimbursement codes) and use enhanced reimbursement rates or other methods to offset costs of evidence-based/family-based interventions as well as reimbursement for training and supervision.

Finally, a key element of infrastructure to support EBP implementation and sustainability is the development and support of Centers of Excellence (COEs) such as the Children's EBP Institute to promote wider and more sustainable implementation of EBPs through training, ongoing consultation and support, fidelity assessment, and outcome monitoring. Such COEs should

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[25] Julian, D. A., Ross, M., & Partridge, C.(2008). Challenges in supporting community implementation of science-based programs: A critical review of local partnerships for success plans, *American Journal of Community Psychology, 41,* 351-360.

[26] Hawkins, J.D., Catalano, R.F., & Arthur, M.W. (2002). Promoting science-based prevention in communities. *Addictive Behaviors, 27 (6),* 951-976.

[27] Chinman, M., Hannah, G., Wandersman, A., Ebener, P.A., Hunter, S., Imm, P. & Sheldon, J. (2005). Developing a community science research agenda for building community capacity for effective preventive interventions, *American Journal of Community Psychology*, 35 (3-4), 143-157.

Chinman, M., Early, D., Ebener, P.A., Hunter, S., Imm, P., Jenkins, P., Sheldon, J., & Wandersman, A. (2004). Getting to outcomes: A community-based participatory approach to preventive interventions, *Journal of Interprofessional Care*, 18 (4), 441-443.

include dedicated staff with expertise in each type of EBP, as well as full partnerships with family members and youth and an emphasis on adaptations for specific cultural groups.

System Design Recommendations

System Design Recommendation #1: Increase leadership roles of families and youth in system design and accountability monitoring by promoting and supporting cross-system community collaborative teams.

Specific roles include:

a. Oversight of local system functioning (i.e., review quality, outcomes and cost data, availability of services, and comprehensiveness of the local service array; propose solutions; and develop annual plans to overcome gaps and needs) and
b. Monitoring and problem-solving for individual families (e.g., review access to intensive services, oversee progress of families enrolled in the most intensive services)

System Design Recommendation #2: Increase leadership roles of families and youth in system design and accountability monitoring by building greater capacity at the DSHS level to use cross-system teams with youth and family leadership.

Specific recommended roles include:

a. Review of state data on outcomes, costs, and quality;
b. Evaluation of the success of state policies and service initiatives and implementation of mid-course corrections; and
c. Review of local plans and local data.

Further, consider methods to improve support to local communities and providers as well as "bust barriers" that exist at the state level. Develop quality assurance standards and indicators based on principles of evidence based practice as well as family-driven, youth-guided care and implement a process for overseeing quality review (e.g., Hawaii). Implement a public awareness campaign targeting providers and allied systems regarding methods for achieving family centered care and effectiveness of specific methods to achieve it (e.g., Arizona)

Attachment to Appendix D

Results from November 2007 Children's Community Forum

Appendix 1.
Results from November 2007 Children's Community Forum

On November 15, 2007, 170 children's mental health system stakeholders participated in a Children's Mental Health Forum held in Tukwila, Washington. Participants were asked to provide their perspectives about the barriers to access and services for children in need of mental health care in Washington State. The specific methods for collecting this input at the Forum included:

(1) Facilitated table discussions and prioritization;
(2) Individual written recommendations; and
(3) Group voting on initial priorities identified through table discussions.

Participants were also encouraged to informally share their perspectives and recommendations to the larger group during the forum; however, given the heterogeneity of these responses, they were not integrated into the overall findings in this report.

Tables 1-3 provide a summary of the top five reported (1) Barriers to access (see Table 1); (2) Recommendations to improve access to mental health care (See Table 2); and (3) Services and supports that would most promote recovery and resiliency in children and families and improve the mental health system (See Table 3). Since group voting allowed for multiple votes per priority, resulting in larger themes (vs. specific recommendations), table and individual responses were crosswalked with group voting findings for consistency. If responses were consistent across the initial and finding group voting priorities, they are described in more detail below and can be further referenced in the tables.

As shown in Table 1 below, a crosswalk between initial table and individual priorities and final group voting priorities indicates that *Access to Care* criteria, particularly the restrictiveness of diagnosis and symptoms and families reportedly having to wait for services until their children meet criteria, were among the top barriers to access. Participants who prioritized this barrier also reported that there were inequities in access based on type of insurance and funding source.

Also prioritized by both tables/individuals and final group votes were *Intra- and Inter-Systems Issues*, particularly poor cross-system collaboration, lack of a continuum of care, and poor coordination among providers.

Stakeholders also prioritized *Lack of Funding* for children's mental health services as a barrier to access, including adequate compensation to recruit qualified mental health professionals (MHPs) and psychiatrists. Similarly, stakeholders reported that there is a *Need for Qualified Mental Health Providers*.

While *Lack of Appropriate, High Quality Services*, particularly prevention and early intervention services, was also widely endorsed as a barrier, it was not prioritized during the voting process and also speaks more specifically to services vs. a barrier to access. However, one of the top barriers prioritized during group voting also spoke to specific services and the lack of those available for children with longer-term needs (e.g., Fetal Alcohol Syndrome [FAS], Developmental Disabilities [DD], and Traumatic Brain Injury [TBI]).

Table 1. Top 5 Reported Barriers to Access: November 2007 Children's Community Forum		
Rank	**Facilitated Table Priorities & Individual Recommendations**	**Group Voting**
1.	**Access to Care** (71% of tables/38% of individuals)	**Inadequate funding/funding silos**
	Diagnosis or symptom acuity requirements too restrictive	
	Families have to wait for services	
	Inequity of access due to type of insurance/no insurance	
2.	**Lack of Appropriate, High Quality Services*** (71% of tables/26% of individuals)	**Poor coordination among providers**
	Lack of prevention services	
	Lack of early intervention services	
3.	**Intra- and Inter-System Issues** (57% of tables/26% of individuals)	**Lack of services for kids with longer-term needs*** (e.g., FAS, DD, TBI)
	Poor cross-system collaboration	
	Lack of a continuum of care	
4.	**Lack of Funding** (52% of tables/ 40% of individuals)	**Lack of Psychiatrists & Mental Health Practitioners**
	Not enough mental health funding	
	Not enough funding to recruit psychiatrists & MHPs	
5.	**Need for Qualified Mental Health Providers** (29% of tables/12% of individuals)	**Inequity of Access Based on Funding Source**
	Lack of adequately trained mental health providers	

* While this question was specifically about barriers to access, stakeholders widely endorsed the need for specific services in response to this question.

Table 2 below highlights the top five recommendations to improve access to mental health care. Table/individual priorities were consistent with group voted priorities for three of the five top

voted recommendations to improve access to services. *Specific Services*, particularly prevention and early intervention services were the top recommended strategy to improve access to mental health services both in the table and individual responses and in the group voting. Similarly, *Statewide Availability of Wraparound* was the 5th top voted strategy to improve access to mental health services.

System Improvements was the next widely endorsed recommendation to improve access to services among tables, individuals, and group voting. This includes improvements in cross-system collaboration and integration. *Increase Access to Care/Modify Access to Care Standards (ACS)* was the next most consistently recommended strategy across table/individual prioritization and group voting. Tables were evenly split in their recommendations for improvements in Access to Care, including opening ACS to serve children with less intensive needs, ensuring better consistency with applying ACS across RSNs, and broadening criteria beyond diagnosis or functioning.

Table 2. Top 5 Recommendations to Improve Access to Mental Health Care:

November 2007 Children's Community Forum

Rank	Facilitated Table & Individual Prioritization	Group Voting
1.	**Specific Services*** (100% of tables/29% of individuals)	**Prevention Services**
	Early intervention services	
2.	**Systems Improvements** (62% of tables/33% of individuals)	**Treat Whole Family, Not Just the Child**
	Improvements in cross-system collaboration	
	Improvements in system integration	
3.	**Funding** (43% of tables/13% of individuals)	**Cross-System Integration**
	Increased flexibility in use of funds	
	Blended/braided funding strategies	

4.	**Information to Increase Awareness of Resources/Reduce Stigma** (38% of tables/ 18% of individuals)	**Modify Access to Care Standards to Serve More Children**
	Public information/social marketing campaign to reduce stigma & increase access	
	Educating families about available mental health resources	
5.	**Increase Access to Care** (29% of tables/18% of individuals)	**Statewide Availability of Wraparound**
	Open Access to Care Standards (ACS) to less intensive needs	
	Better consistency in applying ACS across RSNs	
	Access not based on diagnosis or functioning alone	

Treating the Whole Family, Not Just the Child was the 3rd highest voted strategy, but was not as highly endorsed during initial table/individual prioritization. *Funding* (i.e., flexible and blended/braided funding) and *Information to Increase Awareness of Resources and Reduce Stigma* (i.e., social marketing campaign and education to families about resources) were both prioritized among the tables and individual responses but were ranked lower in the group voting.

Table 3 below displays the top 5 reported services and supports that most promote recovery and resiliency in children and families and improve the mental health system. *Specific Services*, particularly *Wraparound, family-driven services,* and *peer-to-peer support* were recommended by tables, individuals, and group votes. *Infant mental health care* was also recommended, which overlaps with the next consistently recommended service/support across respondents, *Prevention and Early Intervention*. *Systems Improvements*, particularly availability of a *full continuum of care*, were also widely endorsed. *School-based Mental Health Services* were also consistently recommended across stakeholders.

While *Funding*, particularly *flexible* and *blended/braided funding*, was the 2nd most consistently prioritized service/support among table and individual respondents, it was not as highly prioritized during the group voting process. *Parent & Youth Involvement in System Design and Accountability Monitoring* was the 4th highest voted during group voting, though not as highly endorsed during initial table/individual prioritization.

Table 3. Top 5 Reported Services & Supports That Most Promote Recovery & Resiliency: November 2007 Children's Community Forum		
Rank	**Facilitated Table Priorities & Individual Recommendations**	**Group Voting**
1.	**Specific Services** (81% of tables/37% of individuals)	**Prevention & Early Intervention**
	Wraparound	
	Family-driven services	
	Infant mental health care	
	Peer-to-peer support	
2.	**Funding** (48% of tables/9% of individuals)	**School-Based Mental Health Services**
	Flexible funding	
	Blended and braided funding	
3.	**Prevention & Early Intervention Services** (33% of tables/16% of individuals)	**Whole Continuum of Care** (i.e., prevention, advocacy, respite, residential)
4.	**System Improvements** (33% of tables/ 5% of individuals)	**Parent & Youth Involvement in System Design and Accountability Monitoring**
	Need a full continuum of care	
5.	**School-Based Mental Health Services** (29% of tables/17% of individuals)	**Family-Driven, Strengths- and Needs-Based Services**

November 2007 Children's Mental Health Forum: All Reported Data

170 stakeholders participated in 21 table groups of six to eight, to discuss access to the children's mental health system and the services and supports that are most needed in the current array. Each table was asked to prioritize their top three responses to the questions listed below. The table priorities and the additional information from 82 written responses by individual participants were grouped into similar categories. Each category within a question area that received four or more responses is listed in the tables below and ranked in order of the most frequently cited priorities.

What are the barriers to access in our current children's mental health system?

#	Barriers to Access	Tables that prioritized N=21	Individuals who prioritized N=82	Additional information
1	**Access to Care**	15	31	45% of the tables that prioritized this barrier said that access is too restrictive, either by diagnosis of symptom acuity. Families having to wait for services (33%) and inequity of access due to type of insurance or no insurance (17%), made up 50% of the total responses in this category.
2	**Services***	15	21	67% of the table responses in this category specifically stated that Early Intervention and Prevention were lacking.
3	**System Improvements**	12	21	Slightly more than 50% of the responders in this area said that poor cross-system collaboration and the lack of a true continuum of care were problematic.
4	**Funding**	11	33	45% of tables who responded in this category indicated that there is not enough mental health funding. 27% said there were not enough MHPs and psychiatrists.
5	**Providers**	6	10	2/3 of the responding tables felt that providers need more training.
6	**Information**	5	12	All tables and individuals in this category of response said that families need better access to information on what resources are available.

*Please note that both questions about access garnered responses having to do with services.

What would streamline, improve or enhance access to mental health care?

#	Improvements to Access	Tables that prioritized N=21	Individuals who prioritized N=82	Additional information
1	**Services***	21	24	55% of tables who prioritized services said Early Intervention was the most needed.
2	**System Improvements**	13	27	54% of tables and 96% of individuals who prioritized system change specifically called for improvements in collaboration and system integration.
3	**Funding**	9	11	The majority of responses called for increased flexibility in use of funds, including blended and braided funding strategies.
4	**Information**	8	15	100% of responding tables specified a Public Information campaign to reduce stigma and improve access. 100% of the individuals who responded said to educate families on available MH resources.
5	**Access to Care**	6	15	Tables were evenly split on their ideas about improving this area: 1/3 said open ACS to less intensive needs; 1/3 said better consistency in applying criteria is needed across RSNs, and ; 1/3 stated that access should not be based on diagnosis or functioning alone.
6	**Education**	4	5	Tables that responded with this category were evenly split on prioritizing providers' needs for training in Infant Mental Health and treating Special Populations (DD, FAS, TBI)
7	**Workforce Development**	4	5	50% of tables and all of the individual respondents in this area said more slots in universities are needed for child psychiatrists and mental health professionals.

*Please note that both questions about access garnered responses having to do with services.

What services and supports would most promote recovery and resiliency in children and families and improve the mental health system?

#	Needed Services and Supports	Tables that prioritized N=21	Individuals who prioritized N=82	Additional information
1	**Specific Services**	17	30	47% of tables (8) responding in this area requested Wraparound and Family-driven Services; Individual responders said Infant MH (27%) and Peer-to-peer Support (43%) were needed.
2	**Funding**	10	7	More than 50% said increased flexibility in use of funds, including blended and braided funding strategies were needed.
3	**Prevention & Early Intervention**	7	13	*(Results from Service Needs responses.)* Early Intervention and Prevention were specifically prioritized by one third of all tables.
4	**System Improvements**	7	4	71% of tables with this response said a full continuum of care is needed.
5	**School System Integrated with MH Services**	6	14	28% of all tables at the forum sited specific system integration as a needed strategy.
6	**Treat the Whole Family**	6	4	28% of all tables at the forum said to look at the needs of the entire family.
7	**Evidence-based Practices**	5	7	Two tables and two individuals prioritized better integration of EBPs with Wrap and family-centered approaches.
8	**Crisis Services**	5	5	Three of the five tables that sited Crisis Services called for family-focused, short-term crisis stabilization services.
9	**Community-based Services**	5	2	Tables and individuals who prioritized this area said more normalized supports and community networks were needed.
10	**Social Marketing**	5	0	To reduce stigma and distribute information on available services
11	**Respite**	4	4	Is needed for families with mentally ill children

Summary Priorities from the Voting Process

After the table groups prioritized their top three responses to each question, staff collected the information, collated it and transferred generalized topic areas to flip charts for individuals to vote on during the afternoon portion of the Forum.

Barriers to Access

There were 256 votes cast by participants in 24 different categories. The table below shows the top 11 categories, which represent 94% of all Barriers to Access votes cast. (As was reflected in the previous summaries of the table discussions and prioritizations, many references to services were made during the Access discussions. These are included in the Service and Support section.)

What are the barriers to access in our current children's mental health system?

Priority	Votes	General Categories
#1	39	Inadequate funding; Funding silos
#2	36	Poor coordination between providers
#3	32	No services for kids with longer term needs (FAS, DD, TBI)
#4	23	Lack of psychiatrists and MH practitioners
#5	21	Inequity of access based on funding source
#6	18	Lack of respite
#7	17	No Infant Mental Health
#8	16	Lack of continuum across levels of need
#9	15	Access to Care Standards
#10	13	Long waits for inpatient and outpatient treatment
#11	11	Kids don't fit into just one service system.

Improvements to Access

There were 277 votes cast by participants in 19 different categories. The table below shows the top 10 categories, which represent 93% of all Access Improvements votes cast.

What would streamline, improve or enhance access to mental health care?

Priority	Votes	General Categories
#1	54	Prevention services
#2	49	Treat the whole family, not just the child
#3	47	Cross-system integration
#4	22	Modify Access to Care Standards to Serve More Kids
#5	19	Statewide availability of Wraparound
#6	16	School-based Healthcare
#7	15	Workforce development at the university level
#8	14	Easier to navigate, family-friendly system
#9	14	Empower consumers
#10	8	Increase training

Needed Services and Supports

There were only 156 votes cast by participants in this afternoon session. The number of different categories was much larger than in the morning sessions: 35. The table below shows the top 10 categories, which represent 76% of all Service votes cast.

What services and supports would most promote recovery and resiliency in children and families and improve the mental health system?

Priority	Votes	General Categories
#1	45	Prevention and early intervention
#2	19	School-based mental health services
#3	16	Whole continuum of care, including prevention, advocacy, respite and residential care
#4	8	Parent and youth involvement in system design and accountability monitoring
#5	6	Family-driven, strengths- and needs-based services
#6	6	Community-based services as step-down from CLIP placements
#7	5	Wraparound in all communities
#8	5	Integration of EBPs into Wrap process with support to maintain fidelity
#9	4	Funds for early childhood education
#10	4	Increase of multi-system approaches

Appendix 2:
Results from RSN Interviews and Questionnaires

In February 2008, RSNs were encouraged by MHD to provide their perspectives regarding access and services in the children's mental health system. In order to facilitate a higher response rate, a mixed mode approach was used to collect these data from RSNs, including both interviews and self-administration of a questionnaire, both of which included the following three questions:

(1) What are the barriers to access?
(2) What services and supports are most needed?
(3) What strategies have you tried to fill these gaps?

Eight of the 13 Washington State RSNs agreed to complete an interview or questionnaires. Tables 1-3 provide a summary of RSN-specific responses to each question above, respectively.

As shown in Table 1, most RSNs (88%) reported difficulties with access for uninsured and non-Medicaid children; they reported that in many cases, these children have to go into crisis before they can receive the services they need. Similarly, most RSNs (75%) reported barriers related to children who do not meet criteria for services. This includes children not meeting the Access to Care Standards or having private or other insurance that prevents them from getting the services they need when they do go into crisis. A related issue is the barrier of serving children with complex needs or who do not meet diagnostic criteria for services (50% of responding RSNs). These include children with severe behavioral challenges, developmental disabilities, autism-spectrum disorders, and children in foster care.

Half (50%) of responding RSNs specified the lack of more appropriate, high quality services (e.g., EBPs, transition services, crisis supports) as a barrier to access. Fifty percent of responding RSNs also reported that the lack of family services and supports (e.g., mental health services for parents, difficulty with system navigation) and lack of qualified mental health providers (including child psychiatrists, bilingual providers, and providers in rural areas) are also barriers to access.

A smaller percentage (38%) reported that geographic distance and lack of transportation were barriers. Twenty-five percent reported concerns about systems and funding barriers specific to their region.

See Table 3 for a list of strategies that RSNs have used to fill identified gaps.

Table 1. What Are the Barriers to Access?								
Reported Barriers to Access	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Uninsured & Non-Medicaid Children (7/8 or 88% of responding RSNs)								
1. Non-Medicaid children	x		x			x		
2. Non-Medicaid kids can only get crisis services		x			x			
3. Serving high intensity Non-Medicaid children			x				x	
4. Non-Medicaid refugee or immigrant populations			x					x
5. Non-Medicaid children only served by agencies with sliding fee scales		x						
6. Un- & underinsured children; prevention /less costly treatment extremely limited			x				x	
Not Meeting Specific Criteria for Services (6/8 or 75% of responding RSNs)								
1. Children don't meet Access to Care Standards		x			x	x		x
2. Children with private/other insurance have little available to them until they go into crisis; private providers don't know ACS		x	x		x			x
3. Lack of clarity in current process review for those assessed as not meeting medical necessity (Medicaid)							x	
Serving Children With More Complex Needs/Diagnoses (4/8 or 50% or responding RSNs)								
1. Finding appropriate out-of-home supports for children/youth with developmental delays	x							
2. Children with severe behavioral challenges	x	x						
3. Children with autism spectrum disorders		x						
4. Children/youth in foster care (needing to go to or get out of CLIP)			x			x		

Table 1. What Are the Barriers to Access? (cont.)								
Reported Barriers to Access	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Lack of More Appropriate, High Quality Services (4/8 or 50% of responding RSNs)								
1. Need for evidence-based practices	x							x
2. Lack of community-based crisis supports (e.g., hospitals, hospital diversion and step-down supports)	x							x
3. More costly plans of care when earlier intervention may have prevented crisis			x					
4. Need for safe setting for medication washouts & trials	x							
5. Transition services out of CLIP & inpatient settings						x		
Lack of Family Services & Supports (4/8 or 50% of responding RSNs)								
1. Lack of mental health care for parents	x					x		
2. Difficulty for families to understand/access complex system of options					x			
3. Complexity for families in obtaining /maintaining Medicaid eligibility					x			
5. Need for family-centered care when children do not meet Access to Care Standards	x							
4. Lack of services facilitating family engagement	x							
5. Peer certification process poses barriers (e.g., travel, time-consuming)								x

Table 1. What Are the Barriers to Access? (cont.)								
Reported Barriers to Access	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Lack of Qualified Mental Health Providers (4/8 or 50% of responding RSNs)								
1. Need more child psychiatrists	x				x			
2. Need more qualified mental health providers				x	x			x
3. Need for mental health psychiatric nurses					x			
4. Need for bilingual mental health providers				x				x
5. Recruitment of mental health providers in rural areas/lack of services	x			x				x
6. Loss of ESD funding for prevention/intervention specialists for less intensive needs								x
Geographic Distance & Lack of Transportation (3/8 or 38% of responding RSNs)								
1. Need for local services/ Need for local inpatient & residential services				x	x			x
2. Need for low-cost transportation				x	x			
Systems/Funding Issues (2/8 or 25% of responding RSNs)								
1. Fiscal impact of ESH liquidated damages on funding for children's mental health					x			
2. Inadequate state-only funding							x	
3. Interruption of integrated RSN monitoring and responsibility/data processing and management for county mental health services							x	
4. Fiscal/political pressures related to adult consumer needs, WSH census, drift concerns							x	

Table 2 provides an overview of needed services and supports as reported by RSNs. While not a specific service or support, 75% of responding RSNs reported that some type of *integrated policies, practices, and/or funding* across child-serving agencies and systems is needed.

Further, 75% of responding RSNs indicated that *parent/family-centered services* are needed within the system. Among these recommended services, all 75% of RSNs specified the need for assistance with system navigation, parent advocacy and peer services, and better coordination, support, and engagement with families. Sixty-three percent of RSNs reported that a continuum of *high intensity services and supports* is needed; these include crisis services, Wraparound, sub-acute partial hospitalization/hospital diversion, residential, in-home supports, inpatient services (for young children) and ACT-like programs. Sixty-three percent of reporting RSNs also endorsed other *specific community-based services*, including afterschool/summer programs, day treatment, family therapy, respite, the continuum of EBPs, and co-occurring mental health and substance abuse treatment for adolescents. Similar to the barriers identified in the section above, 38% also reported that *services for uninsured and non-Medicaid children and families* are also needed.

Table 2. What Are the Needed Services and Supports?

Reported Needed Services & Supports	RSN-Specific Responses							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Parent/Family-Centered Services (6/8 or 75% of responding RSNs)								
1. System navigators	x		x			x		
2. Parent advocates/Peer providers	x	x	x			x		x
3. Youth advocates	x							
4. Parent support & engagement		x		x		x		
5. Parenting classes								x
Continuum of High Intensity Services & Supports (5/8 or 63% of responding RSNs)								
1. High-intensity services	x			x	x	x		x
2. Continuum of community-based crisis services for families	x			x	x	x		x
3. Sub-acute, partial hospitalization/diversion					x			x
4. ACT for youth in juvenile justice system					x			
5. Wraparound				x	x			
6. Full continuum of residential care	x							x
7. Inpatient for young kids								x
8. In-home supports								x

Table 2. What Are the Needed Services and Supports?								
Reported Needed Services & Supports	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Other Community-Based Services for Children, Youth, & Families (5/8 or 63% of responding RSNs)								
1. After school/ summer programs		x						
2. Family therapy				x				
3. Respite								x
4. Continuum of/more training in EBPs	x							x
5. Day treatment		x			x			
6. Co-occurring disorder treatment				x				
Services for Uninsured Families and Children (3/8 or 38% of responding RSNs)								
1. Services for uninsured or non-Medicaid kids	x		x			x		
Integrated Policies, Practices, Funding Across Child-Serving Agencies/Systems (6/8 or 75% of responding RSNs)								
1. Integrated policies & practices to create cross-system partnerships/ more cross-system collaboration	x					x		x
2. Shared values, philosophy and funding across child-serving systems		x						x
3. Policies and practices that minimize inter-RSN shifting of youth in foster/group care	x							
4. More capacity for inter-agency consultation & team facilitation			x					
5. Stronger network of social service agencies				x				
6. Protected, blended funding across child-serving systems		x						
Other Needed System and Funding Changes (2/8 or 25% of responding RSNs)								
Additional state funding for Wraparound &/or other mental health services					x		x	
Better community funding for non-Medicaid, underinsured, high need families							x	

Table 2. What Are the Needed Services and Supports?								
Reported Needed Services & Supports	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
A locally-operated and locally responsive RSN mental health system with clear management & oversight/ effective data systems							**x**	
More collaborative strategies to maximize strengths of existing system given poor state fiscal environment							**x**	

Table 3. What Strategies Have You Tried to Fill the Gaps?								
Reported Strategies	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Family & youth involvement (6/8 or 75% of responding RSNs)								
1. Network of parent support		**x**				**x**		
2. Supporting parent and youth advocacy	**x**					**x**		
3. Parent Partners & Youth Mentors			**x**		**x** Passages			**x**
4. Crisis services for families	**x**	**x** (SWIFT, in-home)	**x**			**x**		
5. Parent inclusion in RFQ selection						**x**		
6. Family assistance with system coordination and navigation						**x** (FIRST)		
7. Using federal grant money to support family-driven services						**x**		
8. RSN director provides peer counselor training								**x**
Implementing community-based services (7/8 or 88% of responding RSNs)								
1. Wider availability of/more training in EBPs	**x** Partner-ships for Success	**x**	**x** MST, FFT, FIT		**x** TF-CBT			**x** TF-CBT
2. Wraparound		**x**	**x**			**x**	**x**	
3. Therapeutic foster care		**x**				**x** CHAP	**x** CHANCE , MTFC, BRS services	

Table 3. What Strategies Have You Tried to Fill the Gaps?								
Reported Strategies	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
4. Providing services in the community, home, or school to increase access and reduce stigma		**x**			**x** (MAP, Ace)			
5. Programs to keep youth stable at times when school is not in session					**x**			
High Intensity Services (4/8 or 50% of responding RSNs)								
1. Assisting with transition from more restrictive care to divert CLIP placements					**x**			
2. Providing follow up care to children released from CLIP facilities					**x**			
3. Increased crisis services to prevent hospitalization/ out of home placement			**x**					
4. Hospital diversion/ placement prevention services				**x**		**x** (FAST)		
Programs Targeting Increased Access & Outreach (3/8 or 38% of responding RSNs)								
1. Consultation Models	**X** PAL, Tele Health			**x** Tele Health				
2. Providing therapists and case managers to engage families in homeless shelters (HEART)					**x**			
3. Providers with evening and weekend hours to increase accessibility				**x**				
Addressing Specific Gaps to Target Groups in the System								
1. Providing on-site mental health care in Juvenile Detention facilities			**x** King County Systems Integration Initiative		**x**			
2. Programs specifically designed for infant and toddler mental health (earlier intervention)			**x**					
3. Mental Health Training for Juvenile Justice Personnel			**x**					

Table 3. What Strategies Have You Tried to Fill the Gaps?

Reported Strategies	RSN-Specific Responses							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas

Appendix 2.
Table 3. What Strategies Have You Tried to Fill the Gaps? (cont.)

Reported Strategies	RSN-Specific Responses							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
Policy, Organization, and Planning (7/8 or 88% of responding RSNs)								
1. Including culturally diverse groups in program planning		x		x				
2. Building new facilities so that services can be easier to access and more local		x						
3. Regular cross-system meetings to improve system coordination and increase spread of family-centered principles		x	x (IST Inter-agency Staffing Teams)			x (Child-ren's Policy Exec Team)		
4. Joint psychiatry program between community hospital and public hospital					x			
5. Creating liaison positions between systems	x		x	x			x	
6. Cohesive mental health and allied provider network based on open communication and shared values	x	x	x					
7. Expanding information sharing guidelines to include mental health and chemical dependency			x					
8. Standardized screening and assessment			x					
9. Reorienting services toward resiliency and recovery			x					
10. Focusing on developmental assessments of children and youth			x					
11. Ongoing use of data to inform service implementation					x			
12. Consulting providers in developing strategies to fill gaps				x				
Funding Approaches (4/8 or 50% of responding RSNs)								
1. Case rate payment model which allows for flexibility for enhanced rates through provision of recovery-oriented services.			x					
2. Used money from hospital		x						

Table 3. What Strategies Have You Tried to Fill the Gaps?								
Reported Strategies	**RSN-Specific Responses**							
	Thurston-Mason	Greater Columbia	King	North Central	Spokane	North Sound	Pierce	Chelan-Douglas
savings to create programs available to families regardless of insurance								
3. Specifically designating funds to offset costs for evidence-based practices	**x**		**x** (Mac Arthur Models for Change Grant)					
4. Fee for services capacity change to enable higher rates for providers offering higher intensity services						**x**		
5. Using funds from raised sales tax to support mental health, chemical dependency and therapeutic court services			**x**					
6. Applied for SAMHSA grant funding	**x**							

APPENDIX 3

RESULTS OF 2008 WASHINGTON CHILDREN'S MENTAL HEALTH SURVEY

- 3.1 Respondent Characteristics
- 3.2 Needs for Access by Age Groups
- 3.3 Needs for Access by Type of Children/Youth
- 3.4 Preferred Intervention Point for Early Identification and Intervention
- 3.5 Needs for Access by Type of Mental Health Problem
- 3.6 Priority Services by Type of Service
- 3.7 Priority Services by Type of Providers
- 3.8 Training Needs
- 3.9 Access to Evidence Based Practices
- 3.10 Priority Supports for Parents
- 3.11 Overall Priorities
- 3.12 Parent-Specific Questions on Involvement and Engagement in Services
- 3.13 Results from Native American Respondents

2008 Children's Mental Health Survey Results
1. Participant Characteristics

Survey Item:
"Which best describes your point of view as you filled out this survey? (Choose as many as you think apply)"

Total Respondents (N): 1034
Total Responses: 1912
Average Responses per Respondent: 1.85

A total of n=1034 of the 1065 (97.1%) survey respondents provided an answer to an item at the end of the survey asking for their role in the service delivery system for youth and families. Twenty-two response options were provided, and respondents were allowed to select as many of these roles as they liked. The mean number of responses provided was 1.85; however, the vast majority (79%) of respondents limited their self-description to one role (n=581 or 56%) or two roles (n=233; 23%). An additional 10% of respondents chose three roles and another 11% chose four or more roles.

As shown in Figures 1 and 2, when considering all N=1912 responses provided by those surveyed, the two most frequently chosen roles were "Mental health provider" (n=277) and "Family member/parent caregiver" (n=278). "Parent or youth advocate" was also frequently endorsed (n=201); however, there was a good deal of overlap between those who chose both "advocate" as well as "Family member/ parent/provider" (n=80 or 29%). Other roles that were chosen by 10% or more respondents included "Children's Administration staff" (n=131), "School staff" (n=120), and "Other state/county/city government staff" (n=113).

In order to better characterize respondents and conduct analysis by type of respondent, we assigned a primary role to each respondent using four broad categories: Child, youth, or family members (abbreviated "Consumers" in figures and tables in subsequent pages), Mental health providers (abbreviated "Providers" in figures and tables), representatives of partner agencies and organizations (e.g., Children's Administration, schools, juvenile justice, and other child-serving agencies; abbreviated "Administrators" in figures and tables to follow); and other interested stakeholders who chose roles that do not fall into the above categories – these respondents are abbreviated "Community members" (or just "Community" in charts and tables). Table 1 shows the specific roles that were included in each of these broad categories.

Because respondents could choose multiple roles to describe themselves, there is a large degree of overlap across these four categories of respondents (see Venn diagram in Figure 3). To create independent categories of respondent types, we created a hierarchical sorting scheme that resulted in mutually exclusive categories into which each respondent was sorted. First, those who had selected any group indicating that they were the recipient of mental health services or a family member of a child receiving mental health services were separated out and designated as **Consumers**. Second, remaining respondents who indicated that they provided mental health services were designated a **Provider**. Third, remaining respondents who held positions in allied and partner agencies (e.g., Children's Administration, schools, juvenile justice) were characterized as Partner agency staff (or "**Administrators"** for clarity in charts and tables). The remaining respondents, who

were not youth or family members, providers, or representatives from allied agencies, were classified as "**Community**." A second Venn diagram (Figure 4) presents the results of this hierarchical coding scheme, showing the four primary categories without the overlap.

A simplified presentation of the categories used to characterize respondents is presented in Figure 5. As shown, primary respondent types are Youth, Parents, and family members (i.e., "Consumers") which represent n=372 or 34.9% of the total sample; "Providers," which represent n=340 or 31.9% of the total sample; Partner agency representatives (i.e., "Staff"), which represent n=287 or 26.9% of the total sample; and "Community members," which represent n=38 or 3.6% of the total sample. Twenty-eight respondents (2.6%) provided no answer to the question about their perspective.

The remaining Figures in this section present further details on the survey sample, including the type of geographic region in which respondents said they lived. As shown in Figure 6, there was relatively even distribution of respondents who identified themselves as living in urban (n=290; 28%), suburban (n=261; 25%), rural (n=243; 23%) and "mixed" (n=251; n=24%) geographic regions. As shown in Figure 7, urban respondents were more likely to be representatives of partner agencies and providers, while consumers, youth, and family members were much more likely to state they lived in suburban areas.

Because of the requested focus of the current report, we also provide a graphical summary of the percent of respondents who stated they were a parent of a child with a mental illness (Figure 7).

FIGURE 1: Respondent Role/ Perspective

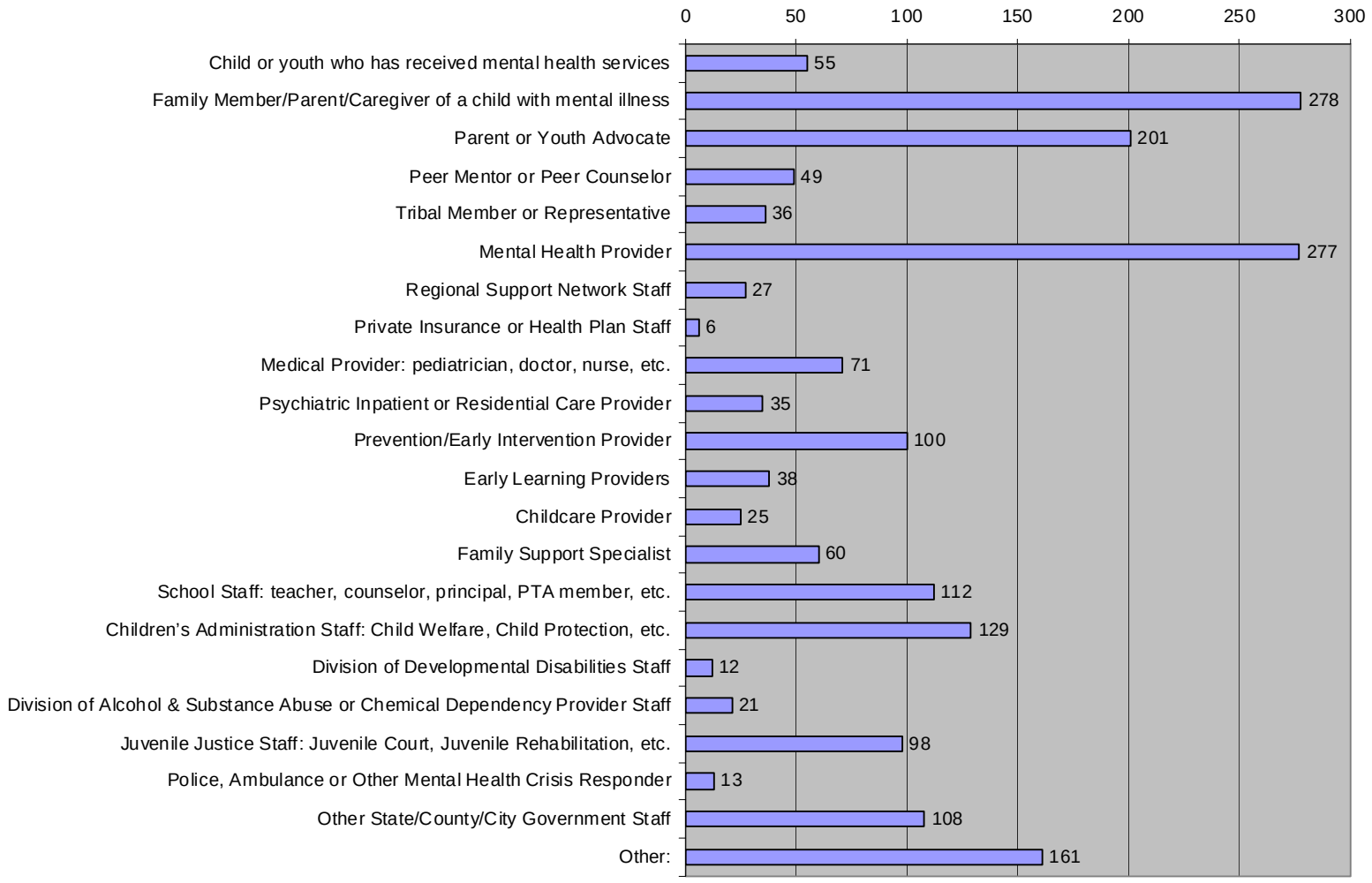


FIGURE 2:
Detailed breakout of respondent roles/perspectives

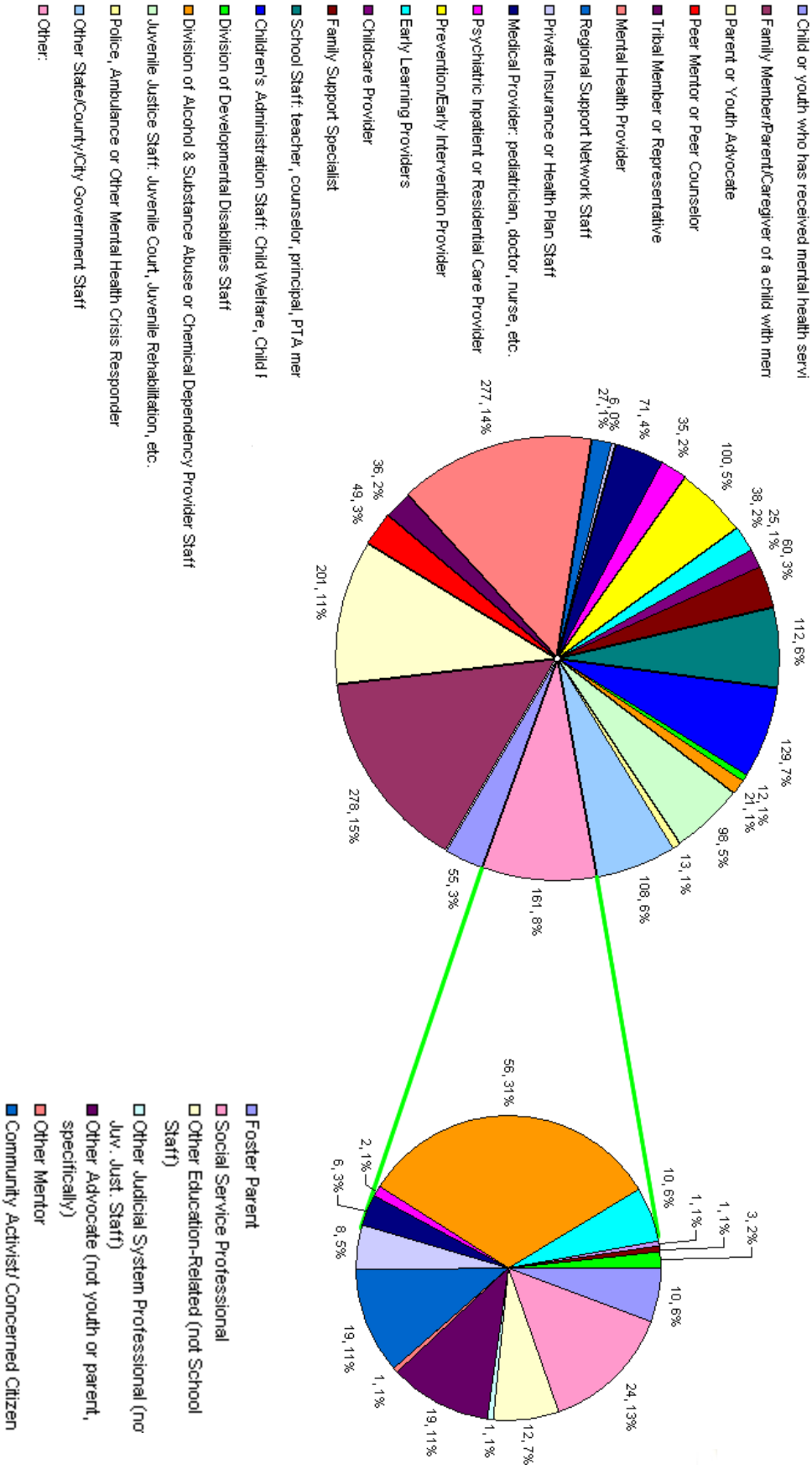


TABLE 1:
Types of roles included in each primary role / perspective category

Respondent category	Types of roles included in category
Consumer n=372	• Child or youth who has received mental health services • Family Member/Parent/Caregiver of a child with mental illness • Foster Parent • Other Consumer • All of the Above • Participants answering "Yes" to "Are you a parent of a child who has received services in the mental health system?"
Providers n=340 (and did not identify as representing one of the "consumer" roles above)	• Peer Mentor or Peer Counselor • Mental Health Provider • Medical Provider: pediatrician, doctor, nurse, etc. • Psychiatric Inpatient or Residential Care Provider • Prevention/Early Intervention Provider • Early Learning Providers • Childcare Provider • Family Support Specialist • Police, Ambulance or Other Mental Health Crisis Responder • Social Service Professional • Other Provider
Administrative and Partner Organization Members n=287 (and did not identify as representing a "consumer" or "provider" role above)	• Regional Support Network Staff • Private Insurance or Health Plan Staff • School Staff: teacher, counselor, principal, PTA member, etc. • Children's Administration Staff: Child Welfare, Child Protection, etc. • Division of Developmental Disabilities Staff • Division of Alcohol & Substance Abuse or Chemical Dependency Provider Staff • Juvenile Justice Staff: Juvenile Court, Juvenile Rehabilitation, etc. • Other State/County/City Government Staff • Other Education-related Staff • Other Judicial System Professional • Researcher • Other Administrative Partner • Attorney • Detention Staff
Community n=38 (and did not identify as representing a "consumer," "provider," or "partner staff" role above)	• Parent or Youth Advocate • Tribal Member or Representative • Other Mentor • Community Activist/Concerned Citizen

NOTES ON HIERARCHICAL CLASSIFICATION SCHEME

- 28 respondents did not answer this question. Of these, four indicated in a previous question that they were parents of children who had received services in the mental health system. Those four were categorized as Consumers, and the remainder were not assigned to a group.
- 13 participants selected that they were a parent of a child who received services in the mental health system, but then did not identify themselves as family members of children with mental illnesses. These respondents were classified as consumers.
- A separate analysis of tribal representatives and members is included in a separate section of this Appendix.

Figure 3:
Venn diagram showing number of respondents in each of the four primary role/perspective categories, and overlap across the four categories

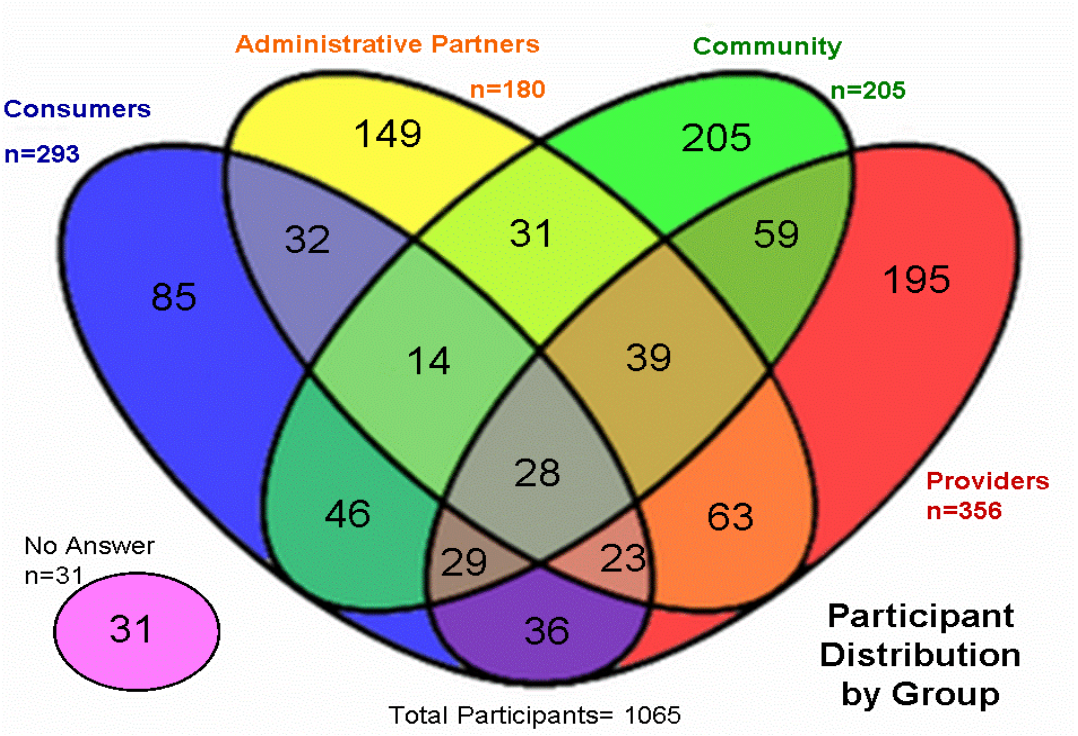


Figure 4:
Venn diagram showing number of respondents in each of the four primary role/perspective categories, without overlap (Ns represent N of respondents in each category in item-by-item analyses to follow)

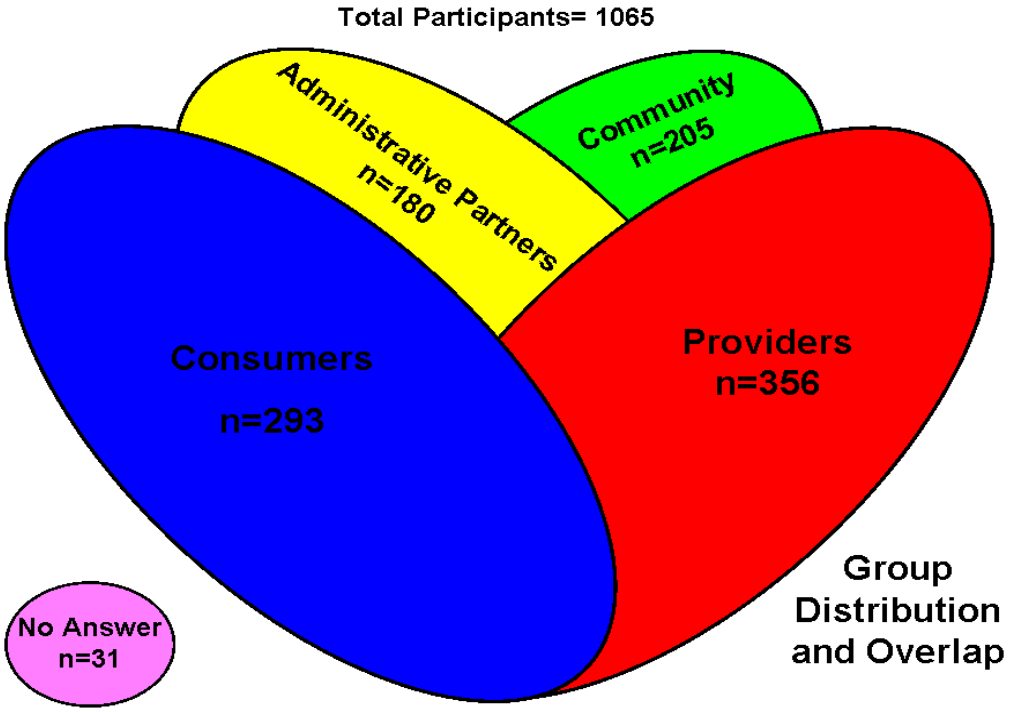
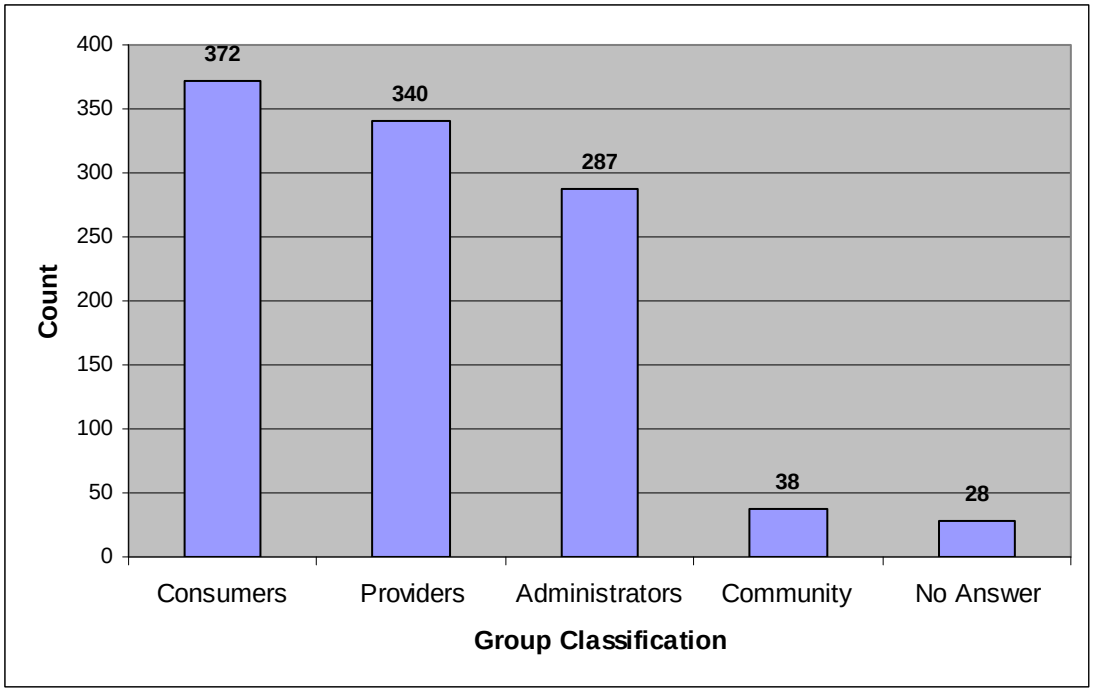
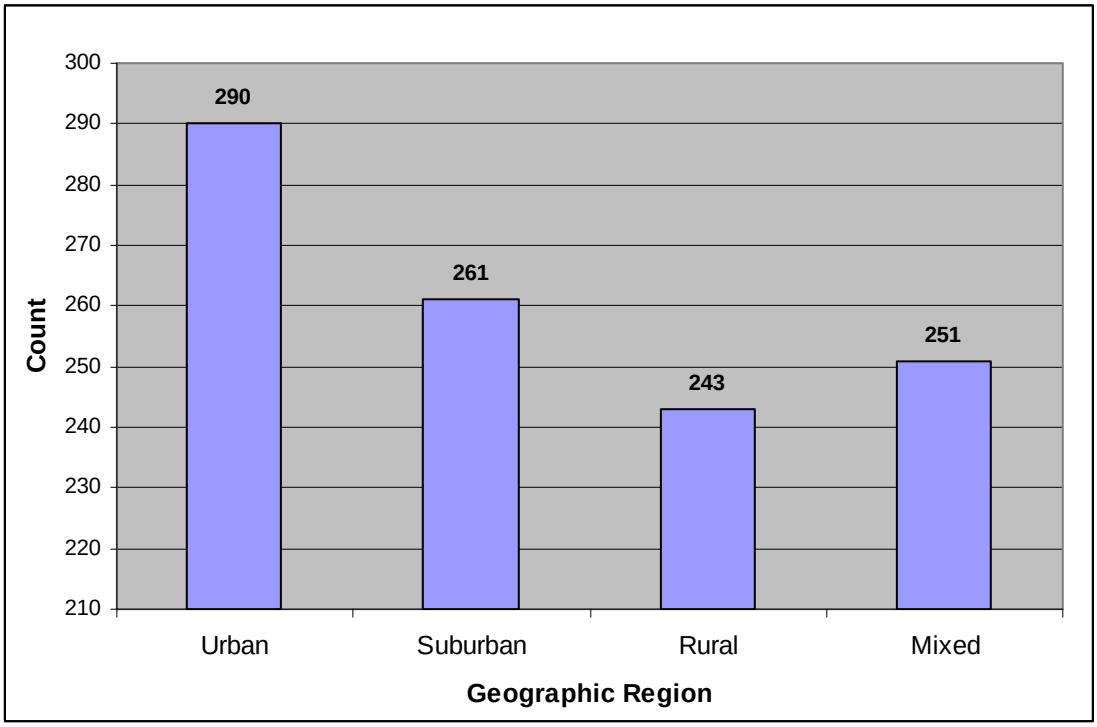


FIGURE 5:
Number and percent of respondents, by primary role / perspective



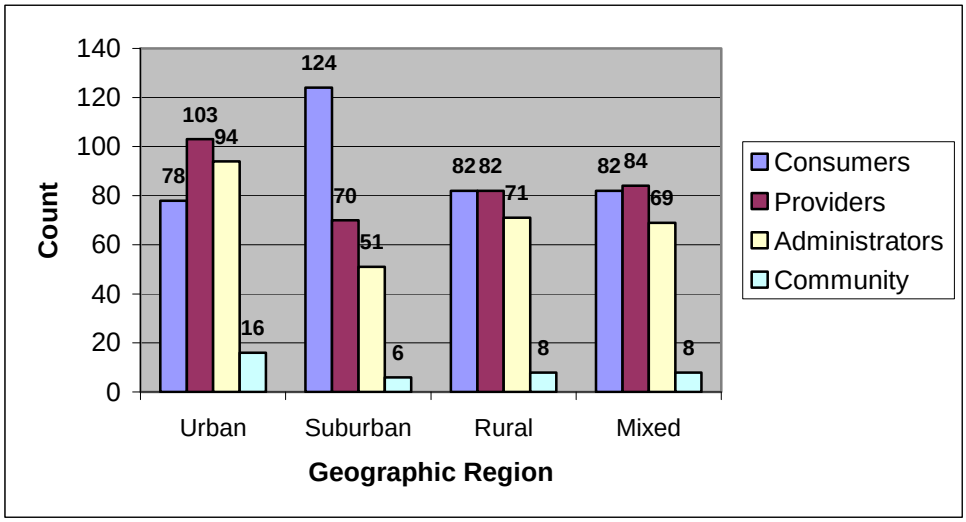
	Count	Percent
Consumers	372	34.93%
Providers	340	31.92%
Administrators	287	26.95%
Community	38	3.57%
No Answer	28	2.63%

FIGURE 6:
Number and percentage of respondents by geographic region



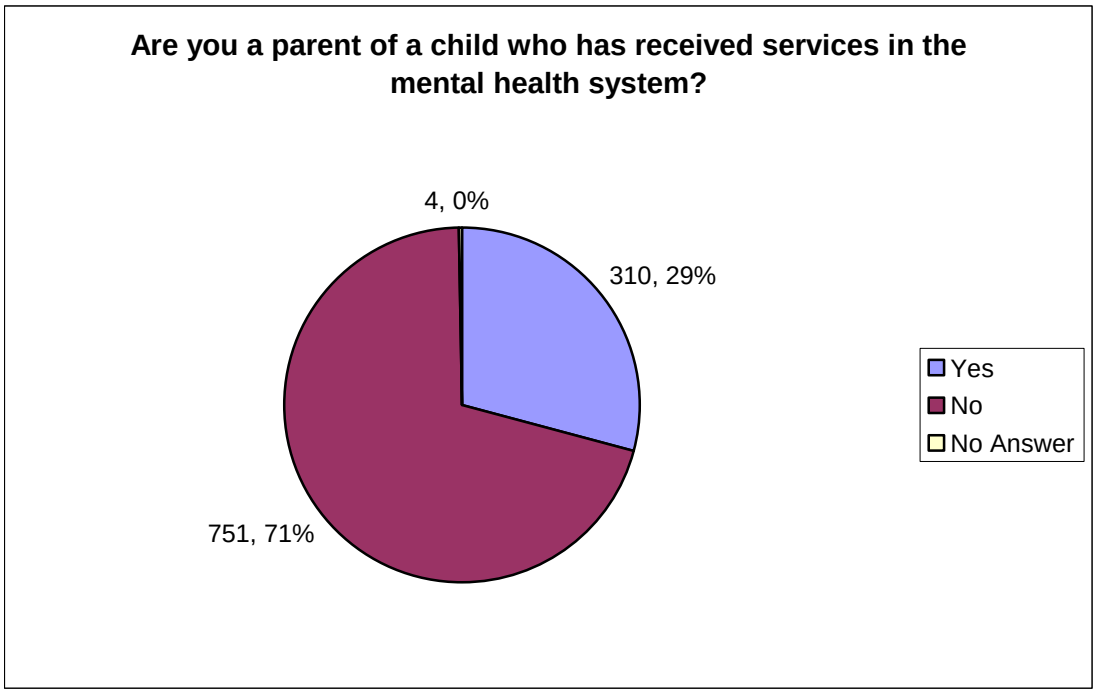
Geographic Region	Count	Percentage
Urban	290	27.75%
Suburban	261	24.98%
Rural	243	23.25%
Mixed	251	24.02%

FIGURE 7:
Number of respondents by geographic region and primary role



	Urban	Suburban	Rural	Mixed
Consumers	78	124	82	82
Providers	103	70	82	84
Administrators	94	51	71	69
Community	16	6	8	8

FIGURE 8:
Proportion of respondents who identify as being a parent of a child with mental illness



2008 Children's Mental Health Survey
2. Need for Access to Services by Age Group

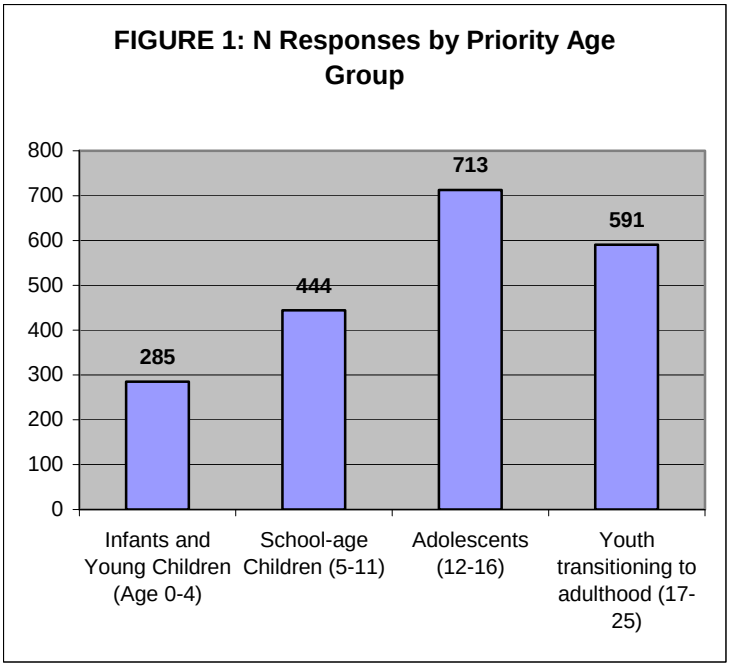
Survey Item:
"Which 2 age groups do you think need better access to services?"
(Choose up to 2 answers)

- **Infants and Young Children (Ages 0-4)**
- **School-age children (ages 5-11)**
- **Adolescents (ages 12-16)**
- **Youth transitioning to adulthood (ages 17-25)**

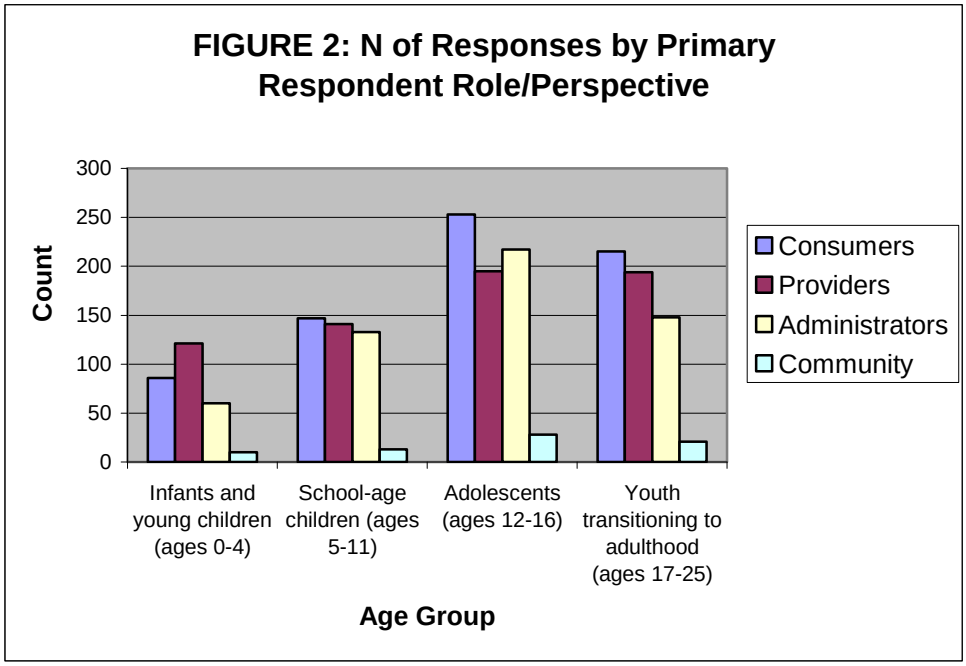
Total respondents (N): 1063
Total responses: 2033
Average Responses per Respondent: 1.91

This survey item assessed the respondents' priority with respect to the age group with greatest need for better access to services. As shown in Figure 1 and Table 1, the top two choices for all groups were adolescents (12-16; 35% of all responses) and youth transitioning to adulthood (17-25; 29% of all responses).

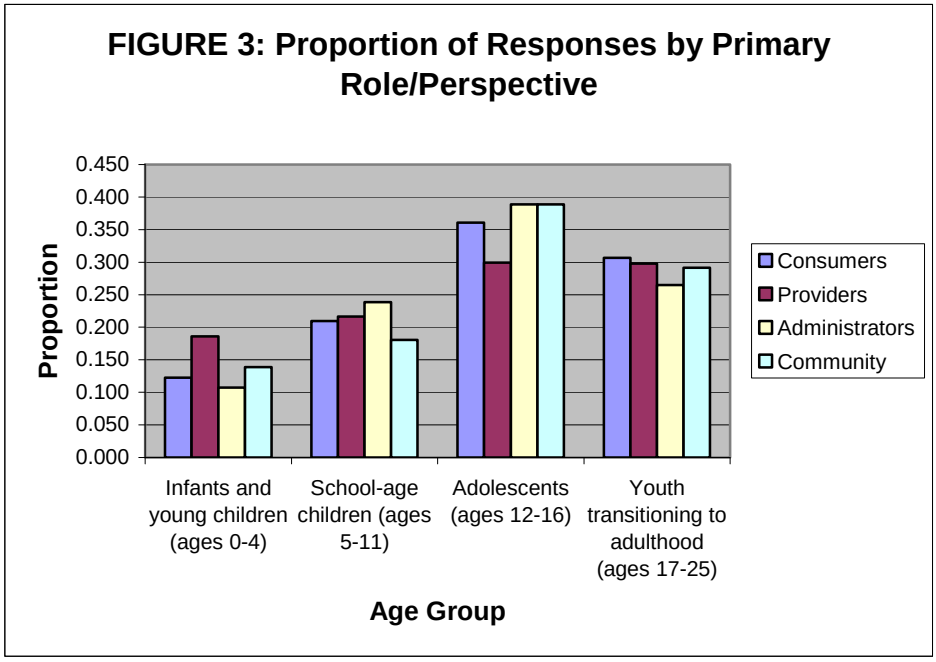
When viewing results by respondent type (Figure 2), respondents of all roles prioritized these two groups as having the greatest unmet need. However, it should be noted that providers were 75% more likely than other groups to prioritize Infants and Young children as needing greater access to services. In general, Providers were less likely to identify any particular age group as needing greater access, while partner agency staff were particularly likely to identify Adolescents as being in greatest need of increased access.



Age Group	Count	Percentage
Adolescents (ages 12-16)	713	67.07%
Youth transitioning to adulthood (ages 17-25)	591	55.60%
School-age children (ages 5-11)	444	41.77%
Infants and young children (ages 0-4)	285	26.81%



Age Group	Consumers	Providers	Administrators	Community
Adolescents (ages 12-16)	253	195	217	28
Youth transitioning to adulthood (ages 17-25)	215	194	148	21
School-age children (ages 5-11)	147	141	133	13
Infants and young children (ages 0-4)	86	121	60	10



Age Group	Consumers	Providers	Administrators	Community
Adolescents (ages 12-16)	0.361	0.300	0.389	0.389
Youth transitioning to adulthood (ages 17-25)	0.307	0.298	0.265	0.292
School-age children (ages 5-11)	0.210	0.217	0.238	0.181
Infants and young children (ages 0-4)	0.123	0.186	0.108	0.139

2008 Children's Mental Health Survey Results

3. Need for Access to Services by Type of Child / Youth

Survey Item:
"Which groups of children need better access to mental health services?"
(Choose up to 3 answers)

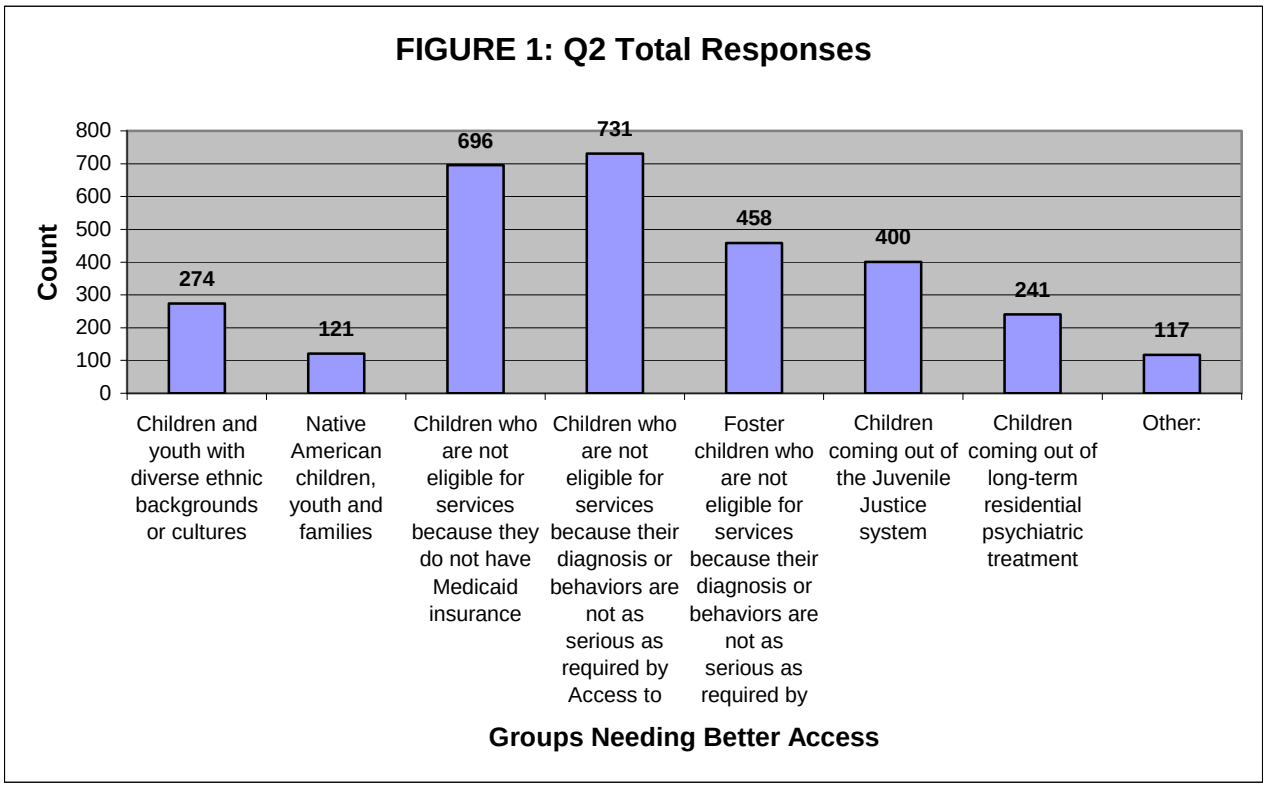
- **Children and youth with diverse ethnic backgrounds or cultures**
- **Native American children, youth and families**
- **Children who are not eligible for services because they do not have Medicaid insurance**
- **Children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care**
- **Foster children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care**
- **Children coming out of the Juvenile Justice System**
- **Children coming out of long-term residential psychiatric treatment**
- **Other**

Total Respondents (N): 1062
Total Responses: 3038
Average Responses per Respondent: 2.86

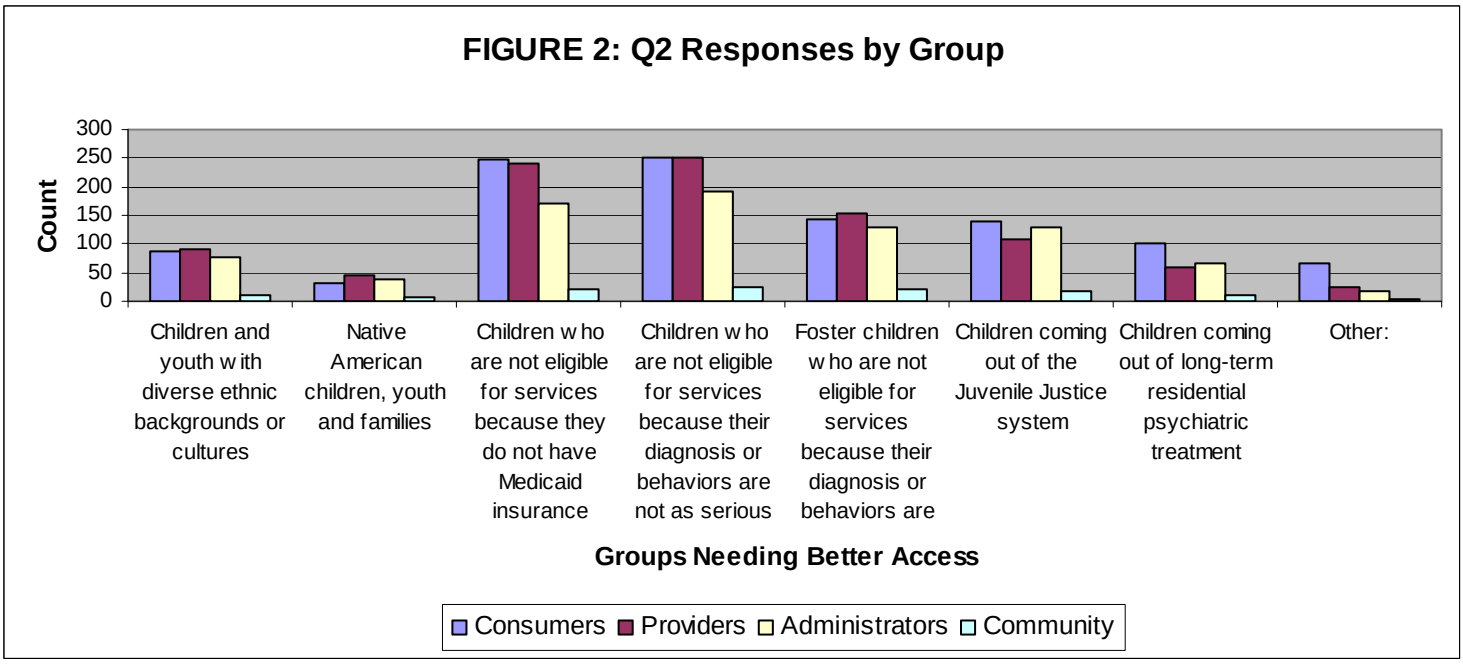
This item follows up the previous item about age groups with the greatest unmet need for access to services with a question about priority need by specific types of youth. Overall, the two responses most frequently endorsed were "Children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care" (24% of all responses) and "Children who are not eligible for care because they do not have Medicaid insurance" (23% of all responses). These were the top priorities across all three main types of respondents; however, these two types of youth were particularly highly endorsed by Consumers and Providers.

As shown in Figures 2 and 3, for Partner agency staff, "Foster children not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care" and "Children coming out of the Juvenile Justice System" were nearly as common a priority as the first two response options. This is likely because of the high proportion of Children's Administration staff in this category. For Community stakeholders, "Children coming out of the Juvenile Justice System" was almost as common a priority as the first two priorities. This may reflect community members' greater concern for preventing crime.

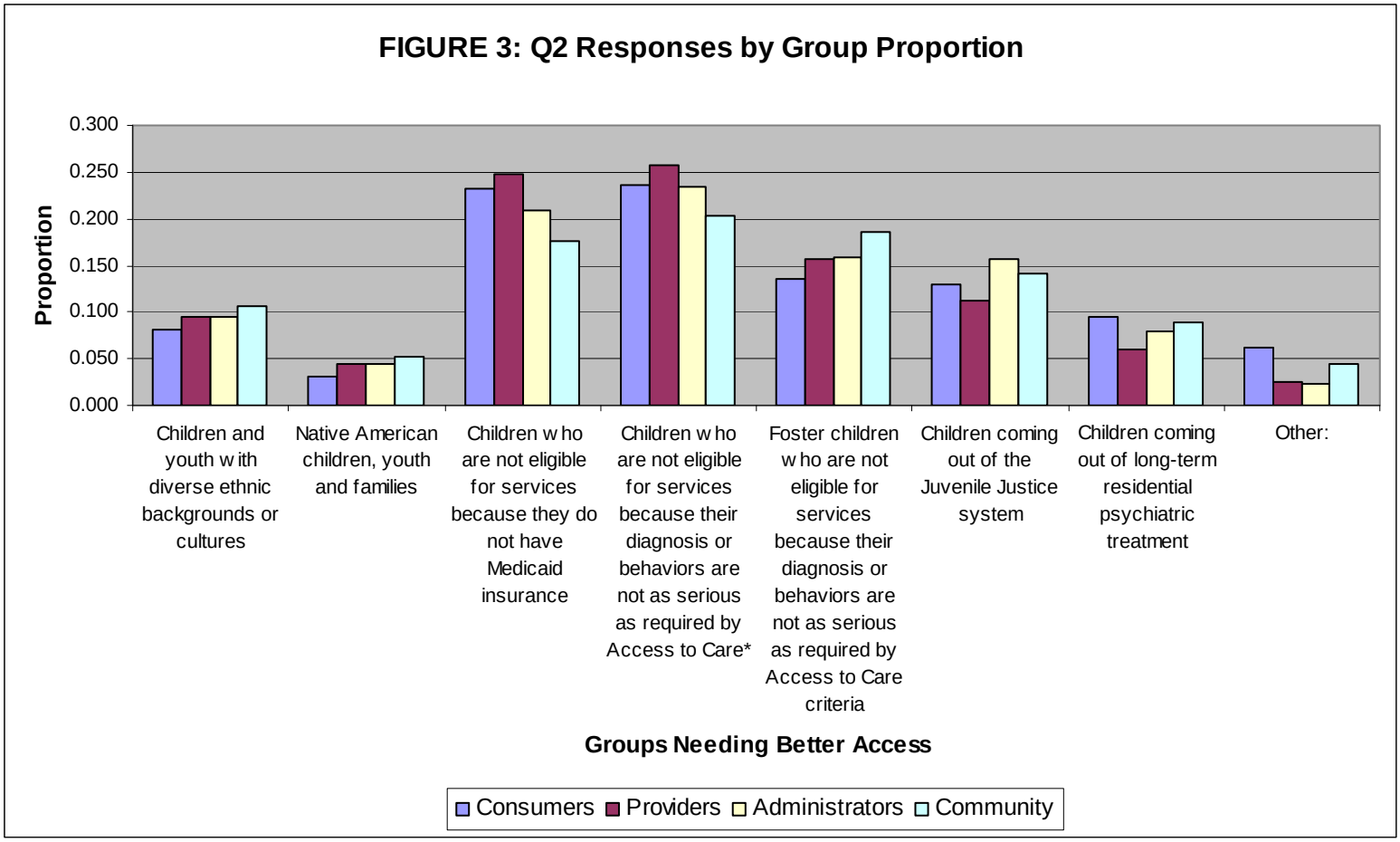
Overall, respondents were less likely to endorse children and youth who are from diverse ethnic backgrounds (9%) or Native American youth (4%), though as shown in the Appendix Section on these respondents, Native Americans were most likely to identify Native youth as being in need of greater access to services among all these categories.



Response	Count	Percentage
Children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care criteria	731	24%
Children who are not eligible for services because they do not have Medicaid insurance	696	23%
Foster children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care criteria	458	15%
Children coming out of the Juvenile Justice system	400	13%
Children and youth with diverse ethnic backgrounds or cultures	274	9%
Children coming out of long-term residential psychiatric treatment	241	8%
Native American children, youth, and families	121	4%
Other	115	4%



Response	Consumers	Providers	Administrators	Community
Children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care*	250	250	191	23
Children who are not eligible for services because they do not have Medicaid insurance	246	239	170	20
Foster children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care criteria	144	152	130	21
Children coming out of the Juvenile Justice system	138	108	128	16
Children and youth with diverse ethnic backgrounds or cultures	86	92	77	12
Children coming out of long-term residential psychiatric treatment	100	58	65	10
Native American children, youth and families	33	44	37	6
Other:	65	25	19	5



Response	Consumers	Providers	Administrators	Community
Children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care*	0.235	0.258	0.234	0.204
Children who are not eligible for services because they do not have Medicaid insurance	0.232	0.247	0.208	0.177
Foster children who are not eligible for services because their diagnosis or behaviors are not as serious as required by Access to Care criteria	0.136	0.157	0.159	0.186
Children coming out of the Juvenile Justice system	0.130	0.112	0.157	0.142
Children and youth with diverse ethnic backgrounds or cultures	0.081	0.095	0.094	0.106
Children coming out of long-term residential psychiatric treatment	0.094	0.060	0.080	0.088
Native American children, youth and families	0.031	0.045	0.045	0.053
Other:	0.061	0.026	0.023	0.044

2008 Children's Mental Health Survey Results

4. Preferred Initial Intervention Point for Youth with Emerging Mental Health Problems

Survey Question:
"What would be the three best ways to get help for a child at the first sign of a mental health problem?"
(Choose up to three)

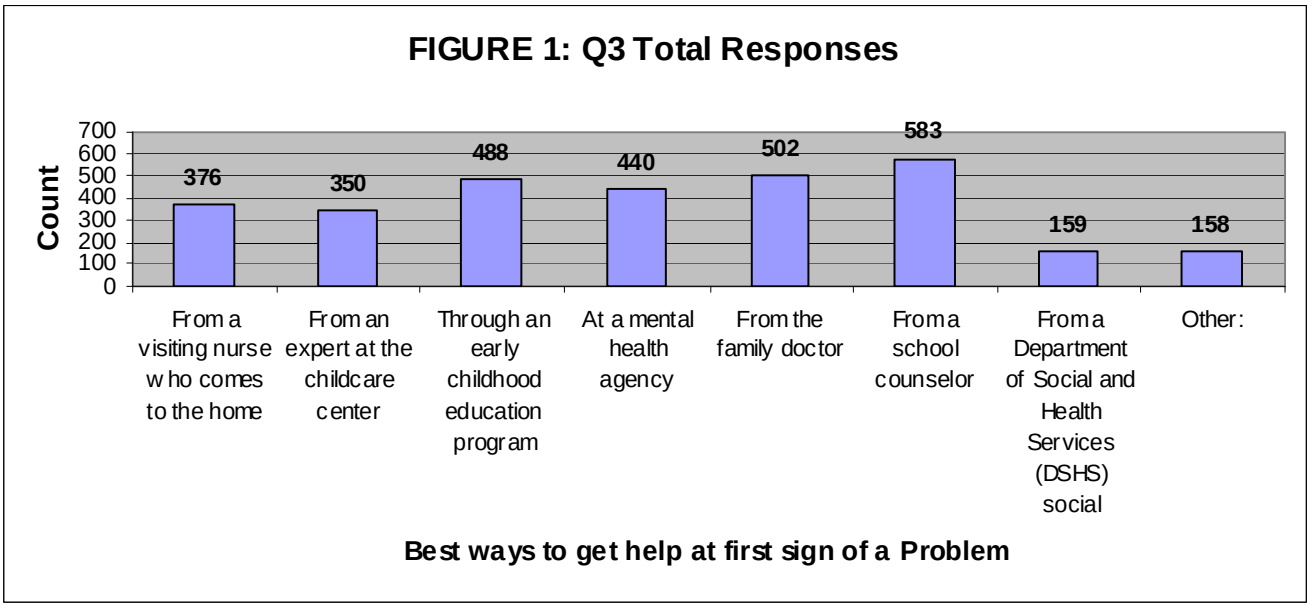
- **From a visiting nurse who comes to the home**
- **From an expert at the childcare center**
- **Through an early childhood education program**
- **At a mental health agency**
- **From the family doctor**
- **From a school counselor**
- **From a Department of Social and Health Services (DSHS) social worker**
- **Other**

Respondents: 1060
Responses: 3056
Average Responses per Respondent: 2.88

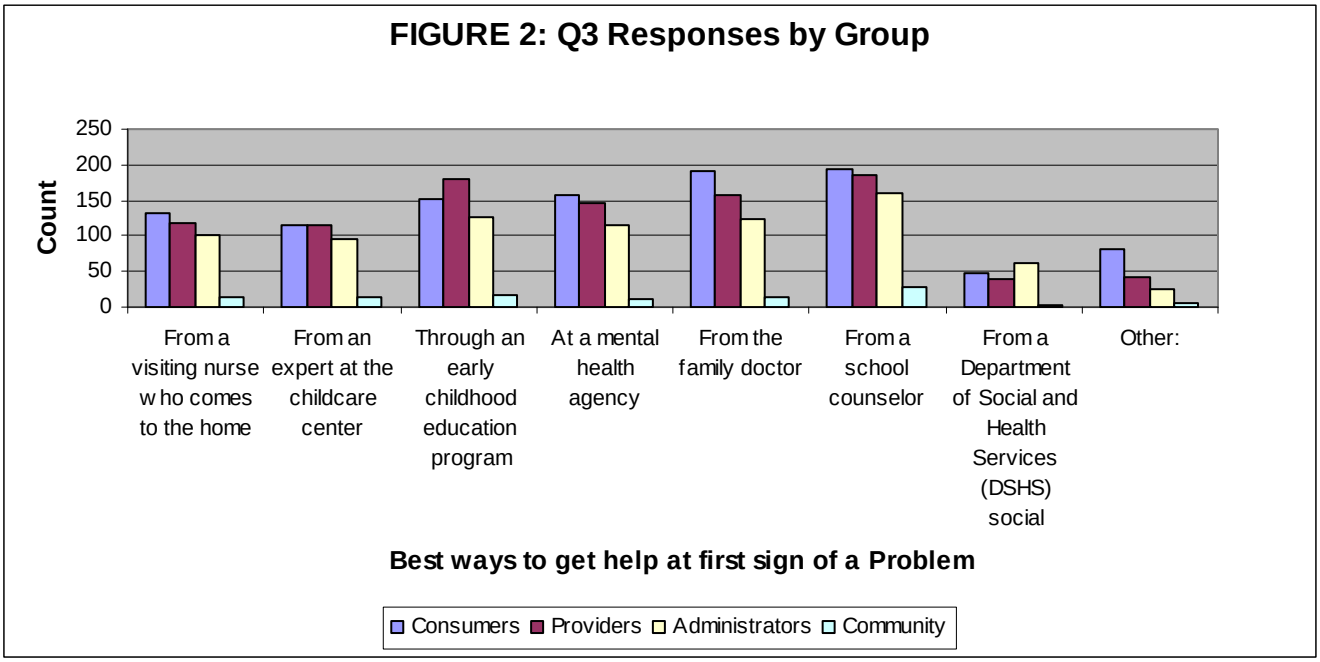
This item assessed respondents' preferences around where to invest resources in initial intervention points for children showing initial signs of a mental health problem. Unfortunately, distribution of responses on this question ranged across the response options and there were also numerous respondents who provided "other" as an answer, making interpretation of results difficult. Overall, as shown in figure 1, no option received more than 20% of all responses. Schools (19%), physicians (16%), and early childhood education settings (16%) were the most popular responses, with mental health centers, visiting nurses, and child care staff also receiving at least 11% of all responses.

For individual respondent types, the most common response for Providers, Staff, and Community members were "From a School Counselor" and "Early childhood education programs." Consumers endorsed "From a Family Doctor" most often, with "From a School Counselor" being their very close second most common choice. This may reflect a family's tendency to seek help from a family doctor when they notice a problem, while members of the other groups may be considering the population of family members who are not aware that their child has an issue, and thus would be less likely to seek help for him from a physician. Providers were also relatively more likely to endorse early childhood settings as a preferred initial intervention point.

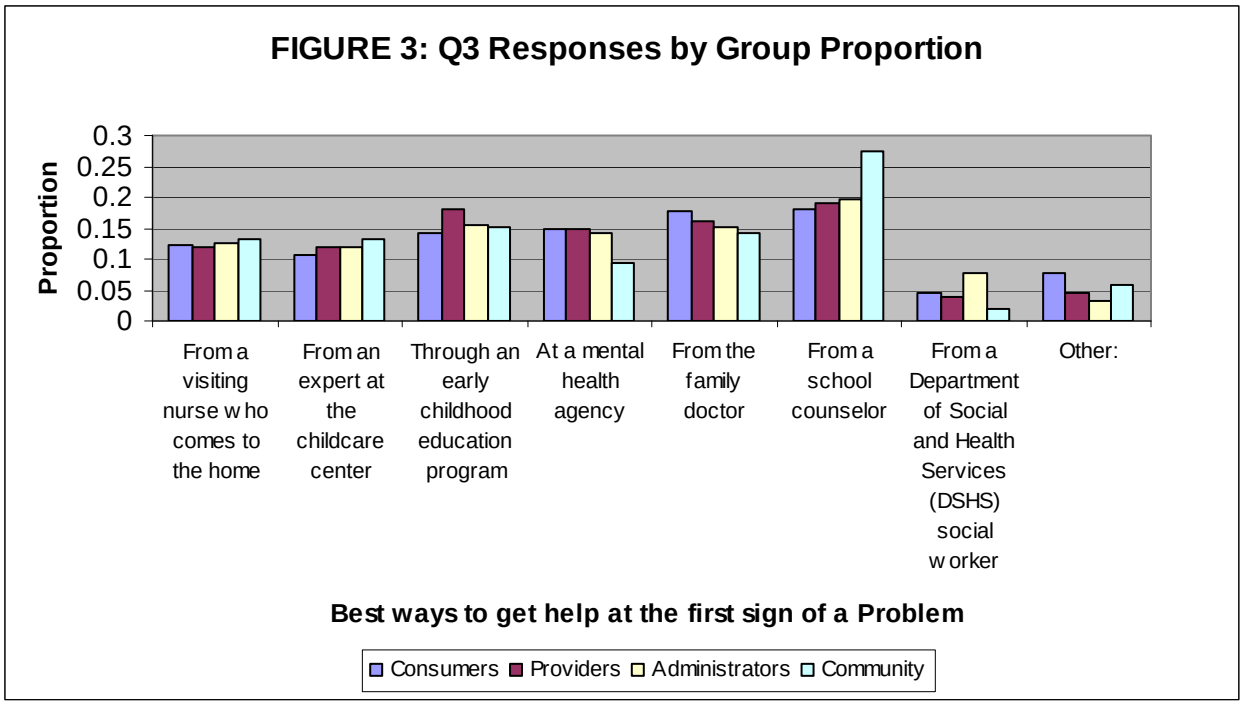
"Other" responses
Because more than 10% of respondents selected "Other," open-ended responses were categorized and analyzed. As shown in Figure 4 and the accompanying table, "Parents and Organizations Supporting parents/families" was the most common category into which respondents provided an open-ended response, with 50 endorsements. It should be noted that the vast majority of these responses were provided by consumers and family members. Other categories that received 20 or more "write-in" responses included "Other Mental Health Organizations," "Other School Staff," "Community groups," and "In-home services."



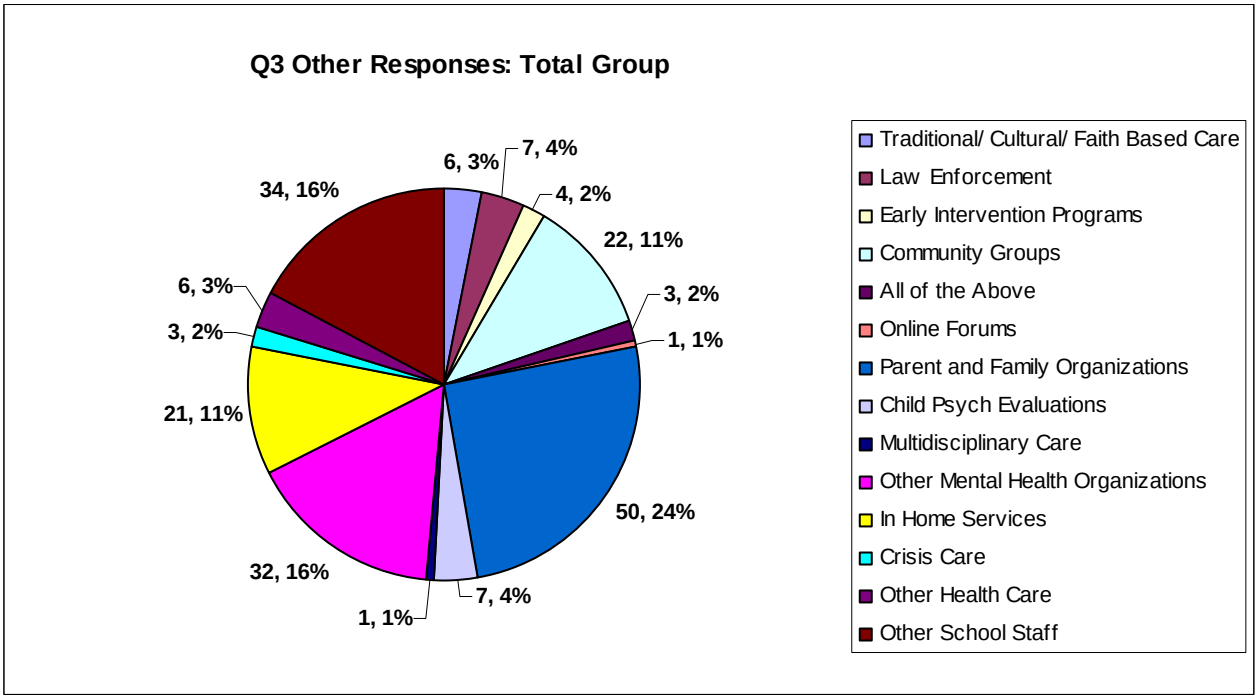
Response	Count	Percentage
From a school counselor	583	19.08%
From the family doctor	502	16.43%
Through an early childhood education program	488	15.97%
At a mental health agency	440	14.40%
From a visiting nurse who comes to the home	376	12.30%
From an expert at the childcare center	350	11.45%
From a Department of Social and Health Services (DSHS) social worker	159	5.20%
Other:	158	5.17%



Responses	Consumers	Providers	Administrators	Community
From a school counselor	193	186	159	29
From the family doctor	192	158	123	15
Through an early childhood education program	152	179	127	16
At a mental health agency	158	145	116	10
From a visiting nurse who comes to the home	132	118	102	14
From an expert at the childcare center	116	116	96	14
From a Department of Social and Health Services (DSHS) social worker	49	39	63	2
Other:	82	43	26	6



Responses	Consumers	Providers	Administrators	Community
From a school counselor	0.180	0.189	0.196	0.274
From the family doctor	0.179	0.161	0.151	0.142
Through an early childhood education program	0.142	0.182	0.156	0.151
At a mental health agency	0.147	0.147	0.143	0.094
From a visiting nurse who comes to the home	0.123	0.120	0.126	0.132
From an expert at the childcare center	0.108	0.118	0.118	0.132
From a Department of Social and Health Services (DSHS) social worker	0.046	0.040	0.078	0.019
Other:	0.076	0.044	0.032	0.057



	Count	Percentage
Parent and Family Organizations	50	24%
Other School Staff	34	16%
Other Mental Health Organizations	32	16%
Community Groups	22	11%
In Home Services	21	11%
Child Psych Evaluations	7	4%
Law Enforcement	7	4%
Traditional/ Cultural/ Faith Based care	6	3%
Other Health Care	6	3%
Early Intervention Programs	4	2%
All of the Above	3	2%
Crisis Care	3	2%
Multidisciplinary Care	1	1%
Online Forums	1	1%

The most popular answers for the write in column were Parent and Family Organizations.

When viewed by group, it becomes overwhelmingly clear that consumers and community members believe that the best way for a child to get help is from a family member or an organization that supports family involvement. It is interesting to compare this to providers' responses, which indicate that other mental health professionals and organizations or school staff would be a better choice. Staff responses seem to mirror those of providers. This may reflect some selection bias; the consumers who answered this survey are most likely parents and family members that have a vested interest in caring for their family's mental health. On the other hand, providers and staff members may be considering the entire spectrum of parental involvement in the cases they've witnessed.

2008 Children's Mental Health Survey Results

5. Need for Access to Services by Problem Area

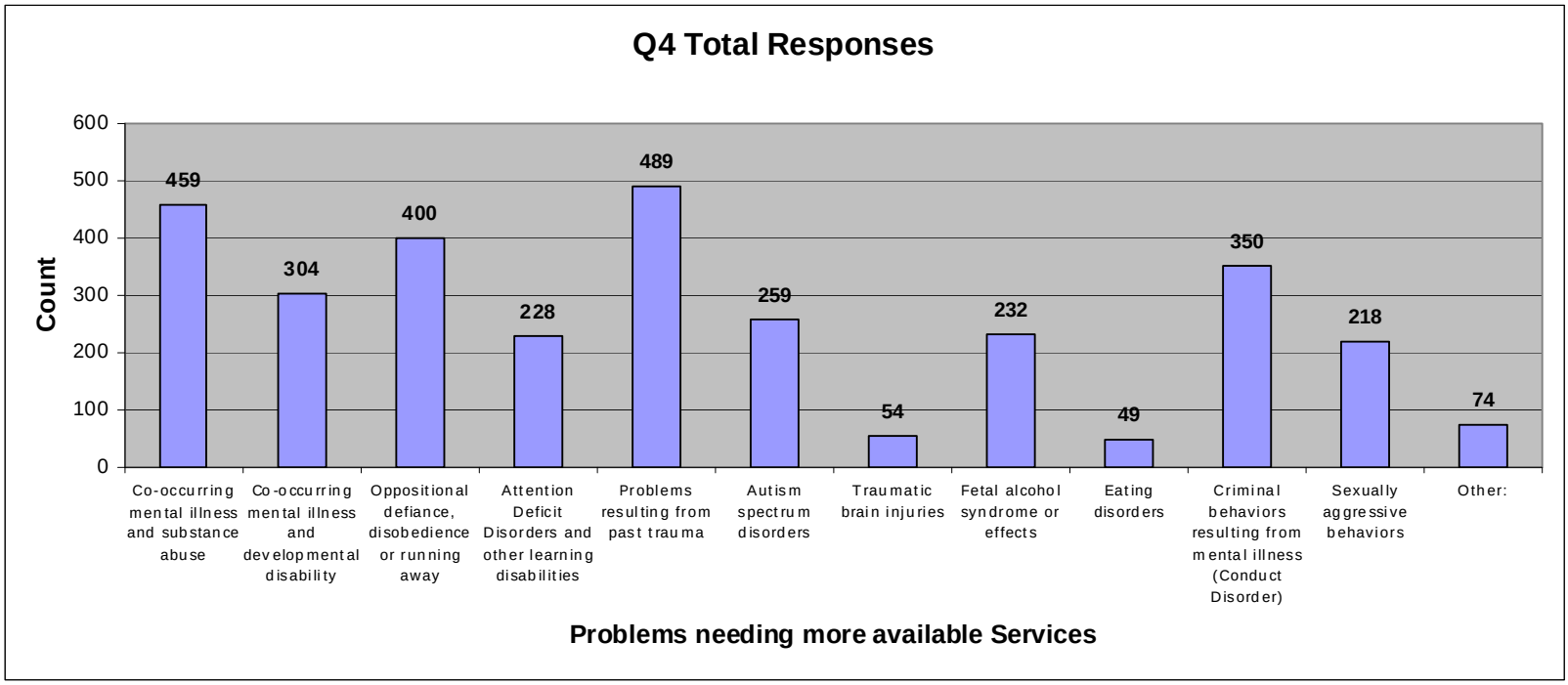
Survey Question:
"Which problems do you think need more services available to treat children?"
(Choose up to three):

- **Co-occurring mental illness and substance abuse**
- **Co-occurring mental illness and developmental disability**
- **Oppositional defiance, disobedience or running away**
- **Attention Deficit Disorders and other learning disabilities**
- **Problems resulting from past trauma**
- **Autism spectrum disorders**
- **Traumatic brain injuries**
- **Fetal alcohol syndrome or effects**
- **Eating disorders**
- **Criminal behaviors resulting from mental illness (conduct disorder)**
- **Sexually aggressive behaviors**
- **Other**

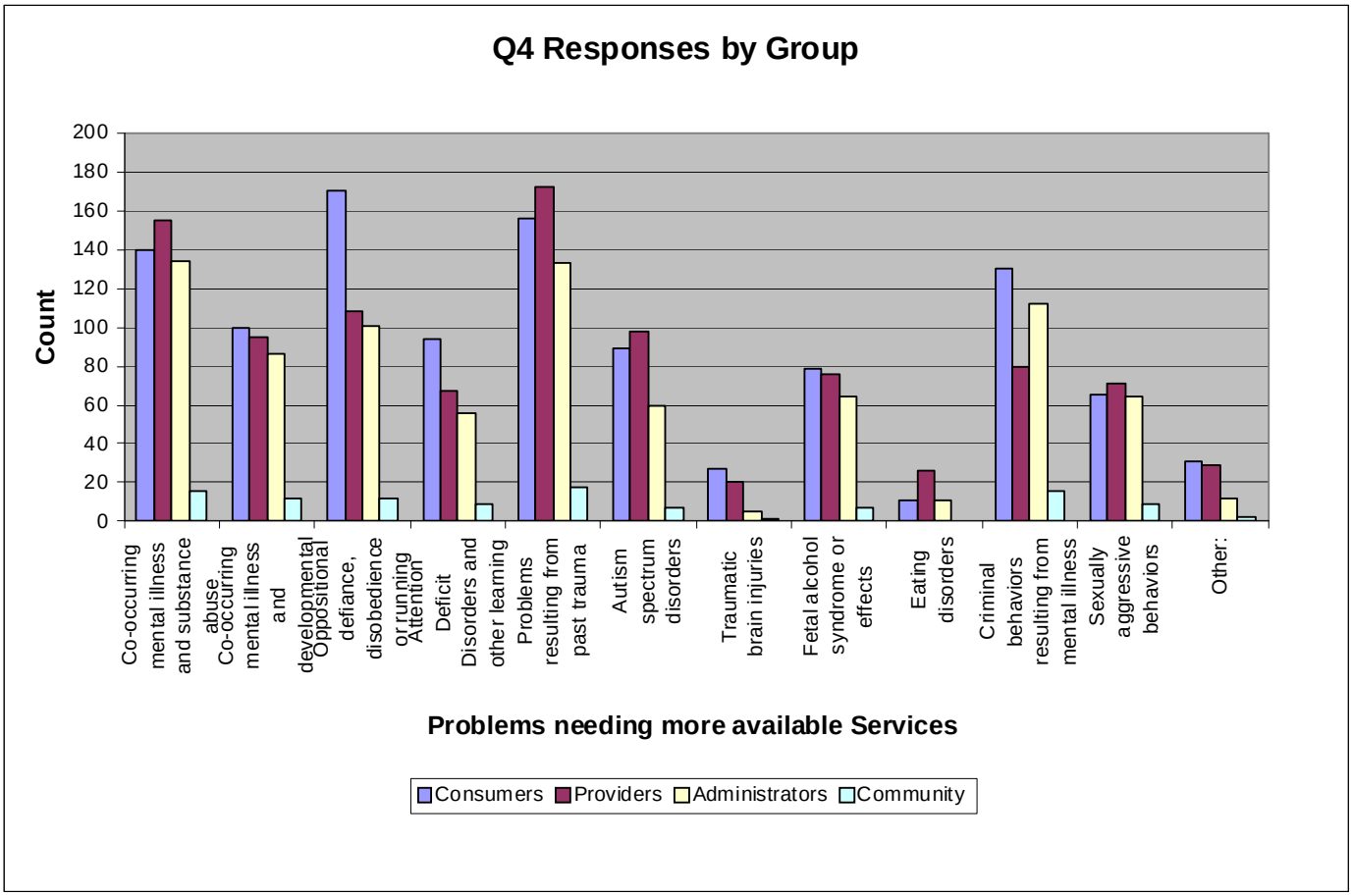
Respondents: 1062
Responses: 3116
Average Responses per Respondent: 2.93

This survey item extends information gleaned from item 3 by asking for specific problem areas in children and youth for which there is a need for greater availability of and access to services. Answers were widely distributed across response options, with the top four overall responses being "Problems arising from past trauma" (16%), "Comorbid mental illness and substance abuse" (15%), "Oppositional and defiant behaviors" (13%), "Criminal behavior (e.g., arising from conduct disorder)" (11%), and "Comorbid mental illness and developmental disability" (10%).

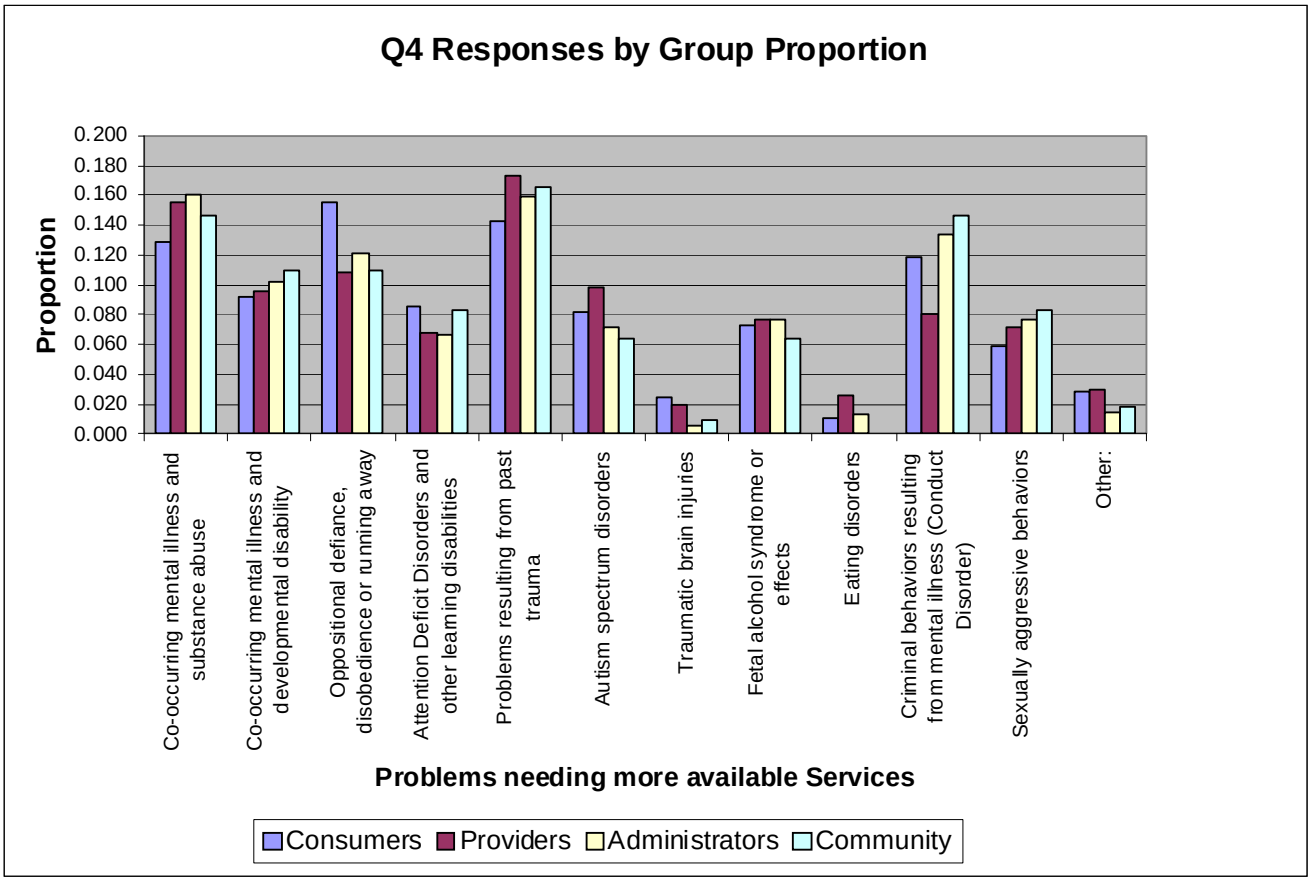
When responses were separated by group, it became clear that providers overwhelmingly chose problems resulting from past trauma as the most important issue, as did partner agency staff persons. Consumers, on the other hand, bucked the overall trend by rating oppositional and defiant problems as the primary problem area for which greater access to services is needed. Consistent with previous items, community members were relatively more concerned about criminal behaviors and substance abuse in conjunction with mental illness than other types of respondents.



Response	Count	Percentage
Problems resulting from past trauma	489	15.69%
Co-occurring mental illness and substance abuse	459	14.73%
Oppositional defiance, disobedience or running away	400	12.84%
Criminal behaviors resulting from mental illness (Conduct Disorder)	350	11.23%
Co-occurring mental illness and developmental disability	304	9.76%
Autism spectrum disorders	259	8.31%
Fetal alcohol syndrome or effects	232	7.45%
Attention Deficit Disorders and other learning disabilities	228	7.32%
Sexually aggressive behaviors	218	7.00%
Other:	74	2.37%
Traumatic brain injuries	54	1.73%
Eating disorders	49	1.57%



Response	Consumers	Providers	Administrators	Community
Problems resulting from past trauma	156	172	133	18
Co-occurring mental illness and substance abuse	140	155	134	16
Oppositional defiance, disobedience or running away	170	108	101	12
Criminal behaviors resulting from mental illness (Conduct Disorder)	130	80	112	16
Co-occurring mental illness and developmental disability	100	95	86	12
Autism spectrum disorders	89	98	60	7
Fetal alcohol syndrome or effects	79	76	64	7
Attention Deficit Disorders and other learning disabilities	94	67	56	9
Sexually aggressive behaviors	65	71	64	9
Other:	31	29	12	2
Traumatic brain injuries	27	20	5	1
Eating disorders	11	26	11	0



Responses	Consumers	Providers	Administrative	Community
Problems resulting from past trauma	0.143	0.173	0.159	0.165
Co-occurring mental illness and substance abuse	0.128	0.155	0.160	0.147
Oppositional defiance, disobedience or running away	0.156	0.108	0.121	0.110
Criminal behaviors resulting from mental illness (Conduct Disorder)	0.119	0.080	0.134	0.147
Co-occurring mental illness and developmental disability	0.092	0.095	0.103	0.110
Autism spectrum disorders	0.082	0.098	0.072	0.064
Fetal alcohol syndrome or effects	0.072	0.076	0.076	0.064
Attention Deficit Disorders and other learning disabilities	0.086	0.067	0.067	0.083
Sexually aggressive behaviors	0.060	0.071	0.076	0.083
Other:	0.028	0.029	0.014	0.018
Traumatic brain injuries	0.025	0.020	0.006	0.009
Eating disorders	0.010	0.026	0.013	0.000

2008 Children's Mental Health Survey Results

6. Need for Access to Services by Service Type

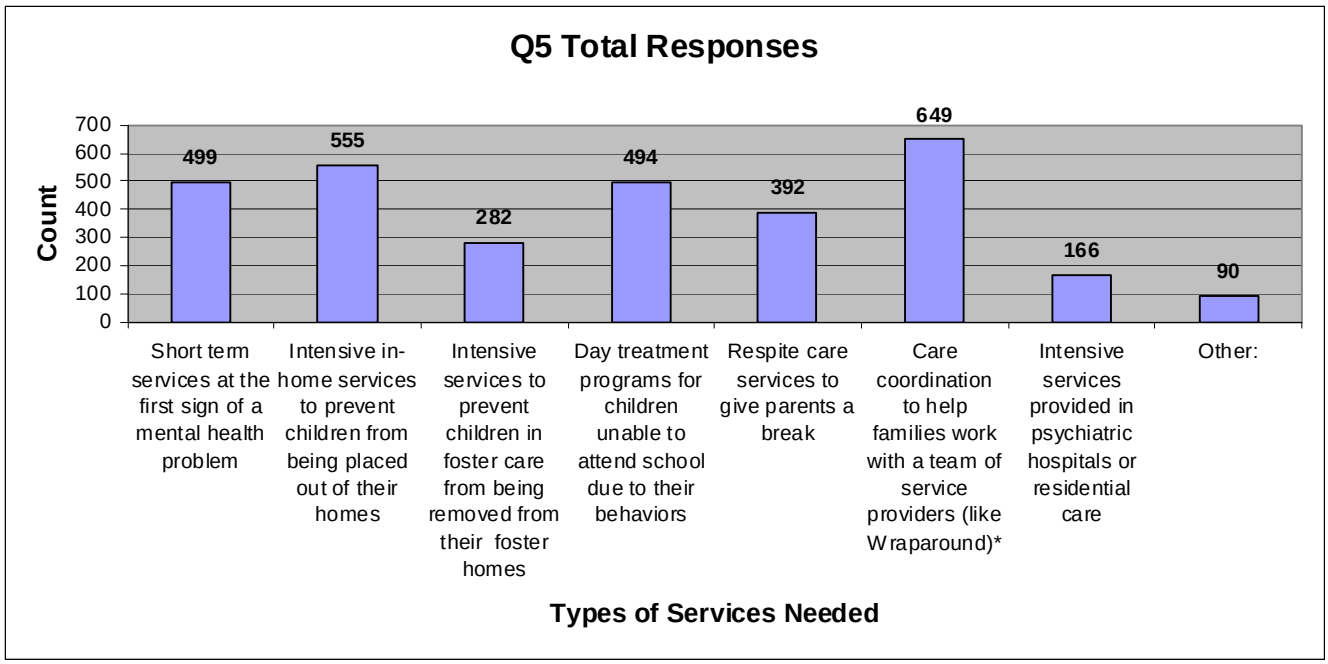
Survey Question:
"Which types of services need to be more available?"
(Choose up to three):

- **Short term services at the first sign of a mental health problem**
- **Intensive in-home services to prevent children from being placed out of their homes**
- **Intensive services to prevent children in foster care from being removed from their foster homes**
- **Day treatment programs for children unable to attend school due to their behaviors**
- **Respite care services to give parents a break**
- **Care coordinator ion to help families work with a team of service providers (like Wraparound**
- **Intensive services provided in psychiatric hospitals or residential care**
- **Other**

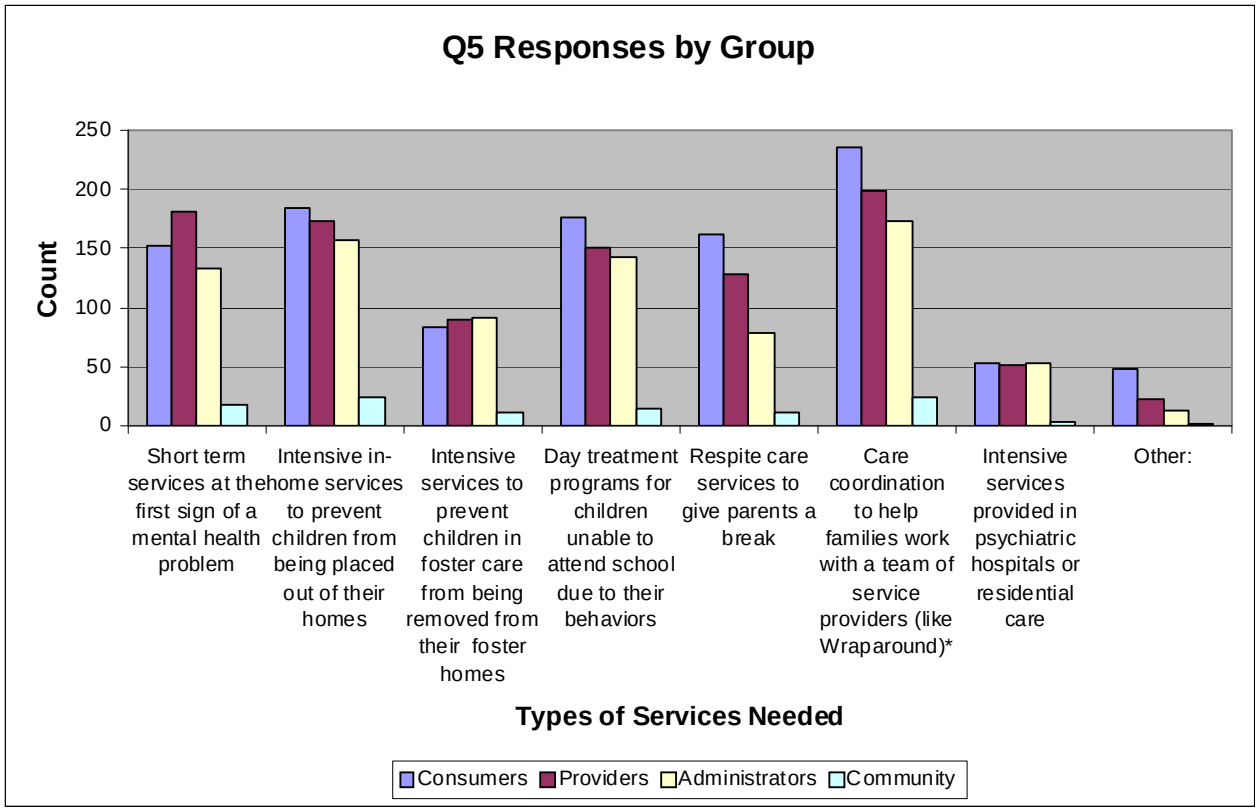
Respondents: 1062
Responses: 3127
Average Responses per Respondent: 2.94

Results from this item extend information from the previous item by presenting a set of specific types of services for prioritization. Again, responses were distributed fairly evenly among four top answers: Care coordination/Wraparound (20%), Intensive in-home services to prevent children from being placed out of their homes (18%), Short term services at the first sign of a mental health problem (16%), and Day treatment programs for children unable to attend school due to their behaviors (16%). Respite care was also endorsed in 13% of responses.

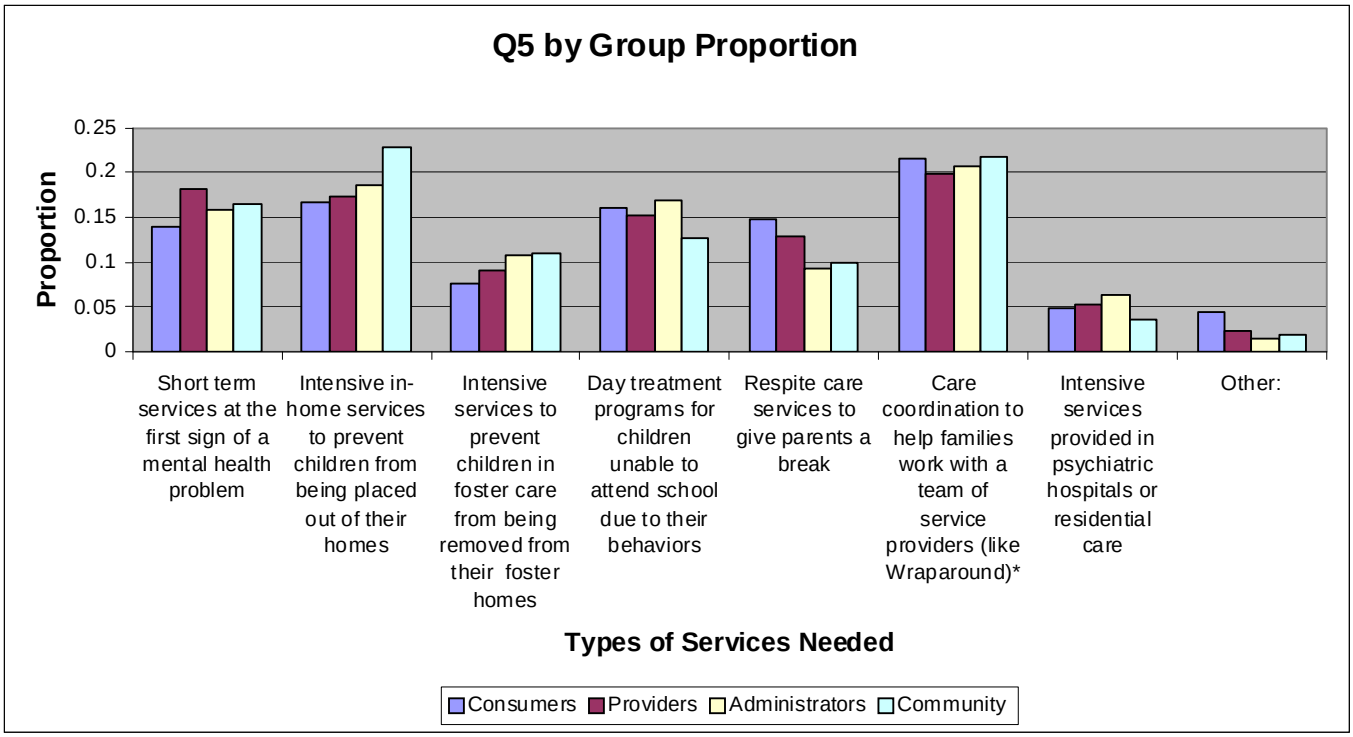
Despite the relatively diffuse endorsement of multiple options presented, Wraparound was the most common response for consumers, providers, and administrators, with community members prioritizing it just slightly beneath intensive in-home services for foster children. Consumers strongly endorsed expanded availability of Wraparound, with intensive in-home services being the next highest priority. Providers and Partner agency staff did not favor any one response as dramatically as these other two groups.



Response	Count	Percentage
Care coordination to help families work with a team of service providers (like Wraparound)*	649	20.75%
Intensive in-home services to prevent children from being placed out of their homes	555	17.75%
Short term services at the first sign of a mental health problem	499	15.96%
Day treatment programs for children unable to attend school due to their behaviors	494	15.80%
Respite care services to give parents a break	392	12.54%
Intensive services to prevent children in foster care from being removed from their foster homes	282	9.02%
Intensive services provided in psychiatric hospitals or residential care	166	5.31%
Other:	90	2.88%



Response	Consumers	Providers	Administrators	Community
Care coordination to help families work with a team of service providers (like Wraparound)	236	199	174	24
Intensive in-home services to prevent children from being placed out of their homes	184	173	157	25
Short term services at the first sign of a mental health problem	153	182	133	18
Day treatment programs for children unable to attend school due to their behaviors	176	151	143	14
Respite services to give parents a break	162	129	79	11
Intensive services to prevent children in foster care from being removed from their foster homes	84	90	91	12
Intensive services provided in psychiatric hospitals or residential care	53	52	53	4
Other	49	23	13	2



Response	Consumers	Providers	Administrators	Community
Care coordination to help families work with a team of service providers (like Wraparound)*	0.215	0.199	0.206	0.218
Intensive in-home services to prevent children from being placed out of their homes	0.168	0.173	0.186	0.227
Short term services at the first sign of a mental health problem	0.139	0.182	0.158	0.164
Day treatment programs for children unable to attend school due to their behaviors	0.160	0.151	0.170	0.127
Respite care services to give parents a break	0.148	0.129	0.094	0.100
Intensive services to prevent children in foster care from being removed from their foster homes	0.077	0.090	0.108	0.109
Intensive services provided in psychiatric hospitals or residential care	0.048	0.052	0.063	0.036
Other:	0.045	0.023	0.015	0.018

2008 Children's Mental Health Survey Results

7. Need for Access to Services by Provider Type

Survey Question:
"Which types of professional providers do you think need to be more available?"
(Choose up to two):

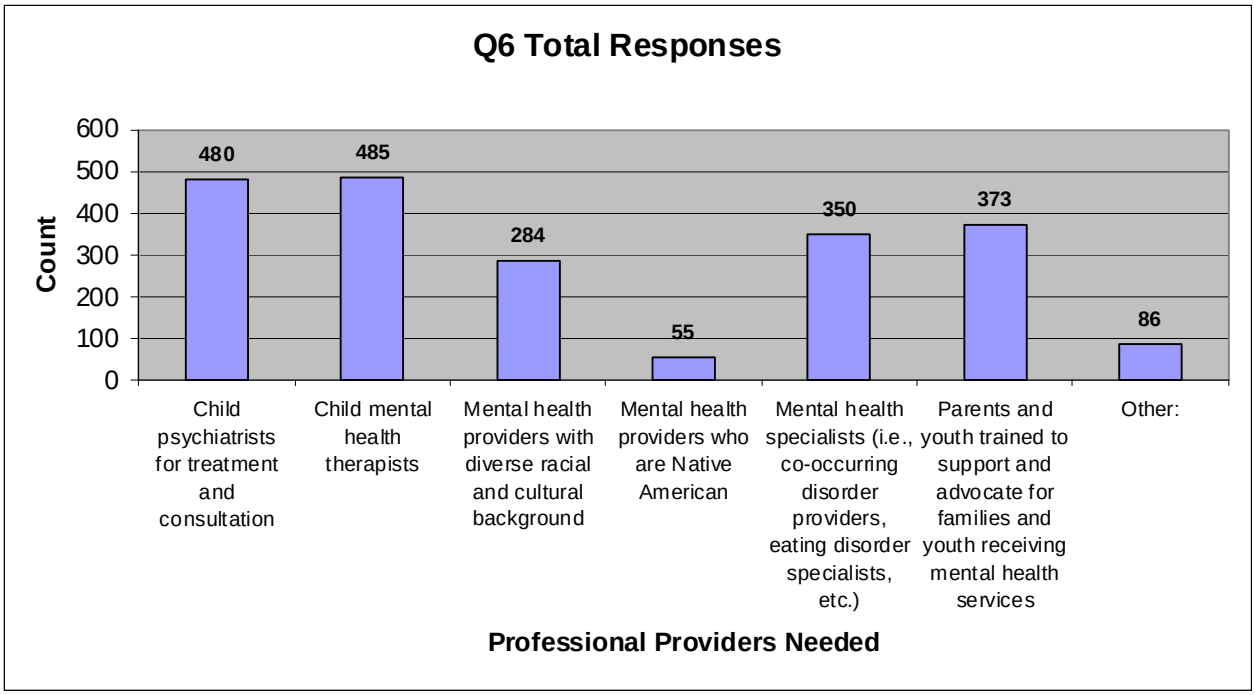
- **Child psychiatrists for treatment and consultation**
- **Child mental health therapists**
- **Mental health providers with diverse racial and cultural background**
- **Mental health providers who are Native American**
- **Mental health specialists (i.e. co-occurring disorder providers, eating disorder specialists, etc.)**
- **Parents and youth trained to support and advocate for families and youth receiving mental health services**
- **Other**

Respondents: 1061
Responses: 2087
Average Responses per participant: 1.97

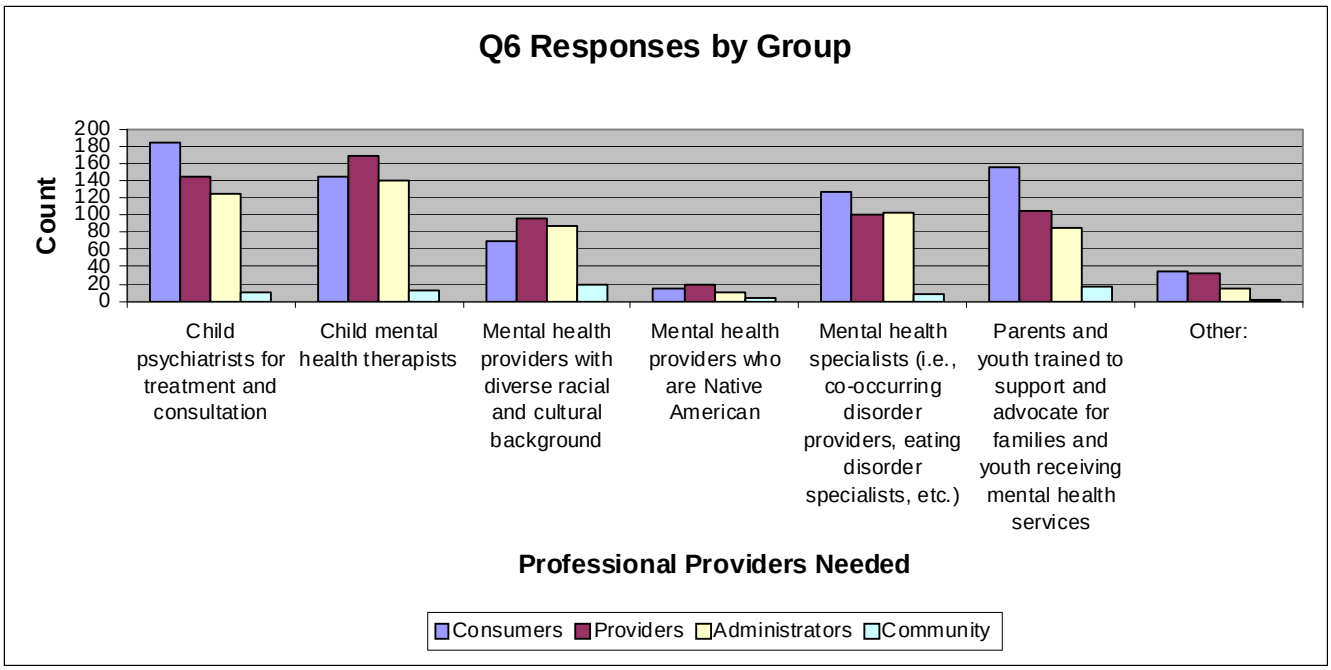
This item presents another opportunity for respondents to present their priority areas for developing increased capacity in the children's mental health system. Results show two clear priorities: increasing availability of Child psychiatrists and child mental health therapists, both receiving 23% of all responses. Less common but still highly endorsed included parents and youth partners (18%), mental health specialists (17%), and mental health providers with diverse backgrounds (13%).

Consumers most frequently endorsed a need for psychiatrists (25%), while providers, and partner agency staff most frequently endorsed mental health therapists. Not surprisingly, consumers and community members were the groups most likely to endorse parent and youth partners as a professional type in need of greater development, endorsing this choice second only to child psychiatrists (consumers) and providers with diverse backgrounds (community members).

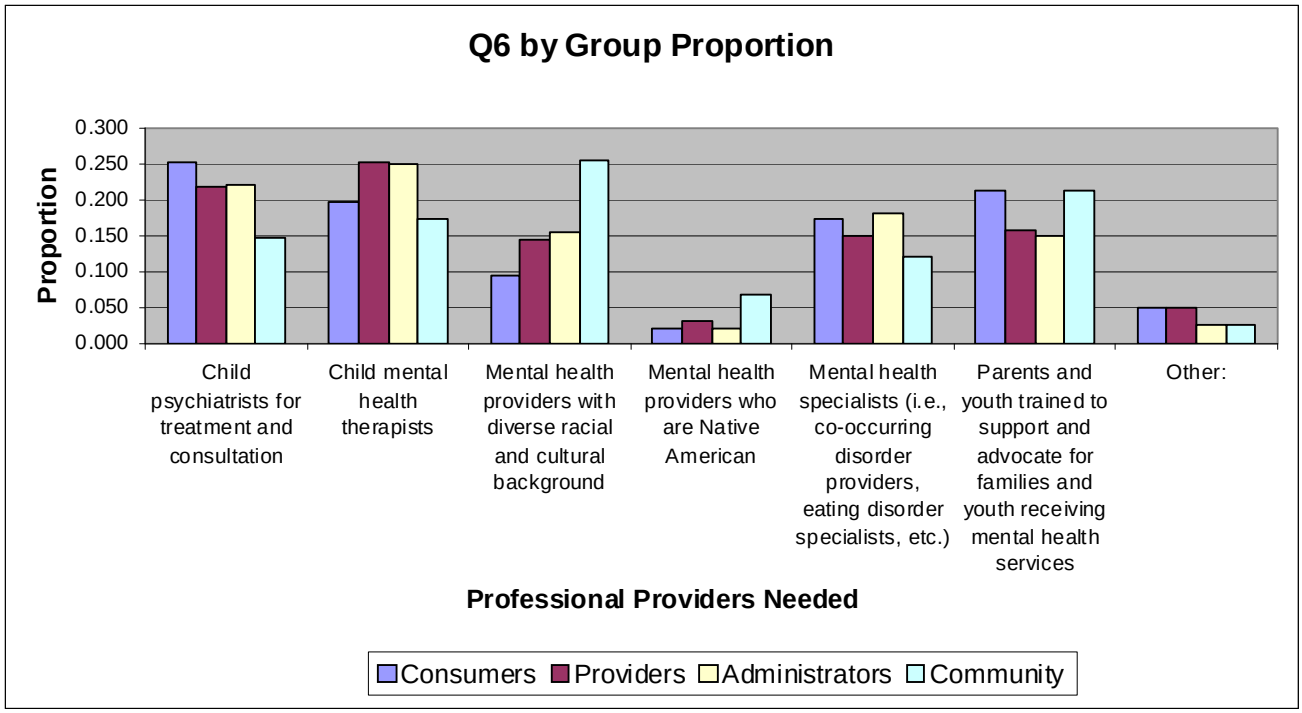
For this item, it is worth noting that "Native American providers" was chosen infrequently by all groups; this may be partly due to the simultaneous inclusion of the option "providers from diverse racial and cultural backgrounds." As shown in the Appendix presenting responses for Native American respondents, 32 of the 74 total responses to this question (43%) endorsed "Native American providers" (18 responses) or "providers from diverse cultural backgrounds" (14 responses).



Response	Count	Percentage
Child mental health therapists	485	22.95%
Child psychiatrists for treatment and consultation	480	22.72%
Parents and youth trained to support and advocate for families and youth receiving mental health services	373	17.65%
Mental health specialists (i.e., co-occurring disorder providers, eating disorder specialists, etc.)	350	16.56%
Mental health providers with diverse racial and cultural background	284	13.44%
Other:	86	4.07%
Mental health providers who are Native American	55	2.60%



Response	Consumers	Providers	Administrators	Community
Child mental health therapists	144	168	140	13
Child psychiatrists for treatment and consultation	184	145	124	11
Parents and youth trained to support and advocate for families and youth receiving mental health services	155	105	84	16
Mental health specialists (i.e., co-occurring disorder providers, eating disorder specialists, etc.)	127	100	102	9
Mental health providers with diverse racial and cultural background	69	96	87	19
Other:	35	33	14	2
Child mental health therapists	144	168	140	13



Responses	Consumers	Providers	Administrators	Community
Child mental health therapists	0.198	0.252	0.249	0.173
Child psychiatrists for treatment and consultation	0.252	0.217	0.221	0.147
Parents and youth trained to support and advocate for families and youth receiving mental health services	0.213	0.157	0.149	0.213
Mental health specialists (i.e., co-occurring disorder providers, eating disorder specialists, etc.)	0.174	0.150	0.181	0.120
Mental health providers with diverse racial and cultural background	0.095	0.144	0.155	0.253

2008 Children's Mental Health Survey Results

8. Priority Training Needs

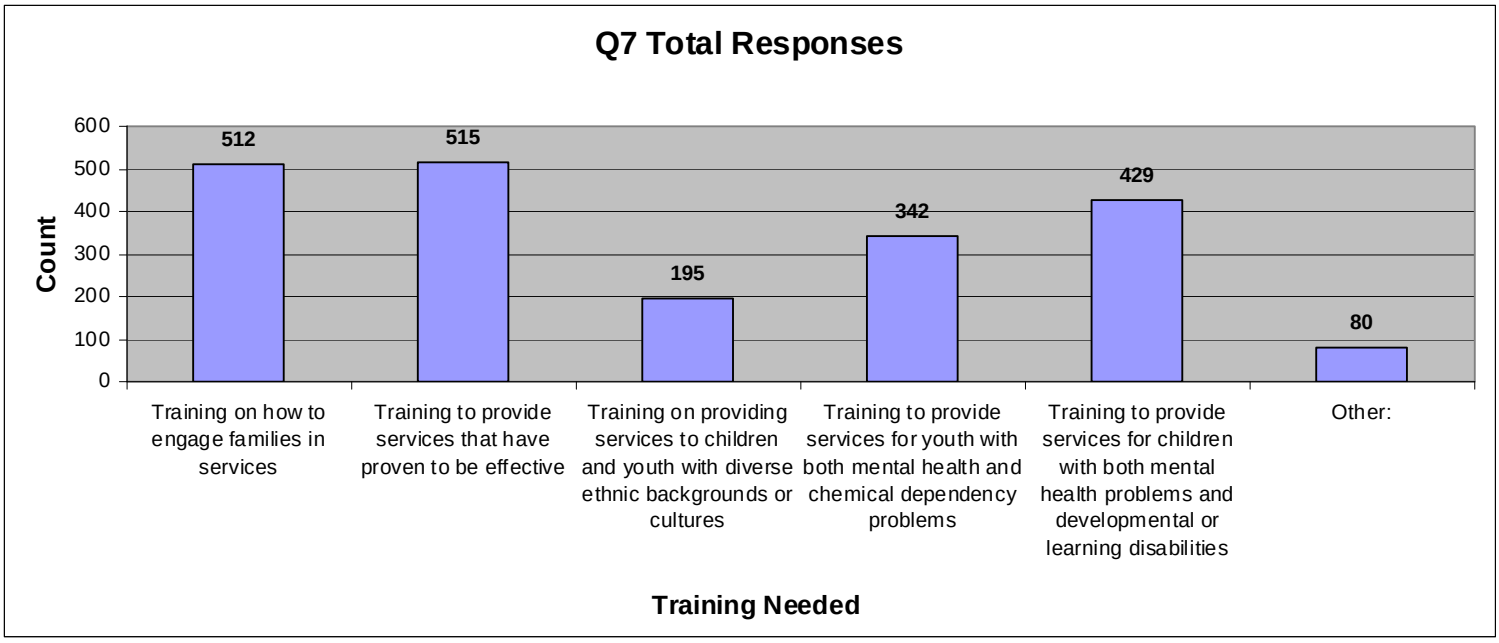
Survey Question:
"What types of training for current and future mental health providers would best improve the quality of services?"
(Choose up to two):

- **Training on how to engage families in services**
- **Training to provide services that have proven to be effective**
- **Training on providing services to children and youth with diverse ethnic backgrounds or cultures**
- **Training to provide services for youth with both mental health and chemical dependency problems**
- **Training to provide services for children with both mental health problems and developmental or learning disabilities**
- **Other**

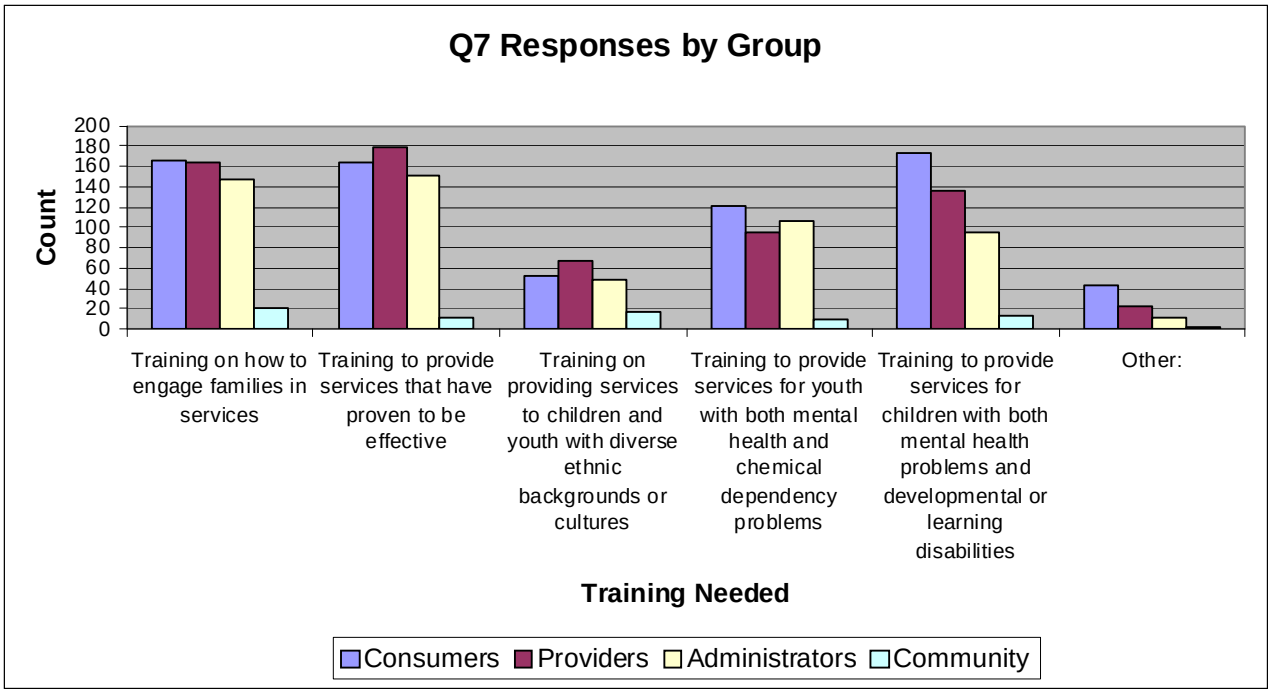
Respondents: 1051
Responses: 2073
Average Responses per Respondent: 1.97

Putting aside types of services that are most needed, this item asked respondents to provide input on types of training for providers that are most needed. In keeping with many scientific trends in children's mental health, two priorities were equally prioritized above all others: "Training to provide services that have proven to be effective" (25%) and "Training on how to engage families in services" (2%). These two response options were followed relatively closely by "Training to provide services for children with both mental health problems and developmental or learning disabilities" (21%) and "Training to provide services for youth with both mental health and chemical dependency problems" (17%). Training on providing services to children and youth with diverse ethnic backgrounds or cultures was less commonly endorsed by respondents (9% of all responses).

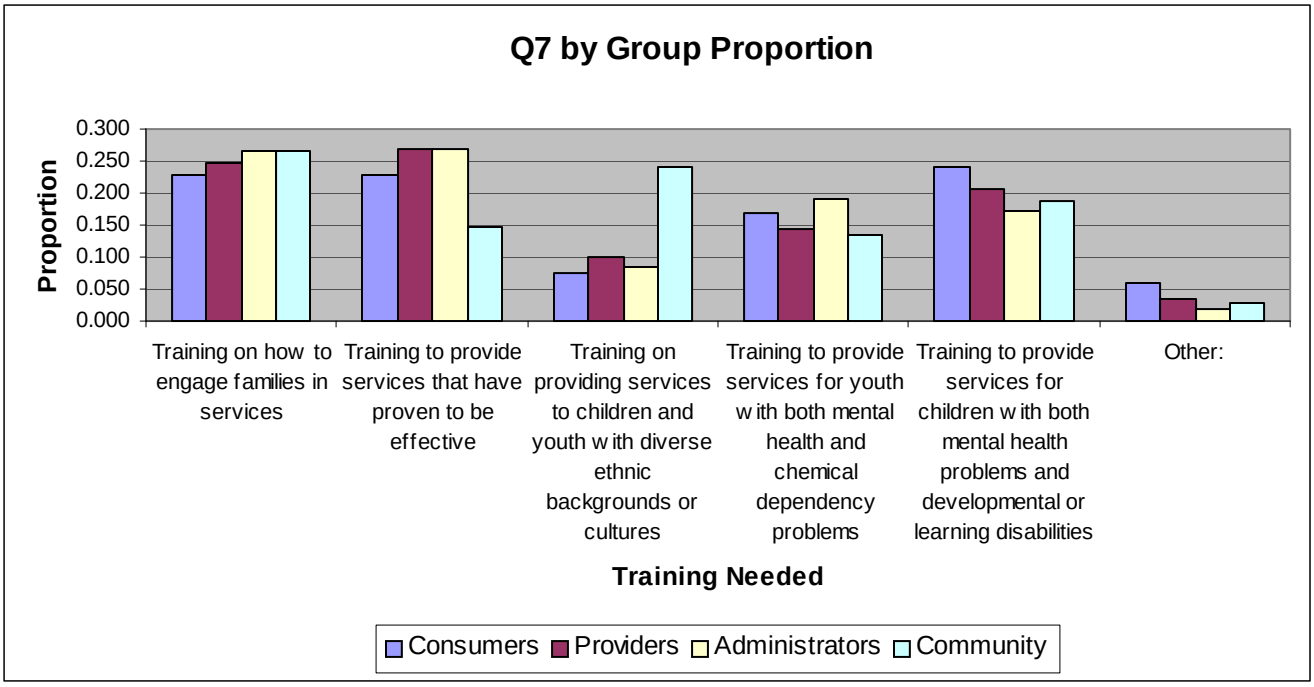
Interestingly, Consumers rated "Training on effective services" as well as "Training on services for children with both mental health and developmental disabilities" more frequently than "Engaging families in services." Community members most frequently endorsed a need for training on family engagement. Providers were most likely to endorse a need for training on effective services.



Response	Count	Percentage
Training to provide services that have proven to be effective	515	24.84%
Training on how to engage families in services	512	24.70%
Training to provide services for children with both mental health problems and developmental or learning disabilities	429	20.69%
Training to provide services for youth with both mental health and chemical dependency problems	342	16.50%
Training on providing services to children and youth with diverse ethnic backgrounds or cultures	195	9.41%
Other:	80	3.86%



Response	Consumers	Providers	Administrators	Community
Training to provide services that have proven to be effective	164	179	150	11
Training on how to engage families in services	165	163	148	20
Training to provide services for children with both mental health problems and developmental or learning disabilities	173	137	96	14
Training to provide services for youth with both mental health and chemical dependency problems	121	96	106	10
Training on providing services to children and youth with diverse ethnic backgrounds or cultures	53	67	48	18
Other:	43	22	11	2



Response	Consumers	Providers	Administrators	Community
Training to provide services that have proven to be effective	0.228	0.270	0.268	0.147
Training on how to engage families in services	0.229	0.245	0.265	0.267
Training to provide services for children with both mental health problems and developmental or learning disabilities	0.241	0.206	0.172	0.187
Training to provide services for youth with both mental health and chemical dependency problems	0.168	0.145	0.190	0.133
Training on providing services to children and youth with diverse ethnic backgrounds or cultures	0.074	0.101	0.086	0.240
Other:	0.060	0.033	0.020	0.027

2008 Children's Mental Health Survey Results

9. Groups Requiring Greater Access to EBPs

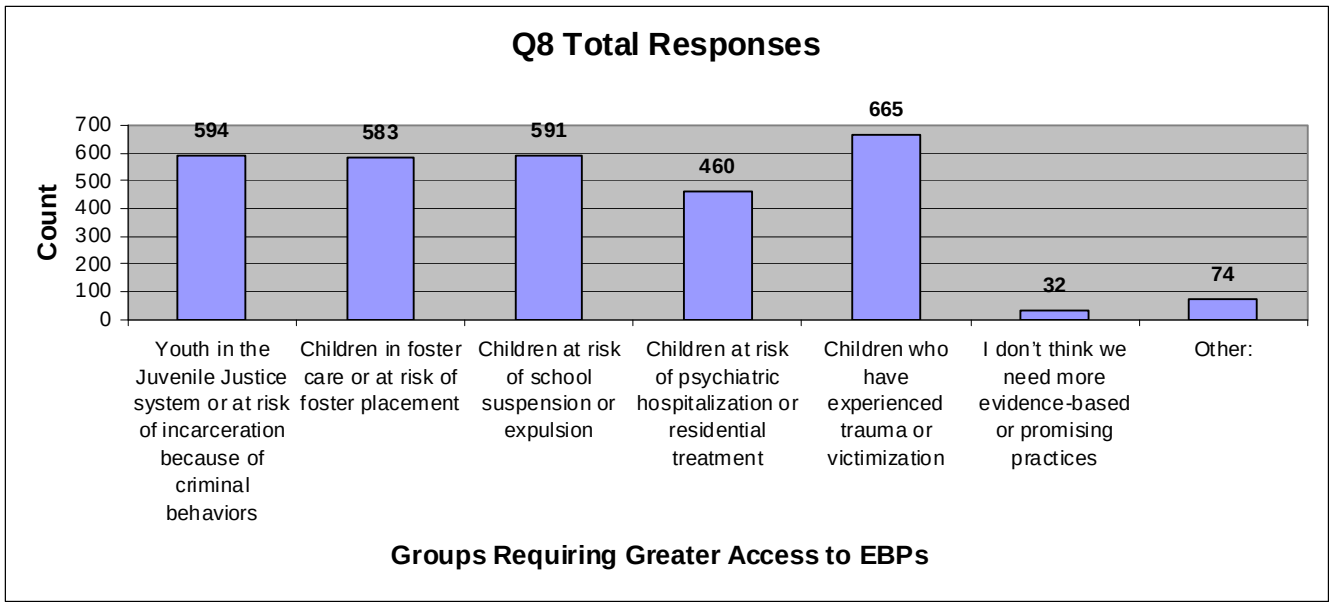
Survey Question:
"If resources were available to provide more evidence-based and promising practices, which groups should receive these kinds of services?"
(Choose up to two):

- **Youth in the Juvenile Justice system or at risk of incarceration because of criminal behaviors**
- **Children in foster care or at risk of foster placement**
- **Children at risk of school suspension or expulsion**
- **Children at risk of psychiatric hospitalization or residential treatment**
- **Children who have experienced trauma or victimization**
- **I don't think we need more evidence-based or promising practices**
- **Other**

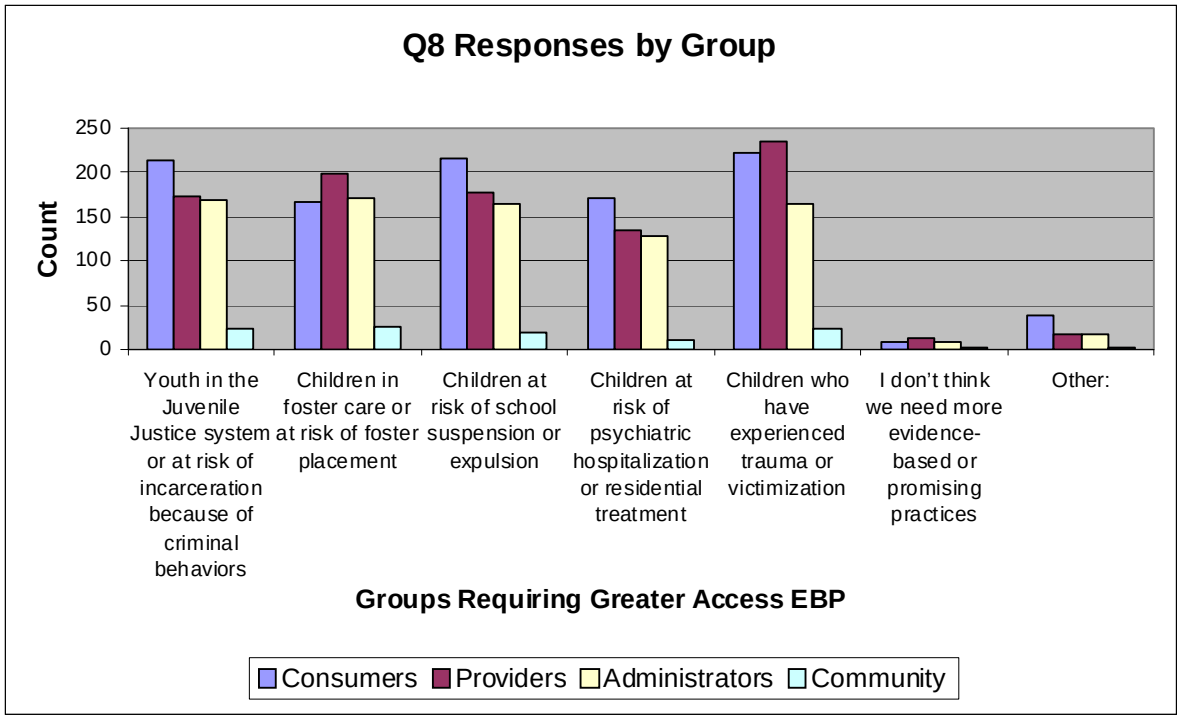
Respondents: 1061
Responses: 2999
Average Responses per Respondent: 2.83

Responses to this item paralleled the previous item about types of youth requiring greater access to services in general. Youth who have experienced past trauma were most likely to receive an endorsement from respondents (22%), followed by three options that were all endorsed by 19-20% of respondents: Youth in the juvenile justice system, youth at risk of school suspension or expulsion, and children and youth involved in the foster care system. Children and youth at risk of placement in psychiatric hospitals or Residential Treatment were somewhat less likely to be prioritized overall (15%). Very few respondents (1%) indicated that they believed expanding access to evidence based practices is unnecessary.

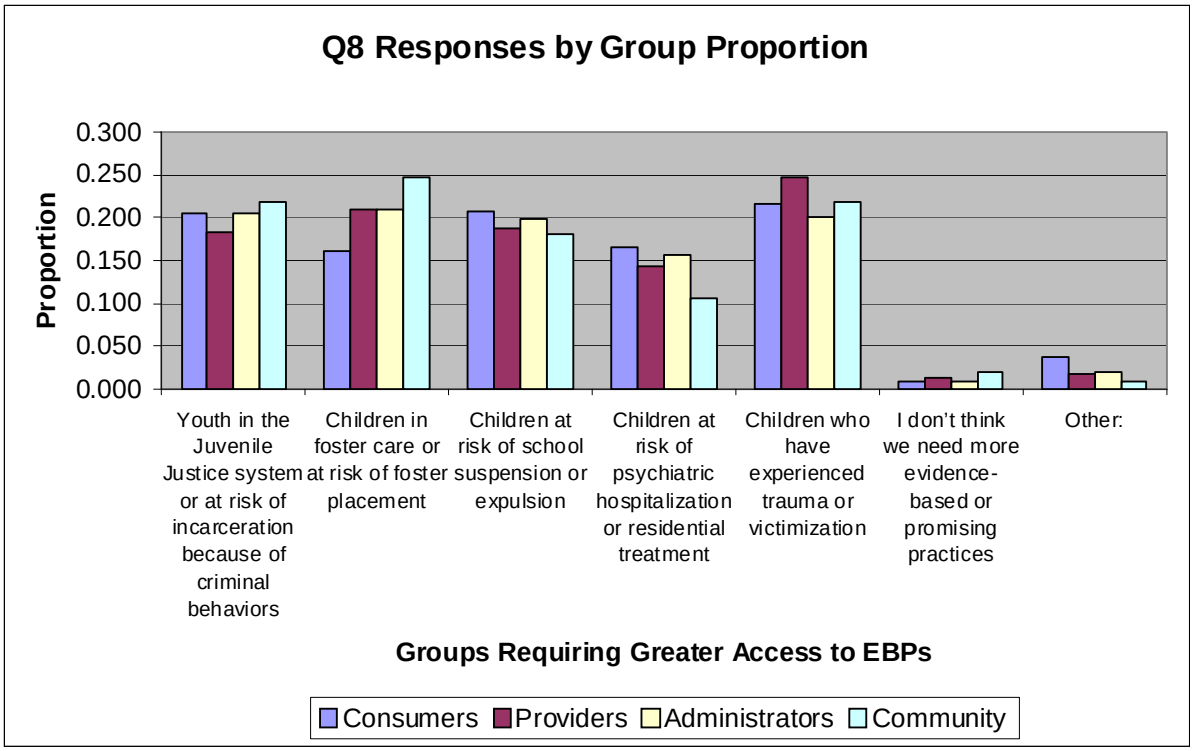
Paralleling breakdowns for respondent types from previous items, providers were more likely to endorse the need for EBPs for youth who had experienced previous trauma. Youth consumers and family members were most likely to endorse a need for EBPs to serve youth in danger of being suspended or expelled from school.



Response	Count	Percentage
Children who have experienced trauma or victimization	665	22.17%
Youth in the Juvenile Justice system or at risk of incarceration because of criminal behaviors	594	19.81%
Children at risk of school suspension or expulsion	591	19.71%
Children in foster care or at risk of foster placement	583	19.44%
Children at risk of psychiatric hospitalization or residential treatment	460	15.34%
Other:	74	2.47%
I don't think we need more evidence-based or promising practices	32	1.07%



Responses	Consumers	Providers	Administrators	Community
Children who have experienced trauma or victimization	223	234	165	23
Youth in the Juvenile Justice system or at risk of incarceration because of criminal behaviors	213	174	169	23
Children at risk of school suspension or expulsion	216	178	164	19
Children in foster care or at risk of foster placement	167	198	172	26
Children at risk of psychiatric hospitalization or residential treatment	171	135	129	11
Other:	39	17	17	1
I don't think we need more evidence-based or promising practices	8	13	8	2



Response	Consumers	Providers	Administrators	Community
Children who have experienced trauma or victimization	0.215	0.247	0.200	0.219
Youth in the Juvenile Justice system or at risk of incarceration because of criminal behaviors	0.205	0.183	0.205	0.219
Children at risk of school suspension or expulsion	0.208	0.188	0.199	0.181
Children in foster care or at risk of foster placement	0.161	0.209	0.209	0.248
Children at risk of psychiatric hospitalization or residential treatment	0.165	0.142	0.157	0.105
Other:	0.038	0.018	0.021	0.010
I don't think we need more evidence-based or promising practices	0.008	0.014	0.010	0.019

Appendix 4.
Gaps & Recommendations Related to SSHB 1088 Identified by DSHS Assistant Secretaries & Administrators

In February 2008, Robin Arnold-Williams, Secretary of the Department of Social and Health Services requested the Assistant Secretaries and Administrators from Children's Administration, Economic Services Division, Juvenile Rehabilitation Program and Aging and Disability Services to identify gaps in the children's mental health system that may translate into specific service recommendations and/or are identified as allowable under existing Medicaid State Plan Amendment modalities.

Tables 1-5 provide a summary of the responses provided by DSHS Administrators and Assistant Secretaries. Gaps and related recommendations were identified in the following five areas: (1) access to services; (2) service array; (3) provider and treatment modality; (4) provider training; and (5) quality improvement.

Table 1. ACCESS TO SERVICES

Identified Gaps	DSHS Division				Recommendations
	CA	ADSA	ESA	JRA	
Difficult Access for Specific Populations					Increase client-family driven & culturally competent services that are accessible, available,& appropriate(i.e., developmentally appropriate). Increase the payment & reimbursement rates to attract qualified mental health professionals. Increase the type of acceptable services for specific age group and population served. Expand local RSN capacity to serve acute children & youth while they are awaiting CLIP beds.
ACS do not include autism-spectrum disorders	x				
ACS do not include disruptive disorders	x				
Kids with trauma histories are not screening in for mental health services	x				
Kids & families with DD can't find providers		x			
Access & availability of mental health services for children with DD		x			
Acceptance of JRA sex offenders into services				x	
Consultation & Evaluations/Assessments					
Inability to access professionals for consultations & evaluations	x				
Lack of med management & psych assessments				x	
Difficulty with consultation with PCPs for youth in community facilities prescribed psychotropic meds				x	
Other Identified Access Issues					
Type of provider allowed is limited		x			
Delays in getting intake & therapy appts	x				
Inability to access inpatient hospital beds	x				

Table 2. SERVICE ARRAY					
Identified Gaps	**DSHS Division**				**Recommendations**
	CA	**ADSA**	**ESA**	**JRA**	
Need for Family- and Home-Based Services					
Family therapy not available in public mental health system	x				Develop integration & availability of culturally competent approaches to services. Improve development of services in rural areas.
Family/couples therapy not available				x	
Gaps in respite services	x				
Flexible & home-based services are lacking	x				
Need for Other Specific Services					
Availability of FIT				x	Increase therapy service modalities (e.g., family therapy, couples therapy, group therapy, family support groups). Deliver holistic & integrated services that are recovery-focused.
Case management services	x				
Gaps in crisis response, & mobile outreach	x				
Transportation services/transportation vouchers for families				x	
Lack of Services in Rural Areas					
Gaps in respite services, crisis response, & mobile outreach, especially in rural areas	x				Expand & develop transportation services.
Services in rural areas lacking (e.g., co-occurring treatment, in-home services, transportation vouchers)				x	
Need for Inter- and Intra-System Partnerships					
Case management & continuity of care for children who cross county lines or regions or are in and out of detention facilities	x				
Lack of recognizing need to build partnerships across service system		x			
Limited number of acceptable services does not always meet the child's need/limits child's ability to access services			x		
Fragmentation of services				x	

Table 3. PROVIDER & TREATMENT MODALITY					
Identified Gaps	DSHS Division				Recommendations
	CA	ADSA	ESA	JRA	
Co-occurring disorder treatment	x				Expand EBPs for treatment of children with serious emotional disturbances.
Access to trained providers specializing in evidence-based treatments		x			
Expand treatment modalities to allow more promising evidence-based treatment options			x		
Mental health services for special populations are lacking (e.g., JRA youth who are sex offenders)				x	

Table 4. PROVIDER TRAINING					
Identified Gaps	DSHS Division				Recommendations
	CA	ADSA	ESA	JRA	
Training for staff in EBPs is limited (e.g., DBT, PCIT, FFT, MTFC, TF-CBT)	x		x		Expand opportunities for providers to participate & receive training in EBPs for treatment of children with serious emotional disturbance.
Need training in DBT specifically	x			x	
Need infant & early intervention training	x				
Need training in medication algorithms for primary care physicians	x				
Lack of training is a big gap in general		x			

Table 5. QUALITY IMPROVEMENT					
Identified Gaps	**DSHS Division**				**Recommendations**
	CA	**ADSA**	**ESA**	**JRA**	
Not enough inpatient therapists trained to deal with children with SED	x				Increase number of bilingual and bi-cultural service providers in local agencies. Improve parent-professional relationships as well as system-wide collaboration. Increase continuity of care across systems.
Ability to provide true range of interventions in a variety of therapeutic settings is limited in most places	x				
Lack of bilingual or bi-cultural services providers	x				
Need for partnerships between parents & professionals		x			
Pressure to meet basic needs often trumps need for mental health services				x	
Training in this area is a major gap			x		

Appendix 5.
Results from September 2008 Children's Community Forum

On September 11, 2008, WIMHRT hosted a second Community Forum, which included 180 participant stakeholders within the children's mental health system. The preliminary findings from the November 2007 Community Forum, RSN interviews/questionnaires, and the Children's Mental Health Survey were used to develop initial recommendations and related follow-up questions to community stakeholders who participated in this second Forum. Community forum participant feedback was specifically solicited using an Electronic Audience Response System, allowing generation of immediate results and answers to each question posed within the Forum.

Forum Participants

The majority of Forum participants represented urban communities (41%; N=58), followed by suburban (33%; N=46) and rural communities (26%; N=36). When asked about the region of Washington in each they live, most participants reported that they were from Western Washington (86%; N=122) while 14% (N=20) reported to be from Eastern Washington.

Figure 1A provides a breakdown of all Forum participants.

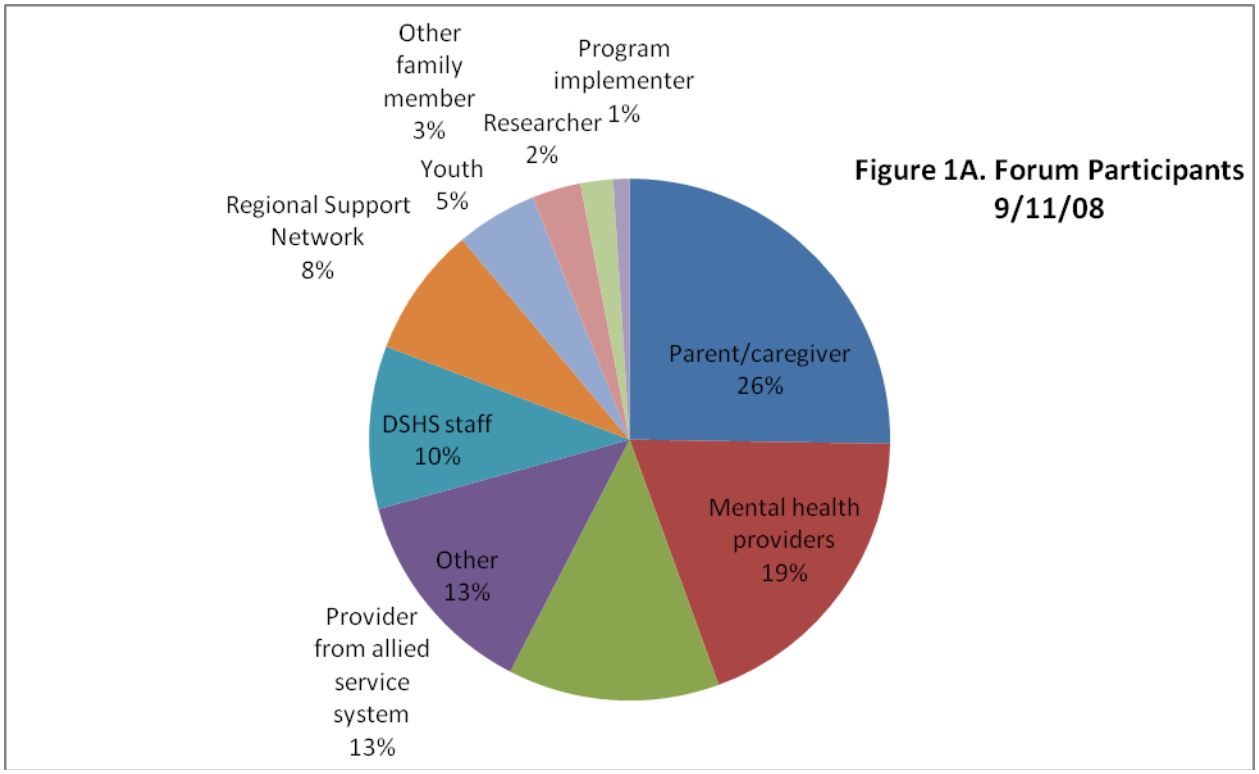


Figure 1A. Forum Participants 9/11/08

Participants who self-identified as being a family member or caregiver of a child or youth who receives or needs mental health services (N=60) were asked to report what age group of child/youth "best describes" them as well as their primary focus at the forum. Most participants reported that they both were a parent/caregiver for adolescents (43%; N=26) and that adolescents were the primary focus for them at the forum (51%; N=70), followed by the following:

Table 1. Family Members and Caregivers at September Forum		
	Which best describes your child/children?	**What is your primary focus for today?**
Young children (0-4 yrs)	22% (N=13)	8% (N=11)
School-age children (5-11 yrs)	22% (N=13)	25% (N=35)
Adolescents (12-16 yrs)	43% (N=26)	51% (N=70)
Transition-age youth (17-25 yrs)	33% (N=20)	16% (N=22)

Forum Questions

Concerns about Access to Care Standards (ACS)

Forum participants were asked two questions related to the ACS: (1) Do they have concerns about the current ACS and (2) If they do have concerns about the ACS, rank the top three biggest problems related to ACS.

As shown in Figure 1 below, most Forum participants (66%) indicated that they "strongly agree" with the statement "I have concerns about the current ACS." Another 30% responded that they "agree" with this statement.

As shown in Figure 2, the top three concerns in order of 1 (highest rank) to 3 across all respondents were:

1. The requirement of too low a level of functioning (i.e., maximum CGAS score is too low);
2. Not enough inclusion of specific diagnoses (e.g, autism, developmental disabilities, severe behavioral challenges); and
3. Little to no access to services for non-Medicaid children, youth, and families.

Figure 2 also shows that the top three most highly represented Forum participants voted similarly.

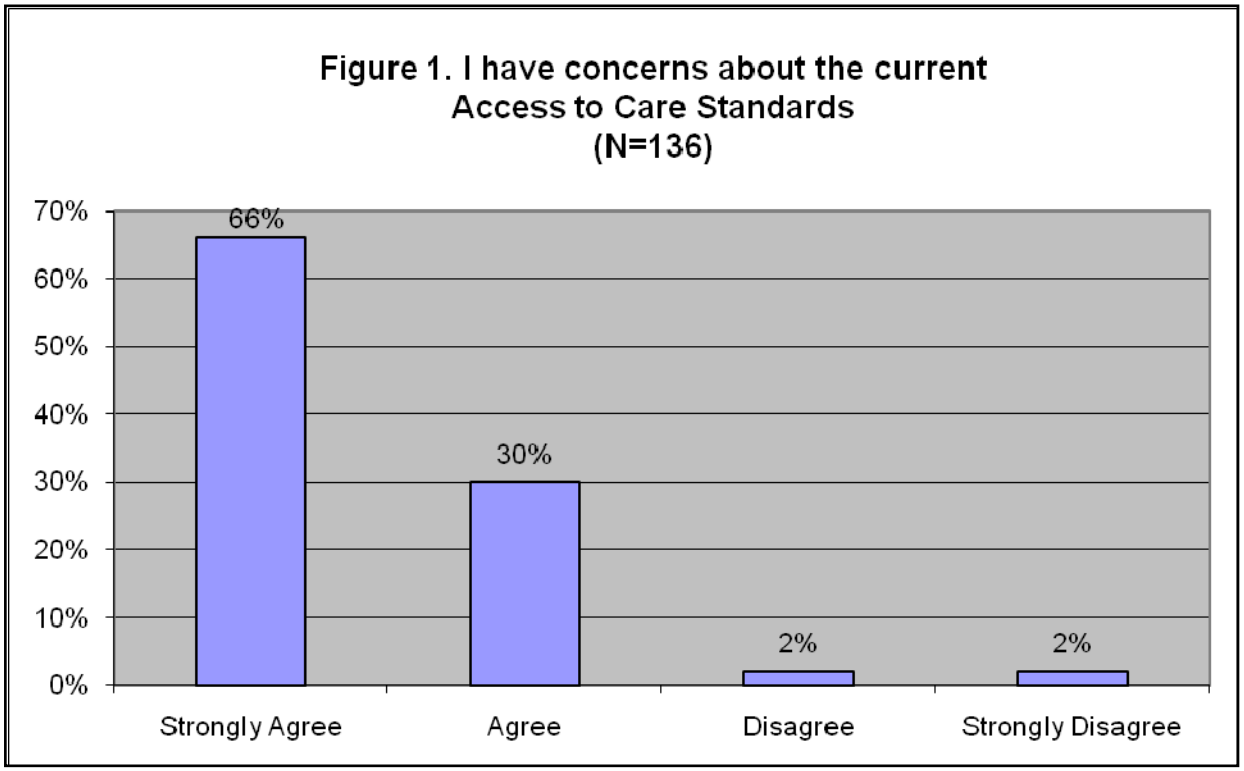


Figure 1. I have concerns about the current Access to Care Standards (N=136)
70%
60%
50%
40%
30%
20%
10%
0%
66%
30%
2%
2%
Strongly Agree
Agree
Disagree
Strongly Disagree

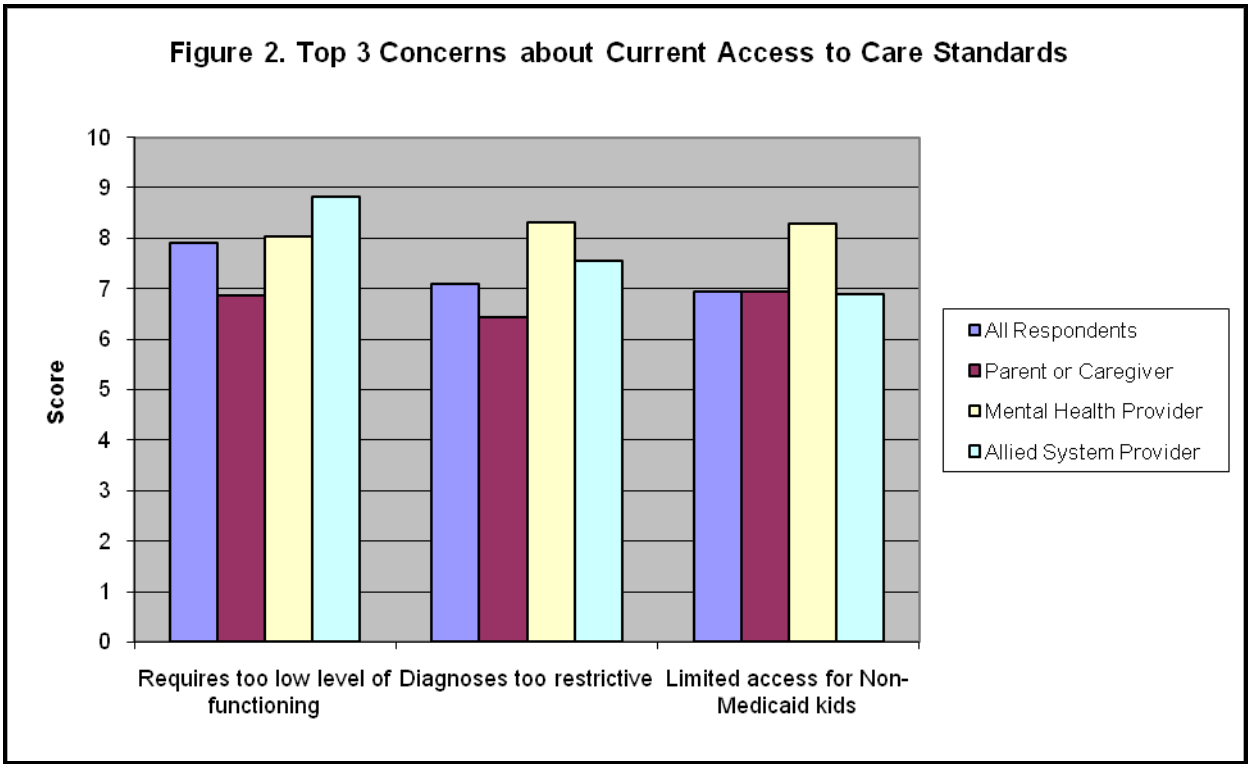


Figure 2. Top 3 Concerns about Current Access to Care Standards
Score
10
9
8
7
6
5
4
3
2
1
0
Requires too low level of functioning
Diagnoses too restrictive
Limited access for Non-Medicaid kids
All Respondents
Parent or Caregiver
Mental Health Provider
Allied System Provider

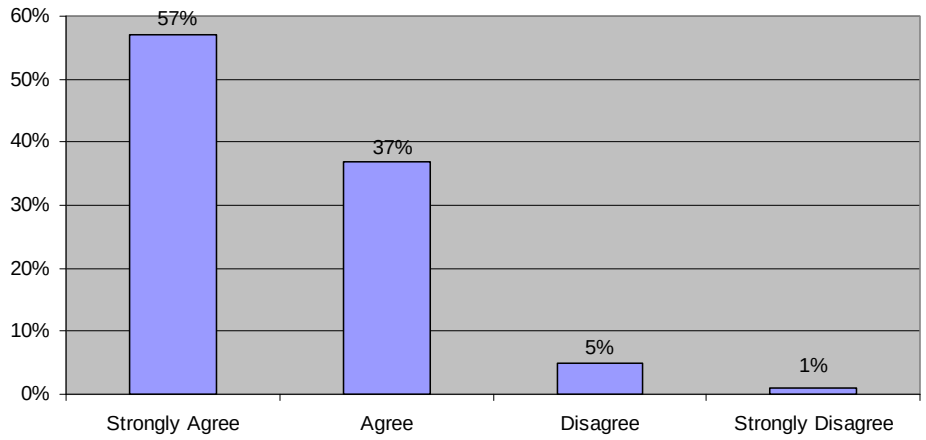
Strategies for Better Engaging Youth and Families

Forum participants were asked three questions related to specific strategies for better engaging youth and families in services; these strategies included:

- Service providers are provided with an incentive for delivering services out of the office, after hours, and on weekends;
- Providers are provided with training in evidence-based and promising family and youth engagement/empowerment strategies (e.g., Columbia's Parent Empowerment Program)
- Family Navigator services are further developed to help families understand the system, the resources available to them, and they are assisted in making choices about those services.

Figures 3-5 indicate that all three sets of proposed strategies were highly endorsed by Forum participants. Provider incentives for increased access and provider training in family/youth engagement and empowerment strategies were supported by a higher percentage of participants (94% overall agreement and 91% overall agreement, respectively); however, this may be due to the fact that there may have been some confusion about the definition of "Family Navigator" within the Forum. The definition enclosed within participants' packets specified that this role is typically carried out by a professional, with the implication that this may not necessarily be carried out by a parent. Even with such a narrow definition, the fact that 75% of participants also endorsed the Family Navigator concept shows that this type of strategy was still favored among Forum participants.

Figure 3. Youth & families could be better engaged in services if the people providing the services were given an incentive for delivering services out of office, after-hours, & on weekends (N=132)



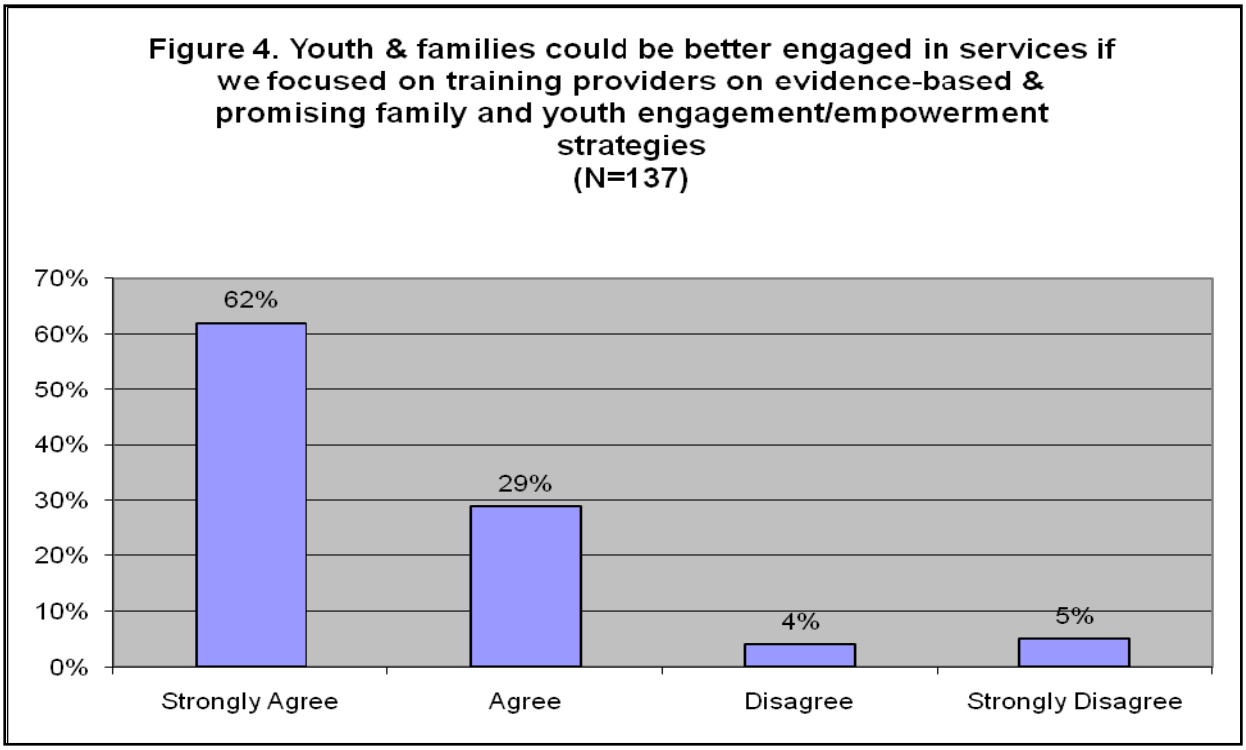


Figure 4. Youth & families could be better engaged in services if we focused on training providers on evidence-based & promising family and youth engagement/empowerment strategies
(N=137)
70%
60%
50%
40%
30%
20%
10%
0%
62%
29%
4%
5%
Strongly Agree
Agree
Disagree
Strongly Disagree

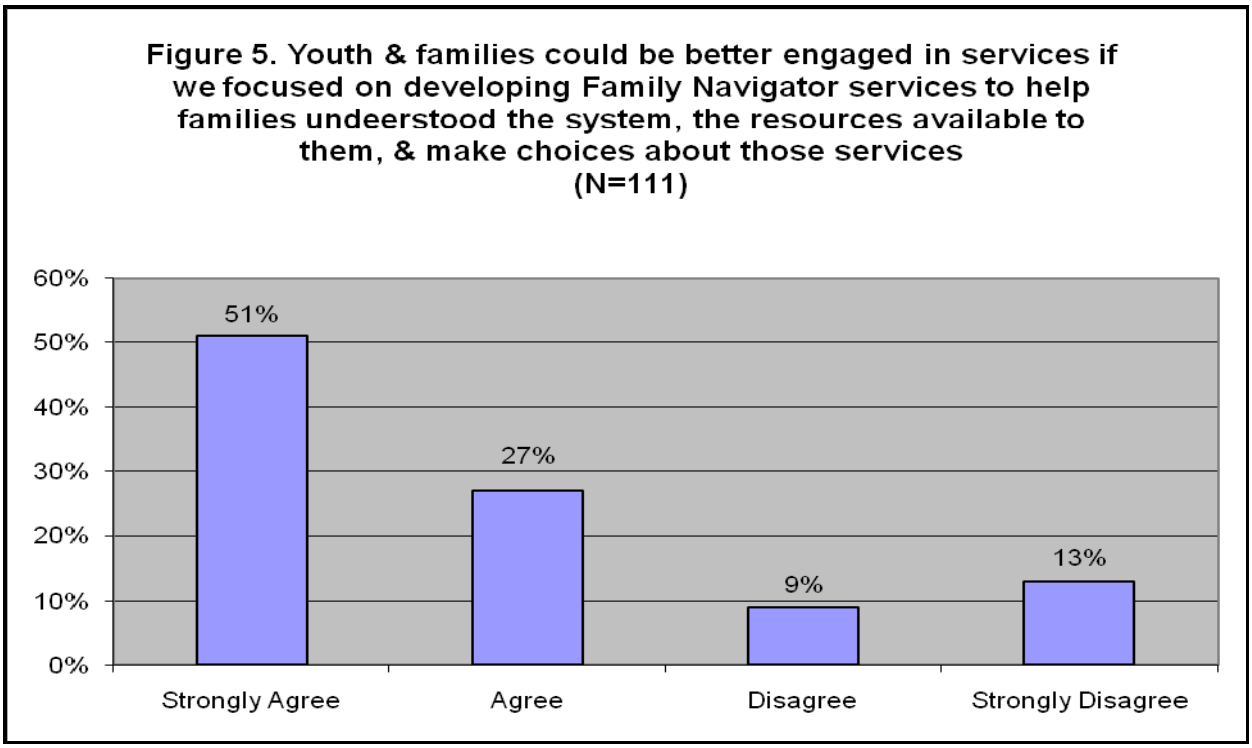
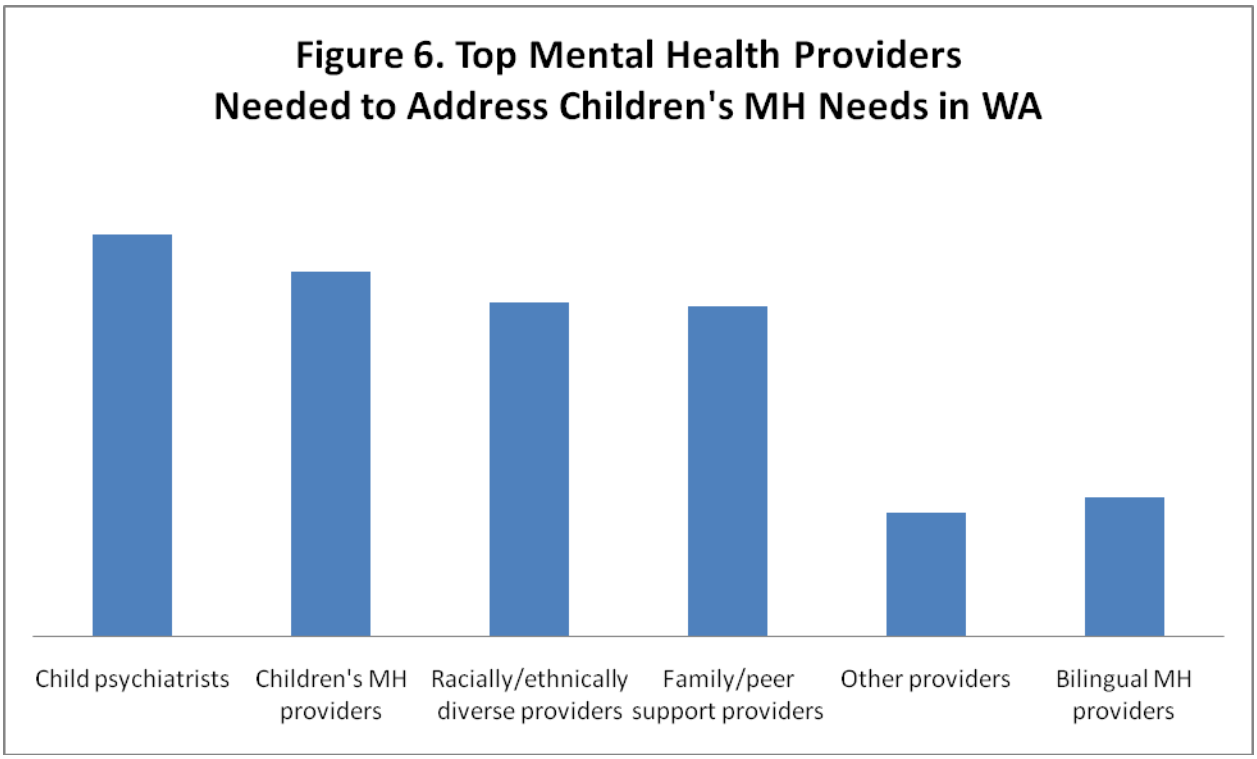


Figure 5. Youth & families could be better engaged in services if we focused on developing Family Navigator services to help families undeerstood the system, the resources available to them, & make choices about those services
(N=111)
60%
50%
40%
30%
20%
10%
0%
51%
27%
9%
13%
Strongly Agree
Agree
Disagree
Strongly Disagree

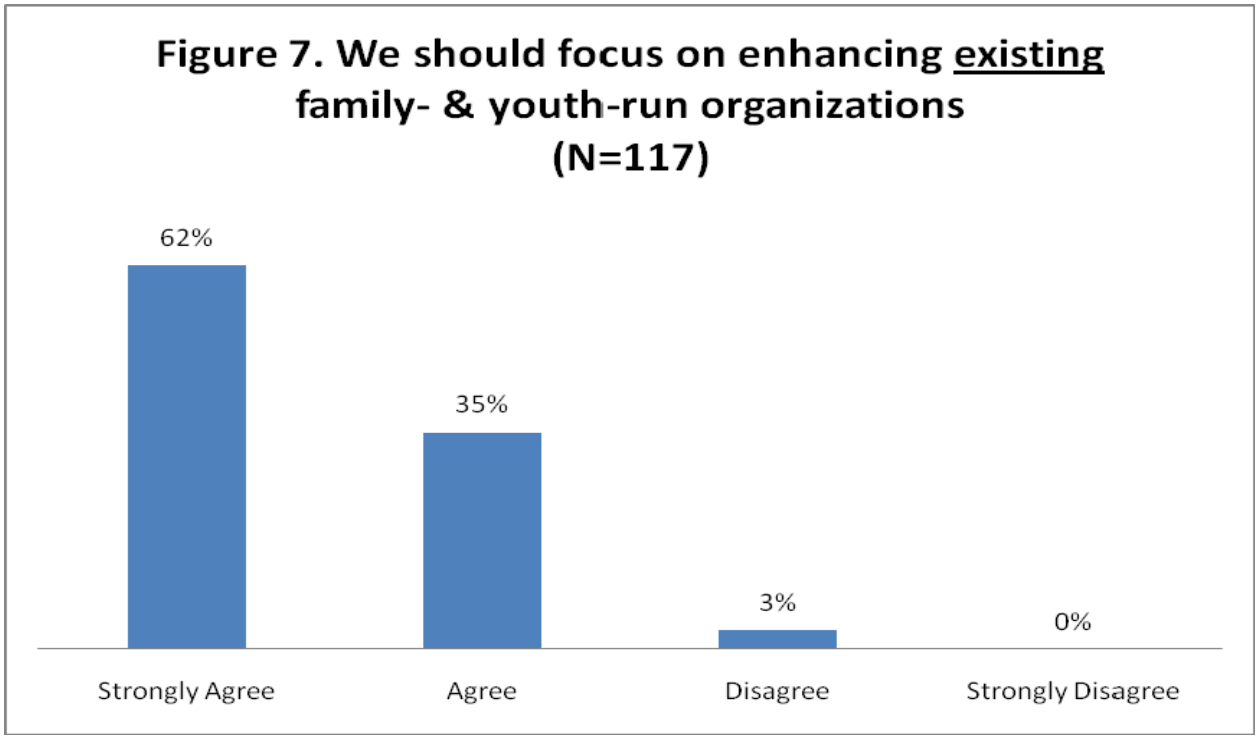
Types of Mental Health Providers Most Needed

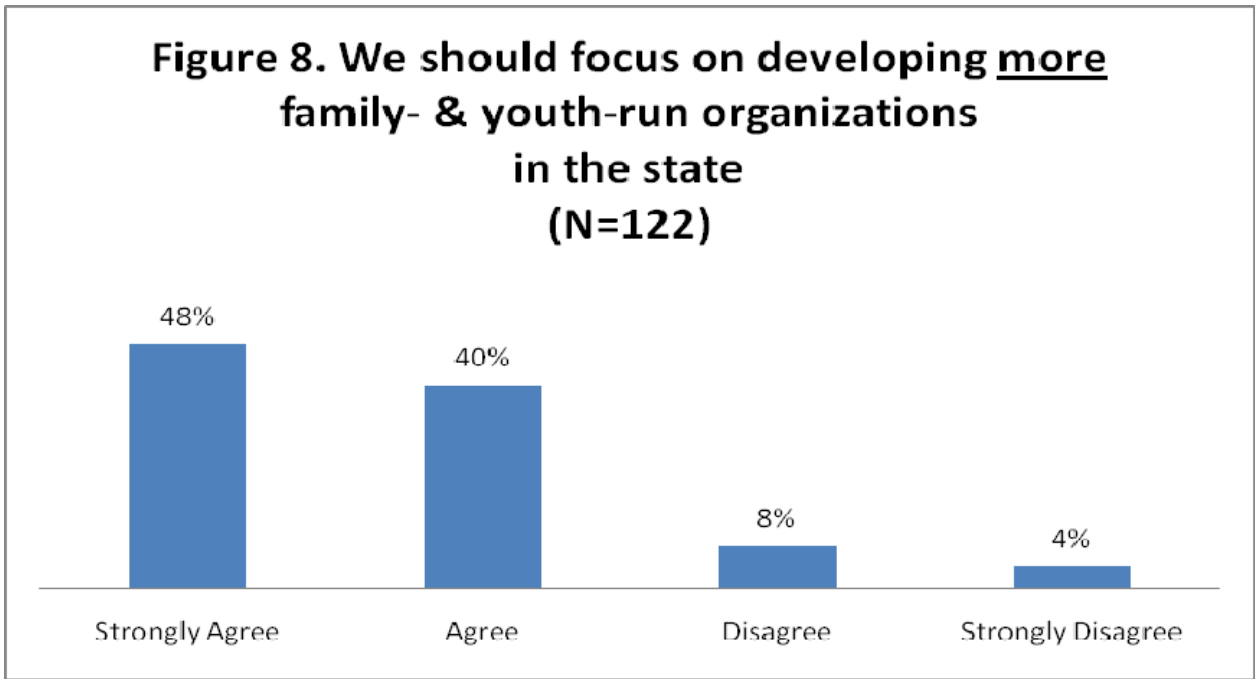
Forum participants were asked to rank their top three choices regarding the most needed mental health providers to address the needs of children, youth, and families in Washington State. As shown in Figure 6, Forum participants identified child psychiatrists, children's mental health providers/therapists, racially and ethnically-diverse mental health providers, and family support/peer-to-peer providers as the top providers needed in this state.



Family- and Youth-Run Organizations

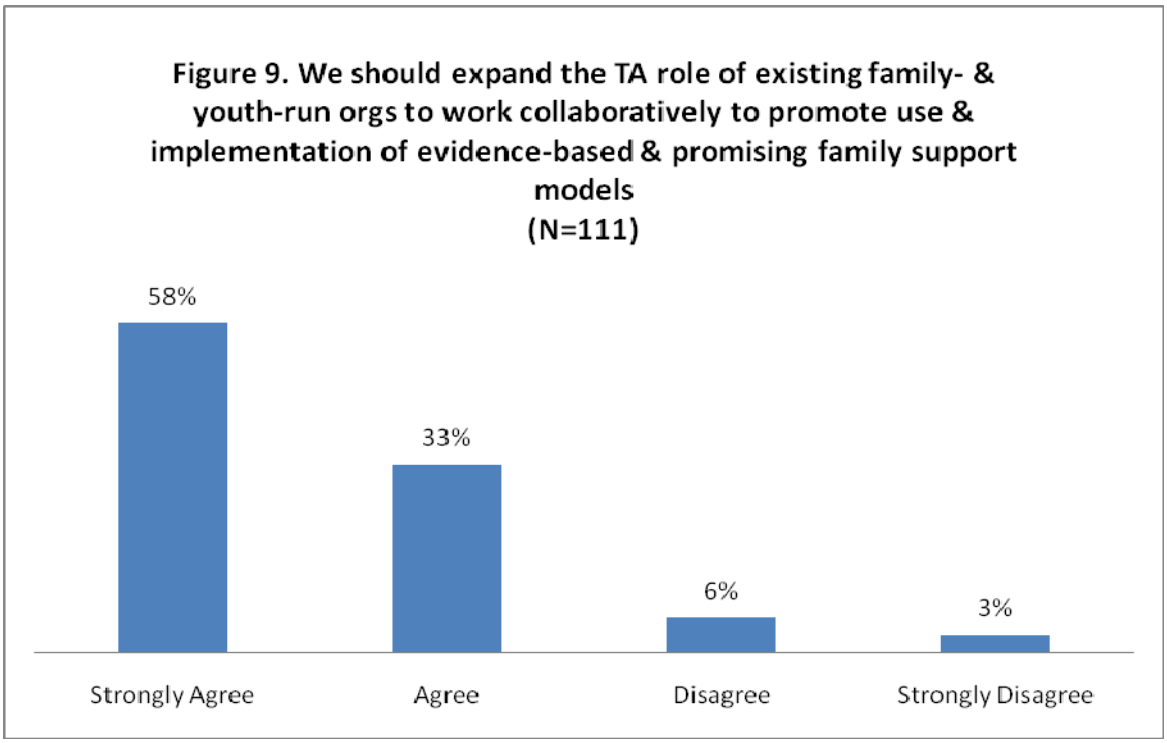
Forum participants were asked three questions related to the development and support of family- and youth-run organizations in Washington State (see Figures 7-9 and 11). As shown in Figures 7 and 8, 97% of Forum participants were in overall agreement with the idea of enhancing existing family- and youth-run organizations (see Figure 7), while 88% were also in support of development of more family- and youth-run organizations in WA (see Figure 8). Both approaches were further supported when participants were given the option to choose only one; 61% indicated that both are equally important (see Figure 11).

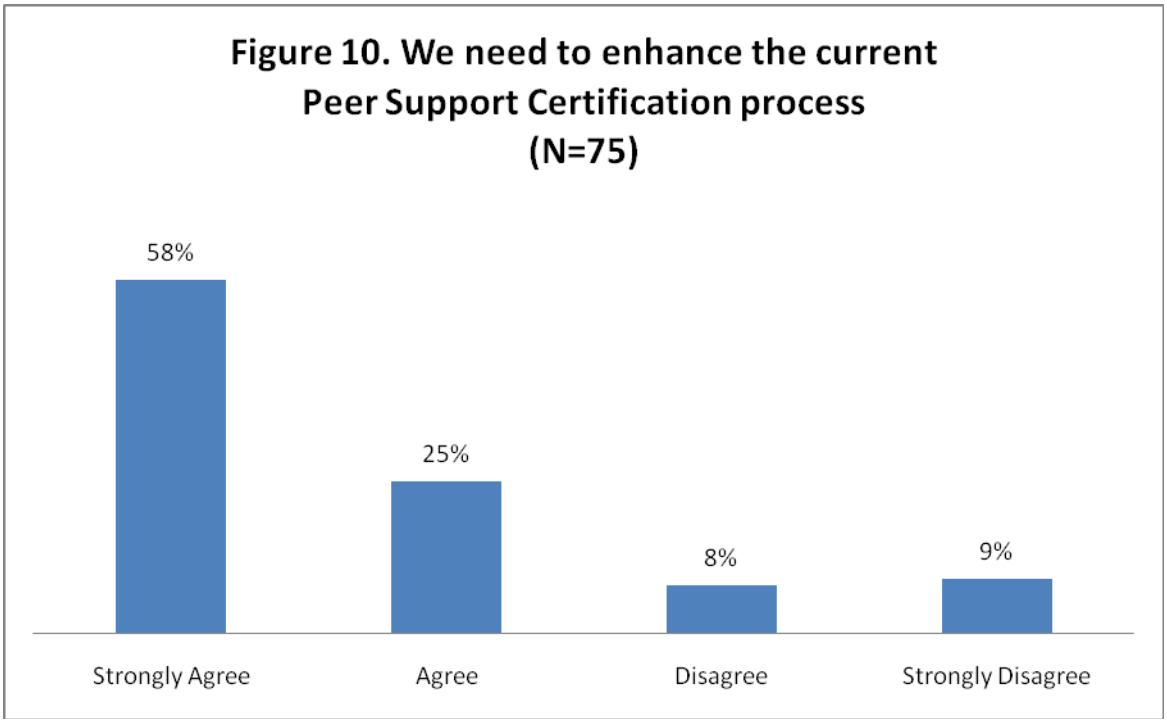


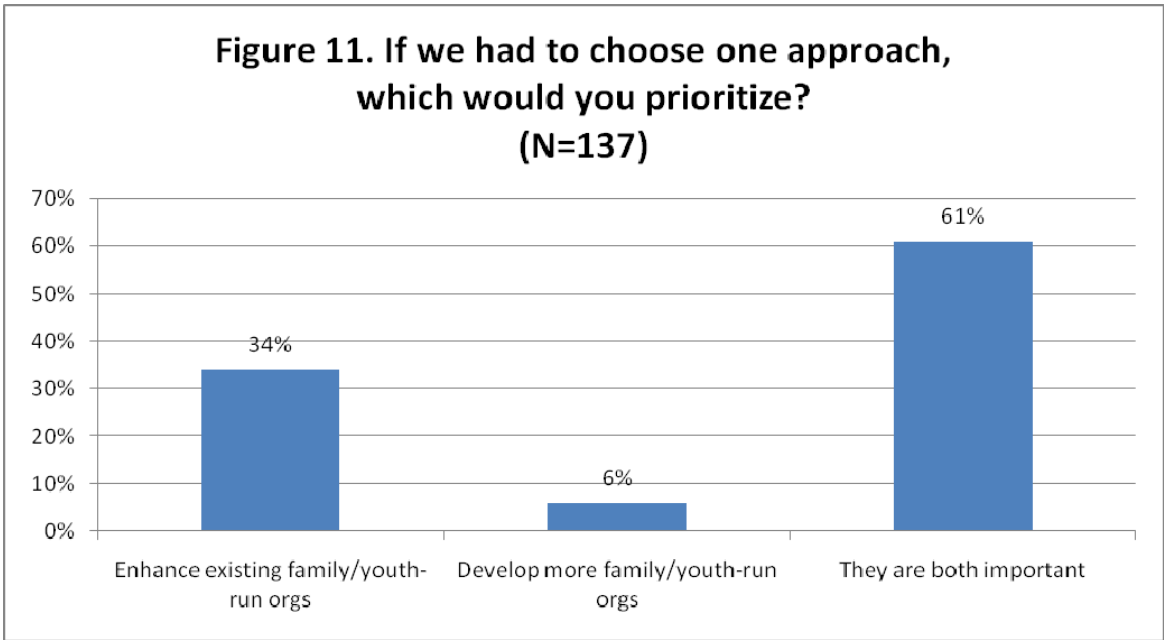


One particular direction to expand such organizations' existing roles is to work collaboratively to promote the use and implementation of evidence-based and promising family support models; this particular proposal was met with 91% overall agreement among Forum participants (see

Figure 9). Furthermore, most participants indicated that the current Peer Support certification process needs to be enhanced (see Figure 10).







EBP Implementation

Forum participants were also asked about implementation of EBPs for specific populations and needs (see Figures 12-17). Most participants agreed overall that there is a need to implement EBPs to address the following needs:

1. Children, youth, and families who need prevention and early intervention (90% agreement overall)
2. Parents with children with serious behavioral problems (89% agreement overall)
3. Youth exposed to trauma (87% agreement overall)
4. Youth with co-occurring mental health and substance use disorders (81% agreement overall)
5. Youth at risk for, or in, out-of-home placement (76% agreement overall)

As depicted in Figure 17, when asked to rank their top three, participants ranked children with serious behavior problems (#1), youth exposed to trauma (#2), families in need of prevention and early intervention (#3), children at risk for/in out-of-home placement (#4), and youth with co-occurring disorders (#5), respectively. Table 2 also provides a breakout of how types of participants rank ordered different EBP needs. Across all data, it is clear that participants prioritized all five EBP areas, with serious behavior problems and trauma ranking at #1 and #2.

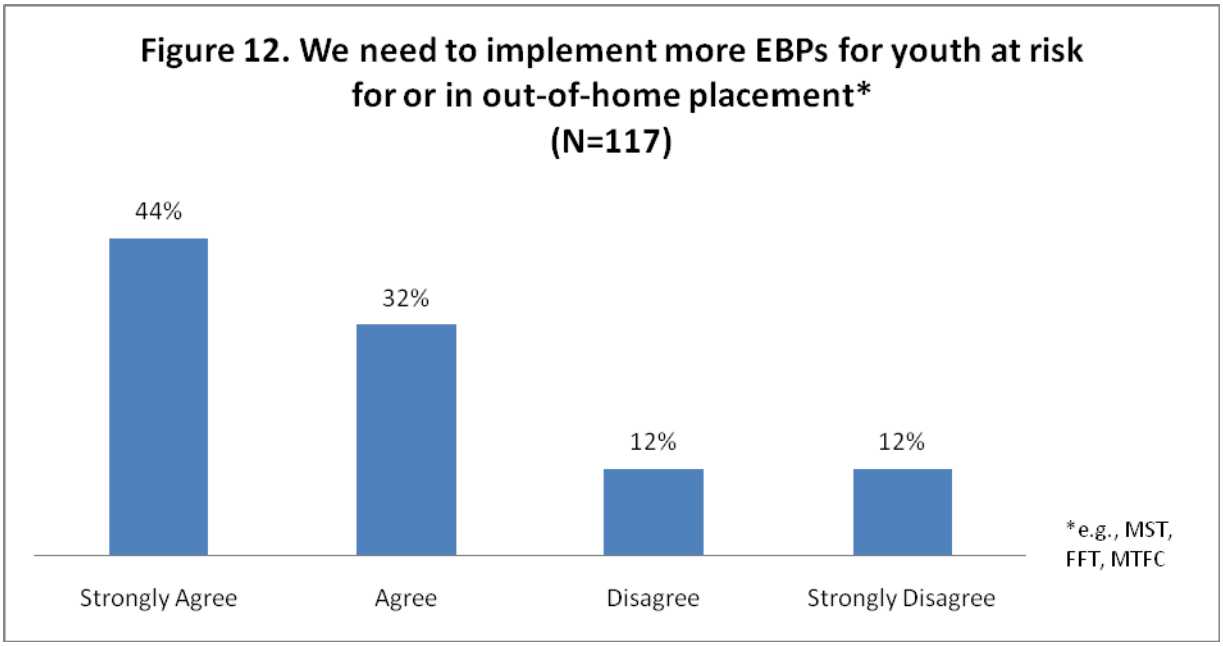


Figure 12. We need to implement more EBPs for youth at risk for or in out-of-home placement* (N=117)
44%
32%
12%
12%
Strongly Agree
Agree
Disagree
Strongly Disagree
*e.g., MST, FFT, MTFC

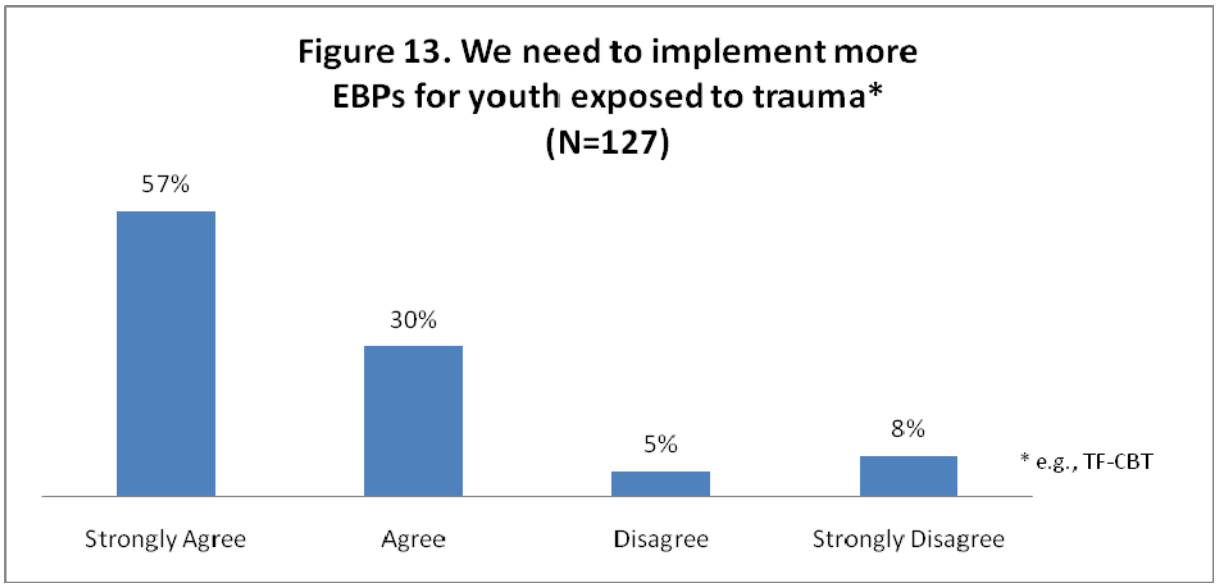


Figure 13. We need to implement more EBPs for youth exposed to trauma* (N=127)
57%
30%
5%
8%
Strongly Agree
Agree
Disagree
Strongly Disagree
* e.g., TF-CBT

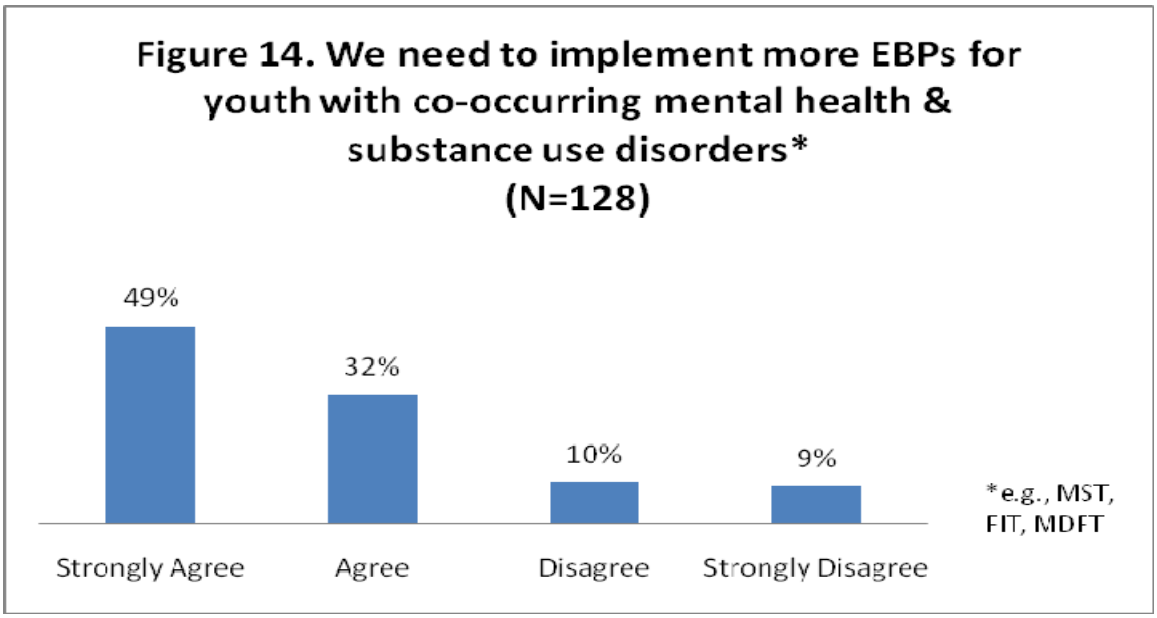


Figure 14. We need to implement more EBPs for youth with co-occurring mental health & substance use disorders*
(N=128)
49%
32%
10%
9%
Strongly Agree
Agree
Disagree
Strongly Disagree
*e.g., MST, FIT, MDFT

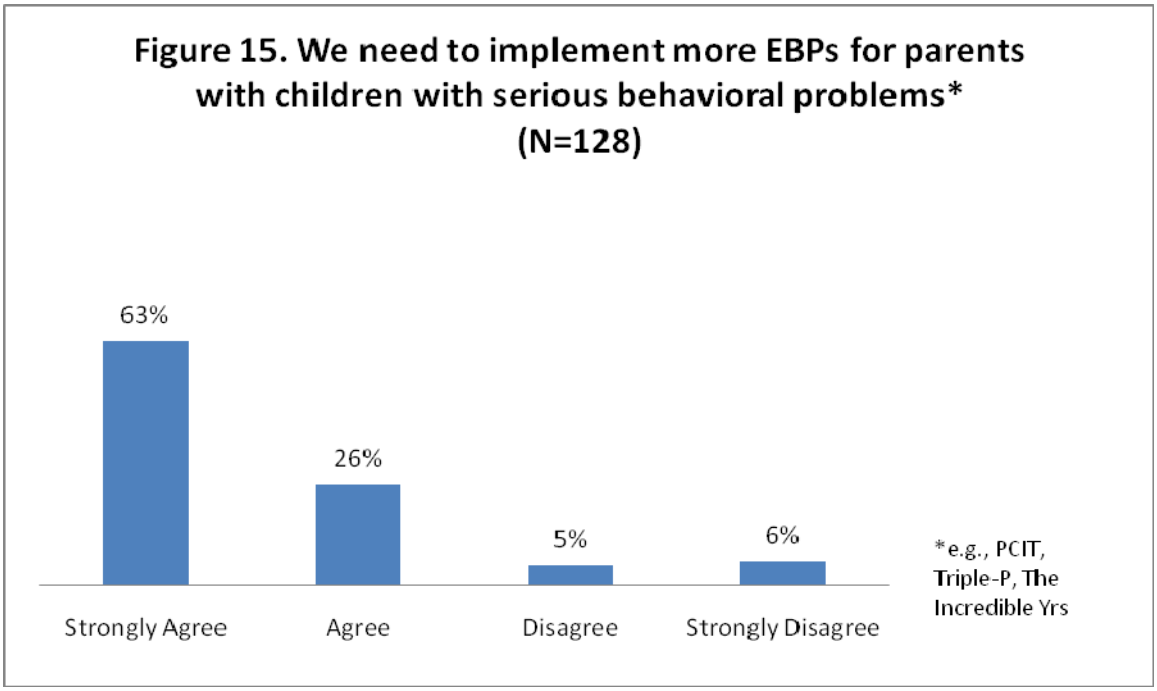


Figure 15. We need to implement more EBPs for parents with children with serious behavioral problems*
(N=128)
63%
26%
5%
6%
Strongly Agree
Agree
Disagree
Strongly Disagree
*e.g., PCIT, Triple-P, The Incredible Yrs

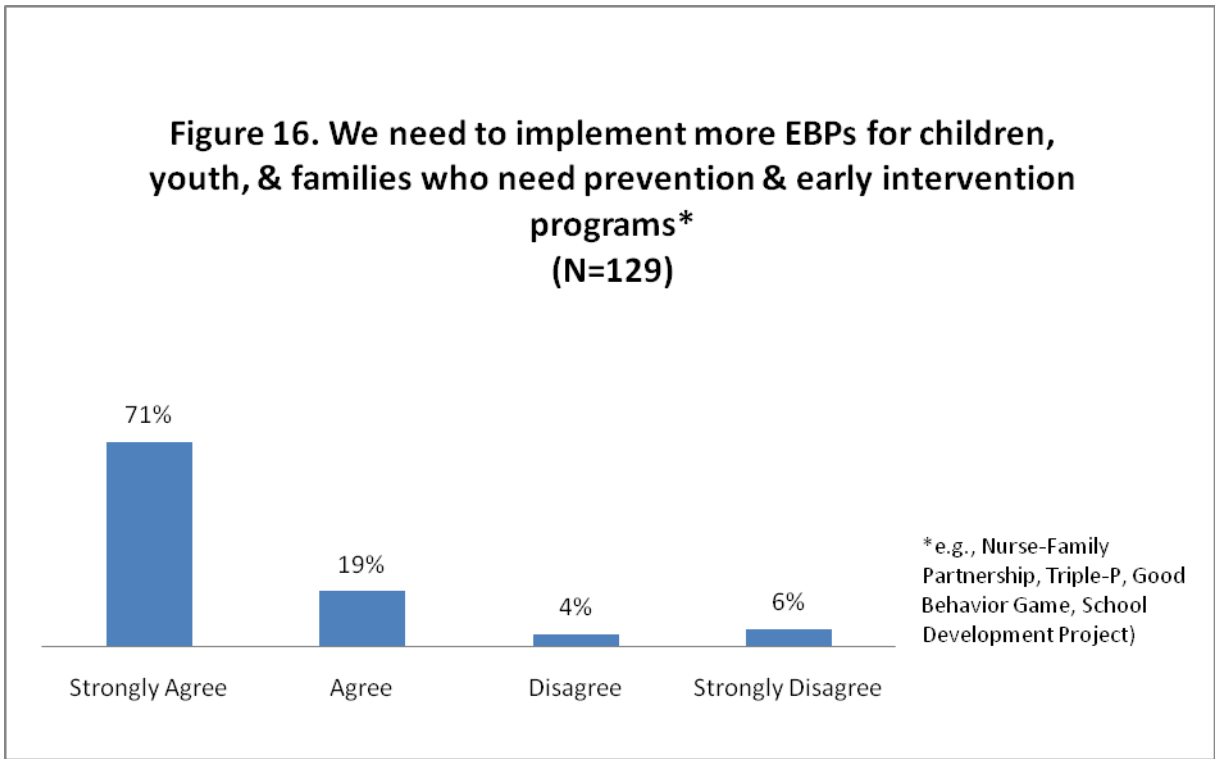


Figure 16. We need to implement more EBPs for children, youth, & families who need prevention & early intervention programs*
(N=129)
71%
19%
4%
6%
Strongly Agree
Agree
Disagree
Strongly Disagree
*e.g., Nurse-Family Partnership, Triple-P, Good Behavior Game, School Development Project)

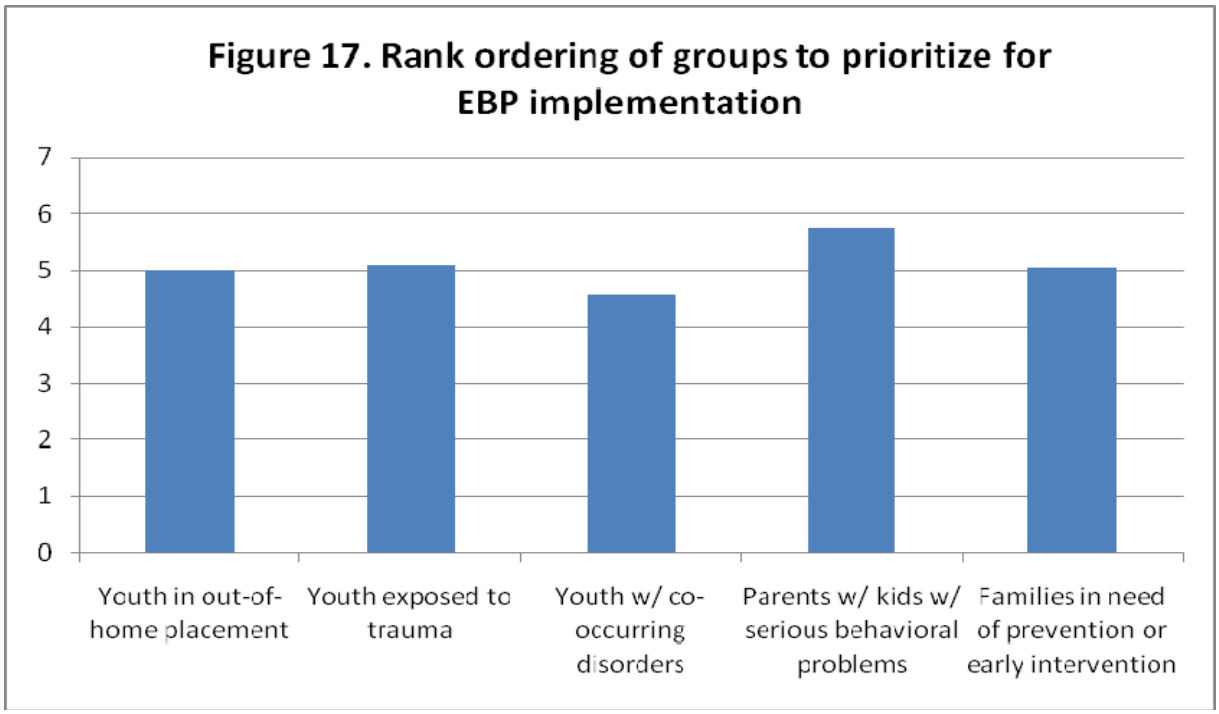


Figure 17. Rank ordering of groups to prioritize for EBP implementation
7
6
5
4
3
2
1
0
Youth in out-of-home placement
Youth exposed to trauma
Youth w/ co-occurring disorders
Parents w/ kids w/ serious behavioral problems
Families in need of prevention or early intervention

Table 2. Rank Ordering of EBPs By Participant Type			
EBPs Targeting Specific Areas of Need/Populations	**Ranked #1**	**Ranked #2**	**Ranked #3**
Serious behavior problems	Parents	MH Providers RSNs	Youth DSHS
Trauma	Family MH Providers DSHS	Allied Providers	
Prevention & Early Intervention	Youth RSNs		MH Providers Allied Providers Implementers
Out-of-Home Placement	Allied Providers	Parents Family Youth Implementers	RSNs
Co-Occurring Disorders	Implementers	DSHS	Parents Family

Barriers to Effective EBP Implementation

Participants were asked about barriers to effective EBP implementation in a variety of ways (see Figures 18-20). Most participants (82%) agreed overall that one of the barriers to effective implementation of EBPs is the lack of a well-trained workforce coming out of colleges and universities (see Figure 18). An even higher percentage (90%) agreed that one of the barriers is the lack of ongoing consultation to program staff and program monitoring of the implementation over time (see Figure 19). As shown in Figure 20, 90% of participants also agreed that another potential barrier is that communities often do not focus their efforts toward identifying the EBPs that may best fit their local needs.

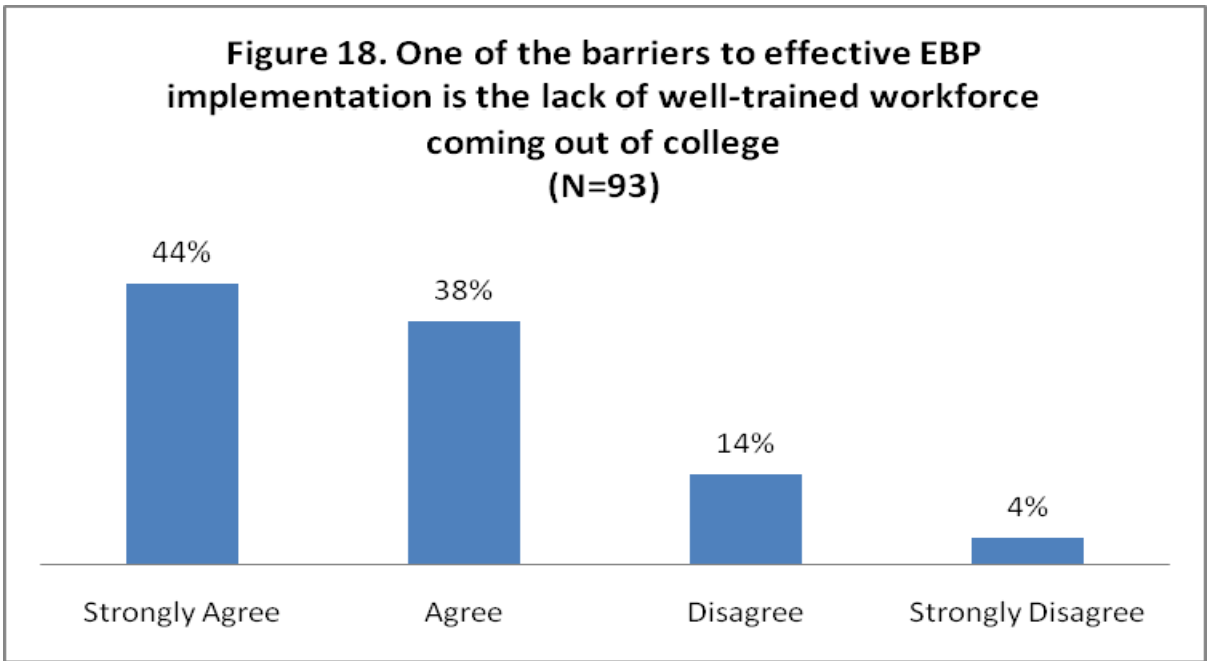


Figure 18. One of the barriers to effective EBP implementation is the lack of well-trained workforce coming out of college
(N=93)
44%
38%
14%
4%
Strongly Agree
Agree
Disagree
Strongly Disagree

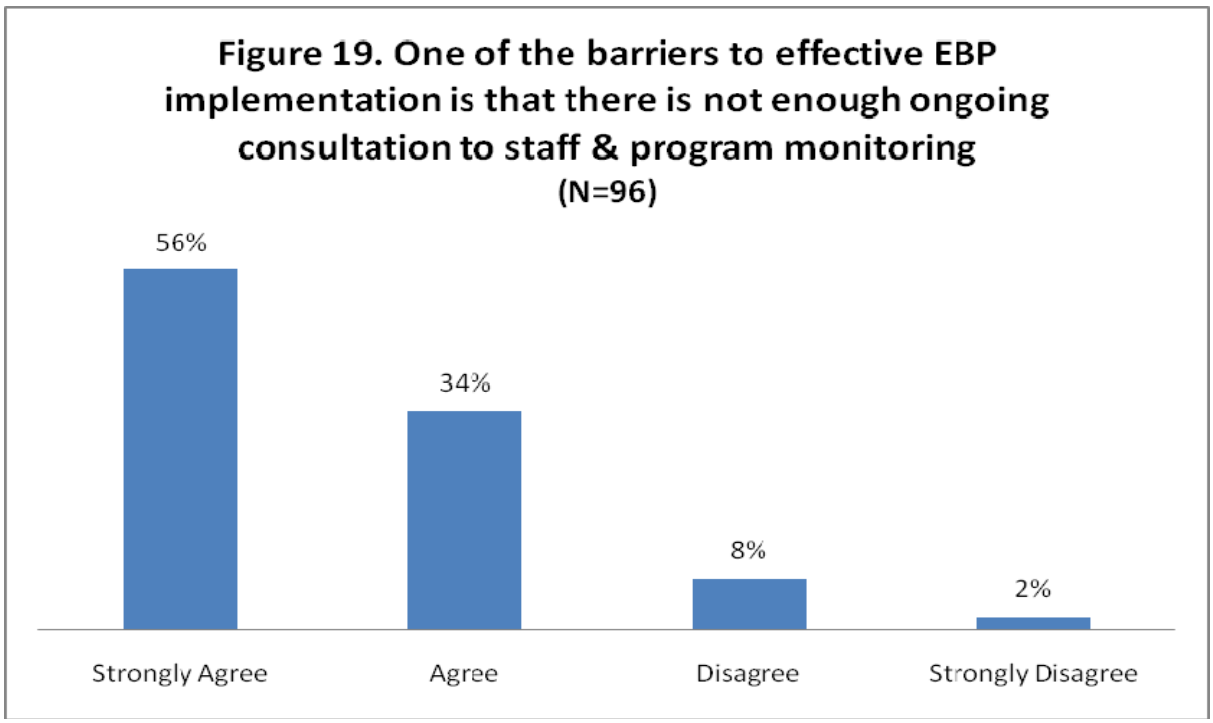
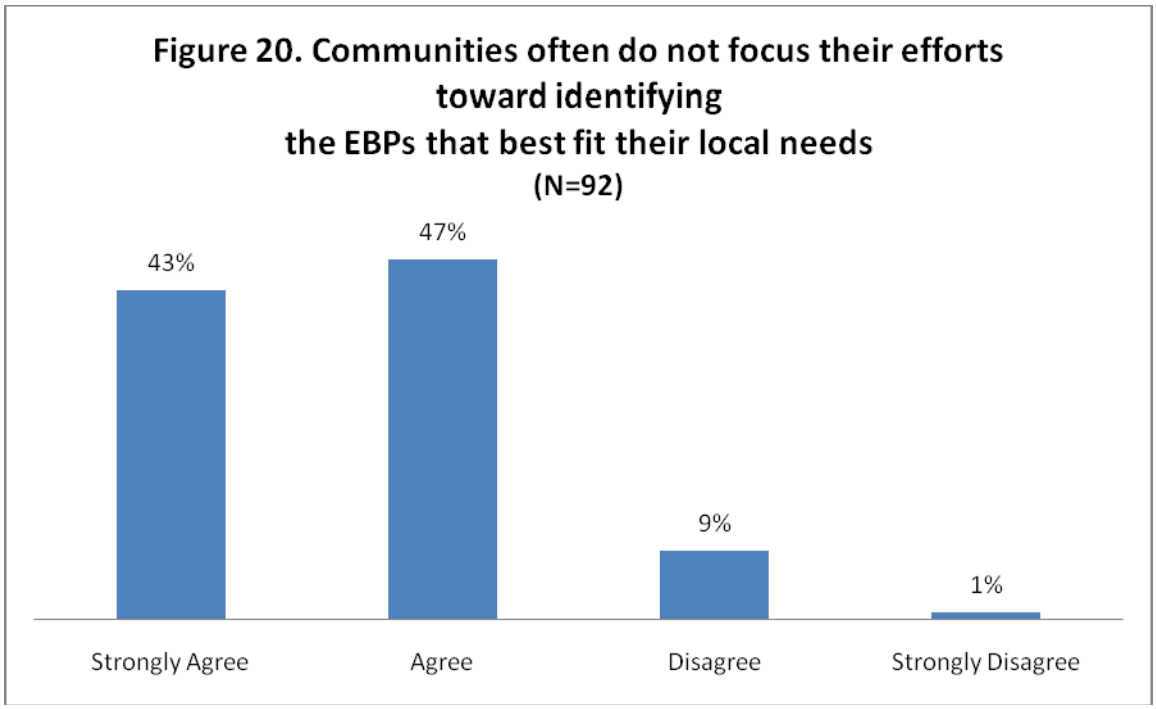
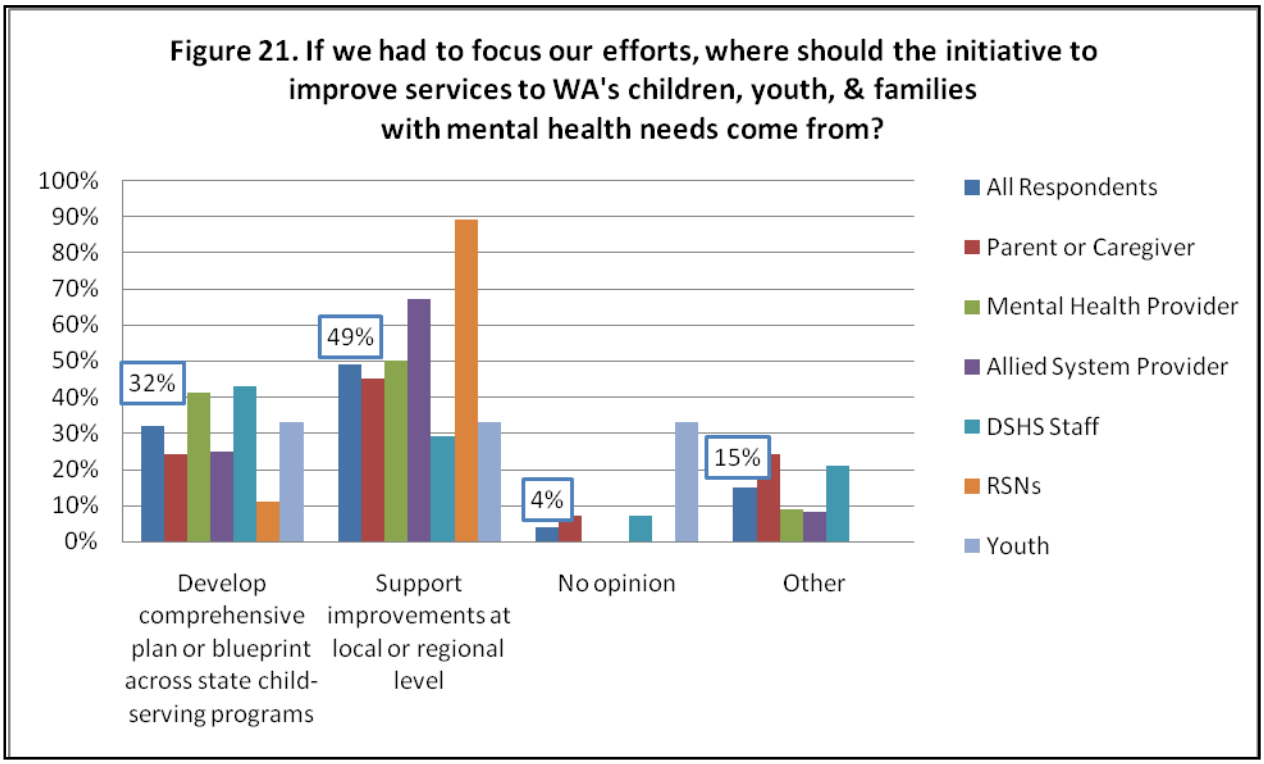


Figure 19. One of the barriers to effective EBP implementation is that there is not enough ongoing consultation to staff & program monitoring
(N=96)
56%
34%
8%
2%
Strongly Agree
Agree
Disagree
Strongly Disagree



System Reform Efforts

Given the sheer depth and breadth of the identified issues facing children's mental health services and access in Washington State, Forum participants were asked where efforts to address these issues should come from, either (1) development of a comprehensive plan or blueprint of action across state programs that serve children, youth, and families or (2) support of improvements developed at the local and/or regional level. As shown in Figure 21 below, slightly less than half of respondents (49%) indicated that the latter approach was a priority for them, with statewide efforts supported at 32%. When responses were further broken down by participant types, most respondents voted similarly, with the exception of DSHS staff who more widely endorsed a comprehensive plan or blueprint across state child-serving programs (43%) compared to local or regional efforts (29%).



Other Concerns

As shown in Figure 22, forum participants further agreed that the age of consent in WA is a concern to them (84% agreement overall), while Figure 23 indicates that they are also concerned that EBPs have not been evaluated with many racially and ethnically diverse populations.

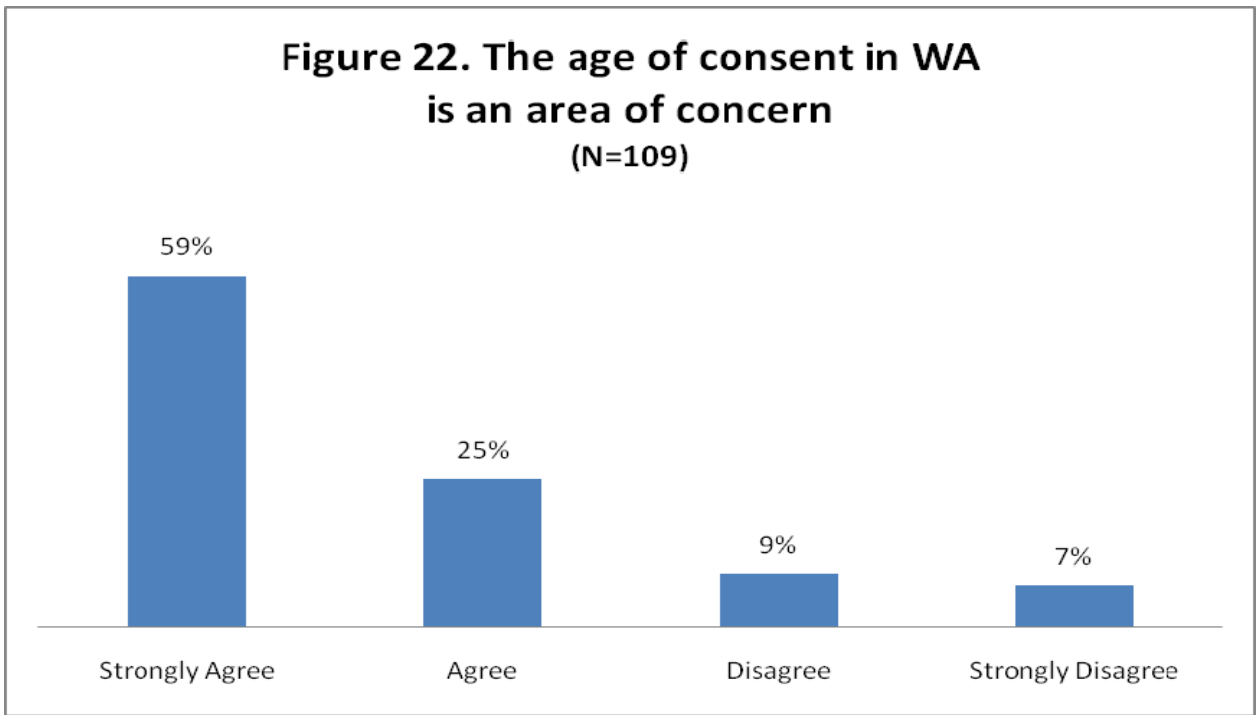


Figure 22. The age of consent in WA is an area of concern
(N=109)
59%
25%
9%
7%
Strongly Agree
Agree
Disagree
Strongly Disagree

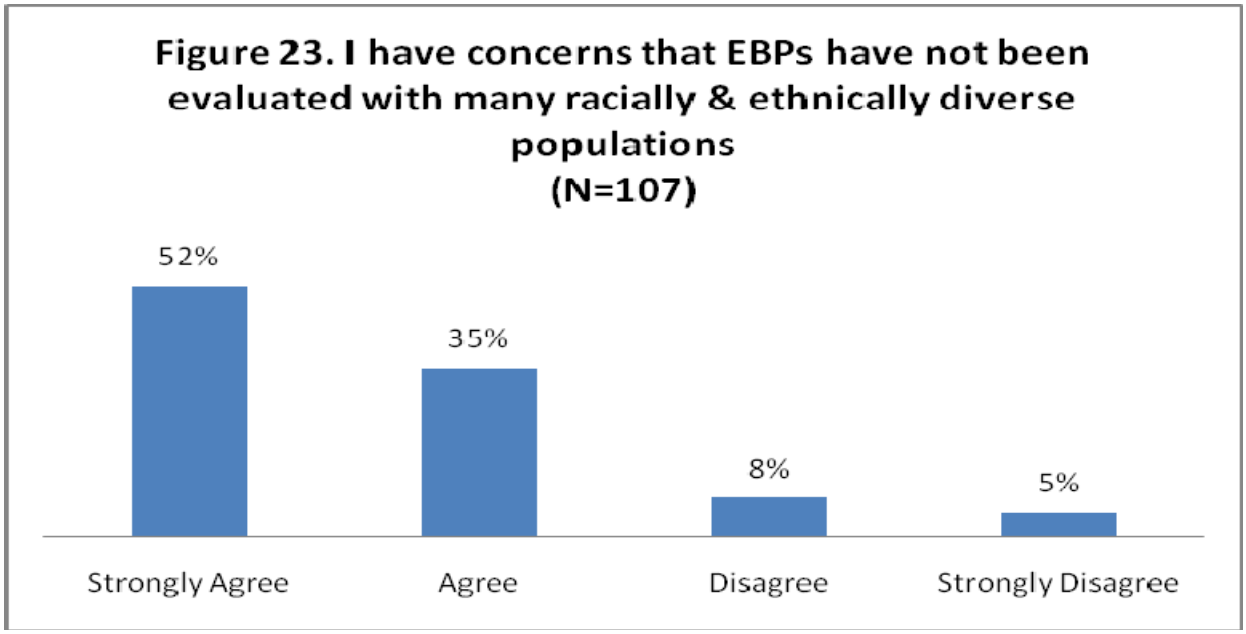


Figure 23. I have concerns that EBPs have not been evaluated with many racially & ethnically diverse populations
(N=107)
52%
35%
8%
5%
Strongly Agree
Agree
Disagree
Strongly Disagree

Appendix 6.
Issues Identified by Tribal and Recognized American Indian Organization Representatives

Prepared By:

TriWest Group
6549 First Avenue NW
Seattle, WA 98117

Analysis and Recommendations for Tribal Governments and their Members

Overview of Relationships Between MHD and Sovereign Tribes in the State of Washington

The basis of the relationship between the government agencies of the State of Washington and the 29 federally recognized Tribes in Washington State is the Centennial Accord signed in August, 1989. The Accord provides a framework for government to government relationships between the State of Washington and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognized the "chief representatives of all elements of state government" to ensure complete and broad implementation of the arrangement. The Mental Health Division (MHD), as part of the Department of Social and Health Services (DSHS), thereby maintains a direct working relationship with each of the 29 Tribes.

Members of the 29 federally recognized Tribes in Washington State are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid Prepaid Inpatient Health Plan (PIHP) and the State-funded service system administered by the Regional Support Networks (RSNs), or a combination of these systems. Given these multiple systems, MHD and each of the 29 Tribes must coordinate activities at multiple levels. While the primary relationship is between each Tribe and the State of Washington, on a day-to-day basis various agents acting on behalf of the State of Washington, including RSNs and state-operated treatment facilities such as Children's Longterm Inpatient Program (CLIP) facilities, all must coordinate their activities with each individual Tribe.

Coordination across these systems is supported through the 7.01 planning and policy development process, through which an overall Updated Report is renewed every two years to coordinate the efforts of DSHS overall, MHD, and the RSNs. Each of the 13 RSNs contracting with MHD are also required to carry out 7.01 planning at a local level with the Tribes located within their geographical boundaries. Coordination is critical, given differences between Tribes in terms of their resources, needs and the services they provide, as well as differences in their relationships with DSHS, MHD, and local RSNs.

MHD also provides two regular forums for coordinating system issues related to the delivery of mental health services through Tribal providers and for Tribal members. The first forum is a monthly Tribal Mental Health Work Group that addresses a broad range of coordination issues. The second is a Tribal Billing Instructions Work Group that addresses issues related to encounter reporting and reimbursement.

Methodology and Approach

There were multiple sources of information drawn upon in developing this chapter. First, input was sought directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS)

DRAFT

managers. In February 2008, two day-long, tribal round table discussions were held on both sides of the State. The first group was held in western Washington at the Puyallup Tribal Health Authority and involved representatives from eight western Washington Tribes (Lummi Nation, Makah Nation, Nooksack Indian Tribe, Puyallup Tribe, Quinault Indian Nation, Skokomish Tribal Nation, Snoqualmie Tribe, and Tulalip Tribes), two IPSS staff, the DSHS Health and Recovery Services Administration Tribal Liaison, and representatives of DSHS child and family serving programs, including the Juvenile Rehabilitation Administration and CLIP facilities. The second group was held in eastern Washington at the Spokane Native Project in Spokane, Washington. The group involved representatives from four eastern Washington Tribes (Colville Confederated Tribes, Kalispel Tribe, Spokane Tribe, and Confederated Tribes of the Yakama Nation), representatives from one RAIO (Spokane Native Project), a faculty member from Spokane Falls College, and one IPSS staff member. Both meetings were also attended by representatives of the Office of the Governor, MHD, and the Mental Health Transformation Grant, as well as consultants facilitating the meetings and a member of the Skokomish Tribe who presented on an innovative collaboration between the Tribe and the University of Washington to support traditional medicine for children and families.

The roundtable discussions focused on three major issues related to children's services in Washington State and defined in the 2SHB1088 legislation: access, services and family centered care. The discussion was wide-ranging at each meeting, expanding to include the broader relationship of Tribal and RAIO services to State Government and the public mental health system. Minutes were taken at each meeting, posted on the MHD website, and distributed to roundtable participants for review and revision. This report was developed based on the final approved minutes from these meetings. Where findings converged with input received from Tribal and RAIO forums held in 2007 as part of MHD's System Transformation Initiative (STI), these earlier forums are also referenced.[1]

Tribal Issues Identified

Through the Tribal roundtables, the following issues were identified by the representatives present as related to the effectiveness of Washington's children's mental health systems in terms of access, services, and family centered care.

Access to Care Across Multiple Systems – One important backdrop to the overall discussion at both groups was the added complexity of service delivery experienced by Native American children and families seeking care by Tribal mental health systems. The burden of the complexity of the system was identified as a major barrier, particularly for families. While a distinct part of the broader public mental health system, Tribal mental health systems are both different and more complex in their regulatory requirements than non-Tribal mental health systems. While RSNs must comply with federal and state regulations through MHD, Tribal providers operate in a system with the additional complexity of direct relationships between

[1] TriWest Group. (July, 2007.) Statewide Transformation Initiative Mental Health Benefit Package Design Final Report – Analysis and Recommendations for Tribal Governments and their Members. Olympia, WA: DSHS Mental Health Division. Available at: http://www1.dshs.wa.gov/pdf/hrsa/mh/preliminary_mental_health_benefit_package_design_report__draft__7_6_07.pdf.

DRAFT

Tribes and the State, as well as Tribes and the federal government. Also, Tribal members are entitled to receive services from multiple systems: Tribal providers, IHS or 638 facilities, RAIOs, and non-Tribal CMHA providers within RSN networks. In addition, some Tribes are geographically situated in multiple RSNs or otherwise have Tribal members who are served by multiple RSNs, requiring separate coordination, sometimes with RSNs that implement their 7.01 coordination requirements with different levels of compliance. This complexity creates a barrier to access for Tribal members on multiple levels, as well as a barrier to coordination of care for families with needs addressed by multiple child and family-serving systems. This finding was also identified by the April 2007 STI Tribal focus groups. The 2008 Tribal Roundtables noted many ways in which Tribal providers are uniquely positioned to coordinate care across these multiple systems for children and families that may be eligible for multiple benefits, but often receive little or no care because of the complexity of accessing these services. The "deep history of trauma" was also noted as compounding these access issues, given the challenges experienced by many Tribal members and other Native Americans in establishing safety and trust with mainstream providers. Also emphasized was the importance of recognizing that each Tribe is different and represents a distinct mental health "system," so what works for one Tribe may not work for another. The need for more consistent implementation of Tribal coordination policies by RSNs was also noted, particularly by those Tribes whose members and providers must interact with multiple RSNs because the Tribe is geographically situated in two RSN areas.

Access to Tribal Providers – Both groups discussed multiple ways in which Tribal provider agencies face barriers to participating in RSN networks. Much of this discussion reinforced earlier findings and recommendations, including findings from the 2007 STI Tribal focus groups regarding barriers related to a lack of clarity regarding the role of Tribal providers in the broader public mental health system, and particularly their involvement in RSN networks. The 2007 report documented significant concern that MHD is in the process of addressing the issue of whether or not Tribal providers were required to be licensed as Community Mental Health Agencies (CMHAs) prior to participation in RSN networks. The 2006 Washington Mental Health Transformation Plan: Phase 1 recognized this lack of clarity when it recommended that: "License/certification criteria needs to be changed to deem Tribally certified professionals and facilities as eligible to be reimbursed for services, including where desired, direct state contracts."[2] Federal law governing the Medicaid program (42 CFR 431.110) clearly states that IHS facilities are not subject to state licensure to qualify for Medicaid participation and "must be accepted as a Medicaid provider on the same basis as any other qualified provider." The requirement goes on to state that, while "the facility need not obtain a [State] license," it nevertheless "must meet all applicable standards for licensure." Lack of clarity regarding the implementation of these requirements has led to barriers in participation for many Tribal providers, including providers serving children and families. The current focus groups detailed other specific challenges to Tribal providers, including increasing cost pressure and needs to respond to referrals from the child welfare and juvenile justice systems, as well as the mental health system.

[2] Chapter 3, page 119.

DRAFT

The role of Native American Ethnic Minority Mental Health Specialists was also discussed. Roundtable participants were generally negative toward the current implementation of the specialist model for Tribal members. One participant observed that it was "institutionally racist" to require a Native American provider to call a non-Native "specialist" for consultation. Others noted that the training requirements are burdensome and the training is generic to multiple races and ethnicities, so often the requirement results in Tribal providers consulting with "specialists" who know little about the culture of the person being served. Other participants noted that the process for designating providers as qualified traditional healers should be less a process of conforming to written criteria than a process whereby a Tribal community formally recognizes traditional healers through its own traditional processes. Overall, these specialists are seen as part of the RSN system and therefore viewed as not well integrated into the Tribal provider system. Ideas discussed in the roundtable for responding to this included repealing the specialist consultation regulatory requirements, allowing Tribes to designate their own specialists, creating a separate training track with fewer generic requirements for Native American specialists, supporting Tribal providers in providing specialists with financial support and time off, and improving the standardization of RSN implementation of the specialist consultation requirements.

Access to Funding by Tribes – Participants from both roundtables noted the need to enhance access to mental health funding by Tribes, Tribal providers, and RAIOs. Several specific points were emphasized, including:

- Access to pilot project funding, such as the wraparound pilots funded under 2SHB 1088, which was legislatively directed to RSNs only;
- Government-to-government contracting between DSHS and Tribes to enhance access to State and Federal Block Grant funds to support otherwise non-reimbursable, community-based supports; and
- Broader consideration of funding Tribal providers and services outside of the RSN system.

Services: Traditional Medicine – Roundtable participants discussed the importance of specific traditional medicine practices and the need for the State and RSNs to work to respond where possible to support and incorporate these approaches and perspectives. While each Tribe's practices are distinct, reflecting their independent cultures and histories, and there is some risk of "medicalizing" traditional healing approaches if they are made subject to the regulatory requirements of specific funding sources (such as Medicaid), participants noted the following services as needed:

- Sweat lodges;
- Approaches for "spiritual sickness," a recognized disorder by many Native American mental health treatment experts that is not currently billable (participants noted that a cross-walk might help guide providers in acceptable diagnostic codes for treating disorders such as this);
- Offering traditional learning activities and engaging respected figures in the community to act as mentors to help connect youth and families with needed supports;
- Recognition of the diverse needs and strengths of Tribal members living in urban settings, where people from multiple Tribes and traditions require services and

DRAFT

providers must respect, understand, and respond to these differences (for example, the Native Project in Spokane serves people from 135 different Tribes, so it is not possible to be "expert" for all of them);

- Flexibility with definitions of what constitutes a service, for example recognizing that some families or children might do better with a half-day activity in a natural setting rather than a 45 minute office-based session;
- Recognition that the time requirements of Medicaid and other medical systems are sometimes in conflict with the cadence of many Tribal members, so there needs to be respect for individuals and families around practices such as filling out forms or complying with structured treatment protocols; and
- Broad recognition that best practices for Tribal members and other Native Americans are different from those of the majority population so that approved practice, diagnoses, and funding can be made more inclusive and accessible to Native people.

Services: Other Specific Needed Services – Roundtable participants identified a range of specific needs related to access to services for Native American children and families. Participants noted the following specific needs:

- Treatment for co-occurring substance abuse and mental health disorders;
- Access to psychiatrists and medication, noting "desperate" need on the part of both children and their families;
- Wraparound service coordination, with fidelity and incorporation of traditional supports, as well as addressing misunderstanding regarding wraparound principles and system policies that discourage the involvement of multiple providers in planning activities;
- The need for accessible inpatient facilities that promote family participation, particularly for Tribes in Eastern Washington and many locations in Western Washington that are located hours from inpatient resources (this need was described as more severe in rural areas given the lack of both inpatient facilities generally and CLIP placements specifically in Eastern Washington for young children, and these shortages were seen as often complicated by differing RSN approaches to managing access to inpatient care);
- More consistent and responsive services from Designated Mental Health Professionals (DMHPs) to respond to situations where the need for involuntary treatment must be assessed (response times of multiple hours in rural Tribal settings, misunderstandings about jurisdictional issues on Tribal land, issues involving the age of consent, and lack of coordination between different RSNs were all noted as current barriers);
- More treatment options for trauma, including training school personnel in trauma-informed care and specific evidence-based approaches for trauma, as well as better access to mental health resources to treat abuse and neglect so that Tribal members are not limited to only accessing resources through Children's Administration;
- Shortages of needed professionals, including those credentialed to provide both mental health and chemical dependence treatment, and licensed professional in rural settings to provide supervision to unlicensed staff;
- Access to mental health professionals who are Native American in all child-serving systems (including mental health, juvenile justice, child welfare, and chemical

DRAFT

- Alternatives to residential treatment so children are not sent outside of their communities;
- Respite options that do not require involvement in the child welfare system (even the use of Voluntary Placement Agreements can be a barrier given historically rooted concerns about the risks of losing custody of children by many Native American families; kinship respite was discussed as a possible alternative) and that are available for multiple age groups, including infants and toddlers, school-age children, and adolescents (current enhanced scrutiny of services such as respite that are funded as Medicaid (b)(3) services was noted as an additional barrier complicating access);
- Concerns about the implementation of evidence-based practices (such as Multisystemic Therapy) and the need to be sure that the implementation of such practices acknowledges any limitations in proven efficacy for Native American youth and families, as well as incorporation of the empirical basis for traditional healing practices;
- Active and culturally tailored efforts to combat stigma of mental illness in Tribal communities;
- More accessible diagnostic options, including complex post-traumatic stress disorder and V codes like parent/child conflict that do not pathologize children and that reflect the effect of external forces and policies that have disrupted families for hundreds of years;
- Mentoring and preventative services; and
- Flexible funding to pay for basic needs such as food and child care to support involvement in mental health services.

Family Centered Care and the Strength of Native American Communities – Participants noted many ways in which the key to healing for children and families rests with the strengths and resources of the broader community, rather than specific mental health programs. The role of mentors and guides based on the specific strengths of each Tribe was particularly emphasized, and the Skokomish Tribe's work with the University of Washington's Evidence Based Practice Institute to implement the Partnership for Success model in their communities was noted as a successful example of how "evidence" rooted in the traditions and strengths of the Skokomish Tribe could be catalyzed and emphasized to help youth in need and their families. The tension between the holistic and circular cultures of Native American communities and the linear and reductionist traditions of Western medicine and systems such as Medicaid were noted. The fit of many Native American cultures with family-centered practices was emphasized, highlighting the importance of responding to the needs and strengths of each individual child, family, and community. Recognizing the value of systems in funding and providing services, the roundtable participants noted the need to help systems "become more human" through increased cooperation, accommodation, coordination, and shift of emphasis to natural supports and traditional healing practices.

DRAFT