Prevention Policy Summit

A Public Health Approach to Mental Health

Prevention Efforts Summary Report

The Mental Health Transformation Project

Office of the Governor
Washington State

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Executive Summary

In 2006, the Mental Health Transformation Project (MHTP) formed the Prevention Advisory Group (PAG). The PAG brought together agencies and organizations that shared an interest in pursuing prevention-related activities and policies, including those focused on early-intervention and mental wellness.

During 2007, MHTP contracted with the State Board of Health (SBOH) to produce a report[1] on the possibilities and need for a public health-based model for mental health. SBOH submitted the report in December. Also during 2007, the PAG received approval for MHTP funding to hold a Prevention Summit in spring 2008. The SBOH report formed the basis of the outreach work to prevention stakeholders in preparation for the Prevention Summit.

Starting in January 2008, MHTP (through the Family Policy Council) conducted five regional community meetings open to the public and interested agencies. It also held numerous talks with agencies and organizations interested in prevention efforts. It disseminated the report in advance of the meetings so participants would be informed and prepared to ask questions about the concepts it contained. MHTP also sent the report to all Prevention Summit registrants, and it became a touchstone for the work done that day. MHTP solicited and analyzed feedback about the report, which was used to formulate polling questions during the Summit.

On May 13, 2008, more than 260 people attended the Prevention Summit in Tukwila, Washington. Working with stakeholders from throughout the state, organizers sought to accomplish several goals that day:1) expand contact and cooperation between stakeholders that have traditionally competed for resources, and 2) discern through the use of an instant electronic-polling system a short set of immediate priorities for prevention work. Organizers put forth nine initial policy “themes,” along with a number of specific strategies, for discussion and polling.

Five Policy Statements emerged from the Summit that reflected the priorities of the participants: [2]

1) Create & support campaigns to market mental wellness.
2) Policies, funding and practices should be advanced that work to bring services to people where they live.
3) Policies, funding and practices should be advanced that integrate health and mental health services into school programming.

[1] *“Mental Health—A Public Health Approach: Developing a Prevention-Oriented Mental Health System in Washington State”—State Board of Health, Dec. 2007.*
[2] Note: Policy statements #3 & 4 above were later combined into one statement (#4 was felt to reflect #3).

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4) Policies, funding and practices should be advanced that engage people with supports and services as they participate in life activities of the community.
5) Blend or braid treatment funding for treatment and support services for persons with co-occurring disorders and eliminate duplicative or conflicting regulations with in the DASA and MHD service systems.

In addition, polling identified six additional recommendations that participants felt were also very important:

-Expand holistic health care for children & families;
-Develop social/emotional learning standards for K-12 education;
-Develop a trauma-informed care model and require implementation in all service systems providing mental health care and/or education;
-Prepare a financing strategy for preventative services in anticipation of aging populations.
-Set policy goal of reduction of child poverty;
-Create funding and support for coordinated school/health programs, including behavioral health.

In June 2008, the TWG reviewed these five priority policy statements and agreed they should be the focus of future work by the PAG.

In January 2009, the TWG funded three prevention/early intervention-related projects recommended by the PAG. In addition, sub-committees of the TWG adopted a number of prevention/early-intervention/mental wellness initiatives. In mid-February 2009, the PAG met to discuss its future work and leadership.

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A. Background and History

In October 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Washington State a five-year grant to examine and transform the mental health system in the state. The grant required a Comprehensive Plan be completed in the first year. The "transformation grant" effort advances the Presidents New Freedom Commission goals, and includes an expectation that policies and practices related to prevention be considered.

Beginning in April 2006, the Mental Health Transformation Project (MHTP), at the direction of the Transformation Work Group (TWG)[3], created a Prevention Advisory Group (PAG) to examine issues related to promoting mental health and preventing mental illness. The MHTP staff consulted with the PAG to develop a chapter called *Prevention and Early Intervention* for Comprehensive Plan. The Plan "recommends a single, well-articulated statewide prevention and early intervention policy with a healthy Washington as a centerpiece strategy."[4]

A few months earlier, the Washington State Board of Health (SBOH) had identified mental health as a focus area within their own strategic plan, and SBOH participated actively in the PAG from its conception. In January 2008, SBOH, in collaboration with MHTP, released a report entitled, "*Mental Health: A Public Health Approach: Developing a Prevention-Oriented Mental Health System in Washington State.*"[5] (the SBOH report). This report outlined the results of two years of information-gathering at community meetings by MHTP staff. In addition, the report described many strategies for moving forward with prevention-oriented work, and identified 14 overarching themes.

The SBOH report became the focus of community discussions and meetings with statewide organizations beginning in January, 2008. All of the individuals representing disciplines on the PAG were asked to give feedback on the report suggest ways to prioritizing the policy themes. PAG members were also asked to give specific examples of policies or practices that would advance each theme (the SBOH report also listed many strategies). Organizations were invited to send written input to the MHTP. Additionally, MHTP conducted five community forums with the assistance of the Family Policy Council and local Community Public Health and Safety Networks. Each community meeting brought local representatives, experts, consumers and stakeholders together to discuss the report and provide input.

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[3] The Transformation Work Group (TWG) is the advisory body for the Mental Health Transformation Project, and consists of agency representatives as well as stakeholder organizations.
[4] Washington State Mental Health Transformation Plan. Chapter 4, Page 122.
[5] http://www.mhtransformation.wa.gov/pdf/mhtg/PublicHealthModelMH.pdf

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The SBOH report intentionally stopped short of making “next step” recommendations to the TWG. After the release of the report, MHTP staff, in coordination with the TWG, decided that a Prevention Summit in May 2008 would be an appropriate next step for moving Prevention efforts forward.

1. Summit Planning Team (SPT)

Once the SBOH report was released in January 2008 by MHTP and the Prevention Advisory Group, it was widely distributed to stakeholders for comment and feedback to help inform the Prevention Summit planning process. About this time, the PAG decided to form a planning team for two purposes: 1) to coordinate content development for the Prevention Summit; and, 2) to lead a community engagement process in anticipation of the Summit. The Summit Planning Team (SPT) consisted of approximately a dozen key members of the PAG and held monthly meetings during the spring following the release of the prevention report.

One of the first tasks undertaken for the Summit planning was to establish a timeline for the community engagement process, as well as all the other logistics to host an event of this magnitude. The planning and registration processes were then subcontracted to the Washington Institute for Mental Health Research & Training (WIMHRT).

A crucial element of the community engagement effort was the contact work done by the SPT. In early February 2008, the SPT designed a contact strategy for getting out the word about the Summit.

To make sure it included everyone who needed to be at the table, the SPT identified three levels of contacts:

- First Tier: Individuals/agencies whose involvement would be crucial to efforts to implement a Prevention policy agenda (mainly legislators & their staff)
- Second Tier: Those individuals/agencies whose involvement would significantly help the prevention process); and
- Third Tier: Interested stakeholders.

Over the course of several meetings, the SPT generated these priority lists and members volunteered to contact those they knew personally or had connected with previously.

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2. Community Engagement

MHTP and SBOH staff met with interested organizations throughout the Prevention consensus-building efforts. During these meetings, staff would first explain the concept of prevention, and then would explain the Summit planning process had unfolded up to that point. Finally, staff requested feedback from the audience, either at that time or by email or phone call. Staff took notes on comments and suggestions so they could be analyzed by MHTP.

Starting in January 2008, MHTP and the Family Policy Council set up a series of five meetings sponsored by community networks throughout Washington State. These meetings, held in April through May 2008, were scheduled outside the King County to Olympia I-5 corridor to reach a representative sampling of communities in the state. Below is a table of locations and dates:

Community Network Meetings—Spring 2008	
Spokane County	4/10/08
Cowlitz County	4/11/08
Walla Walla County [6]	4/28/08
Benton-Franklin Counties (Tri-Cities)	4/29/08
Whatcom County	5/1/08

More than 200 individuals attended these network meetings within six county areas. Interest in the meetings ran highest in the Eastern part of the State, with local newspapers in Walla Walla and the Tri-Cities printing several articles about the meetings and the Prevention efforts.[7] Several communities requested that MHTP staff return for follow-up discussions and update meetings.

3. Meetings with Agencies and Community Organizations

In addition to the community network meetings, from January through May 2008, staff from the MHTP and the SBOH[8] met with several agencies and statewide organizations:

American Indian Health Commission—January 11
WA Council for the Prevention of Child Abuse & Neglect—January 25
King County Aging Advisory Committee—February 8
Mental Health Planning & Advisory Committee—February 13
University of WA, Center for Human Development & Disability—February 21

[6] Note: the visit to Walla Walla also entailed a full day of meetings including with the Rising Sun Clubhouse, students and teachers at an alternative high school, and early-childhood & school aged children's organizations.
[7] See the Mental Health Transformation Project website: www.mhtransformation.wa.gov
[8] David Brenna (Senior Policy Analyst, MHTP) & Craig McLaughlin (Executive Director, SBOH)

WA Association of Area Agencies on Aging—March 13
WA Community Mental Health Council—March 13
University of WA—School of Social Work—March 14
Community Transformation Partnership—March 21
WA Health Foundation—March 25
State Council on Aging—April 22

Additionally, members of the SPT met with or otherwise communicated with the organizations that were unable to provide time on their meeting agendas.

4. Theme and Policy Input

MHTP contracted with staff from the University of Washington to organize the large number of varied recommendations by each policy and practice's demographic target. The policies and practices were then analyzed for their common elements and policy statements were constructed to describe multiple approaches that were applicable across the lifespan. This provided specific examples of programs or practices that fit the broad policy statements.

From the various forms of responses collected during the community engagement process, well over 100 distinct policy ideas emerged. The combined input from formal letters, organizational meetings and community meetings were collected, synthesized, analyzed in a publication entitled, "*Themes and Policies Issue Guide for May 13, 2008 Prevention Policy Summit"* (see Appendix D).

5. Fourteen Cross-cutting Themes & Polling Strategy

The December 2007 State Board of Health report *Mental Health—A Public Health Approach: Developing a Prevention-Oriented Mental Health System in Washington State* described fourteen themes for policies and practices that emerged as common to all of the age-specific groups[9].

In addition, in the weeks leading up to the Summit Day, stakeholders and community members, including consumers and families, had been strongly encouraged to read the full SBOH report and submit their ideas for related policies and programs to MHTP.[10]

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[9] Age specific groups: 1) Early Childhood, 2) School-Aged, 3) Youth-in-Transition, 4) Adult, 5) Older Adult. Participants were asked to self-identify which group they would represent for the day.
[10] Comments were accepted in all written forms—by email, by website submission, by mailed letter, etc.

B. The Summit Day—Process

1. Summit Attendance & Participant Demographics

On May 13, 2008, more than 260 stakeholders attended the Prevention Summit in Tukwila, Washington[11]. The event began with a presentation from Kathryn Power, director of the Mental Health Center of SAMHSA. Her remarks effectively targeted the significance of the event and the concepts for a public health approach to mental health. By design, Ms. Powers' presentation was the only formal address.

Following introductory comments and the keynote speech, the Summit facilitator[12] conducted a series of seven polling exercises. Participants were provided electronic, hand-held polling devices. As practice for the actual polling questions, participants were requested to enter some basic demographic information. This was also helpful for identifying the makeup of the participants. Audience makeup was impressive in its diversity. Many of the participants were executive managers of provider agencies, child care agencies and schools. Consumers, including youth and family members were well represented. State agency executives and elected officials were also well represented. Nine state legislators attended. Each participant was asked via the polling devices to select a demographic area they would represent with their expertise for the day. The results of the demographic selection showed a good distribution of attendees; adults were best represented with 29% of the audience. Older adults were the least represented group, with 13% of the audience.

Participants were assigned seating to mix participants from each of the five age groups (they had self-identified their focus for the day across the lifespan). MHTP staff set up the seating to deliberately encourage discussion across agencies and organizations that might not regularly come into contact otherwise. To keep the conversation focused on the issues of the day, the SPT recruited 26 volunteer facilitators from the stakeholders' groups[13]. Each of the 26 tables had a trained facilitator to lead discussions between polling activities.

2. Nine Priorities at the start of the Summit Day

In the weeks prior to the Summit, the SPT narrowed the 14 themes in the SBOH report to nine priorities, by consolidating some themes that were closely related

[11] The Summit took place at the Doubletree Inn & Suites, Tukwila, WA.
[12] Paul Dziedzic, who has facilitated a number of TWG & other MHTP meetings as well.

and eliminating those without much support, based upon the analysis of feedback from the community-engagement period. The final nine overarching themes presented at the beginning of the Summit Day were:

1. Institutionalize communication and coordination towards common outcomes
2. Market Mental Wellness & Reduce Stigma
3. Increase Funding flexibility and leverage existing funding sources
4. Screen at multiple points of entry
5. Provide care based upon need
6. Ensure age-appropriate services are available
7. Engage people where they are
8. Support transitions across the lifespan
9. Increase & improve provider training

Throughout the day, participants were engaged in a condensed version of the conceptual framing of prevention and mental health that the Prevention Advisory Group had conducted since 2006. The goal of the Summit Day was to further clarify specific themes and strategies to help drive prevention-oriented work in the future.

During the first half of the day's polling process, the nine priorities(along with related strategies) were 'voted' upon to determine what the Summit audience's overall priorities were. In addition, through a series of polls throughout the day, specific priorities for age-related demographic groups were determined as well.

In the second half of the day, participants ranked their preferred strategies (as opposed to priorities) to identify those they saw as a top goal. The participants were polled on each policy twice. In the first poll, they voted on the priorities for their age-specific population. In the second poll, they voted for the priorities that would best meet the needs of the whole population across the lifespan. In both cases, the participants were asked to identify "policies that would advance a public health approach to mental health in the upcoming couple of years."

3. Polling Results

This series of pollings produced 37 strategies that were determined to be the most important for the State of Washington to address first[14]. From those 37 top strategies, 11 strategies rose to the top as the most pressing:

Priority Strategies:

1. Promotion (education) funding to advance mental wellness definition
2. Improve mental illness early detection
3. Mental Health First Aid

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4. Social marketing campaign: seeking help
5. Recovery/resiliency education
6. Nurse Family Partnerships
7. PEARLS: outreach, screening & depression treatment for elderly
8. CAPA Attachment Volunteers: outreach, screening and support to homeless teen moms with newborns
9. School-Based Health Center
10. Spokane School District mental health treatment model
11. DASA funded prevention/intervention specialists in schools

C. Summit Policy Outcomes

1. Four "New" Prevention Priorities for the PAG/TWG

Based upon the Summit Day pollings on specific strategies, the Summit Planning Team (SPT) articulated four Prevention Priorities as it prepared to present the Summit results to the TWG on June 27th, 2008 in Spokane.(Originally, there were five Priority statements, but two were rolled in together to create a total of four). In addition, the eleven strategies that were determined at the Summit to be the most needed were also included in this presentation as *specific* examples of the implementation of the Prevention Priorities.

Under each priority below, a detailed description of the process to undertake fulfilling it is included, along with specific strategies that are examples of ways to advance that priority.

A. Priority One: Create and support campaigns to market mental wellness:

Description: Create and support age-tailored and culturally tailored campaigns on the importance of mental wellness for everyone, not just those with mental illness. Policies should include a well articulated vision on the return on investment in mental wellness and mental illness prevention. Health promotion models are effective ways to educate the public about early childhood development and the mental health needs of children birth to five. This includes education on the importance of parent mental health to child mental health. The campaign should include education on mental wellness in older adulthood.

Specific approaches for mental health promotion would need to be designed. The State Board of Health (January 2008) report cited a number of organizations,

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including the Center for Disease Control and Prevention (CDC) and the World Health Organization, that have begun addressing health promotion for mental health. Without better definitions for what constitutes mental health, however, promotion remains subject to popular misunderstanding about mental illness, including stigmatizing attitudes. The principle outcomes of health promotion are typically population behavior change toward more health check-ups and early detection of disease. The same goals would be sought in a mental health promotion effort; individuals detecting indicators of emerging problems and responding with help-seeking behaviors.

Social marketing campaigns are distinct from ad campaigns. Social marketing requires determinations such as target audience, research to identify what messages will resonate with the target audience, and resources to build and implement the elements of the campaign. [15] Population-based awareness for mental wellness can be included in a limited way over the final two years of the Project, but more focus and resource will be required in the future. Examples of current or possible future efforts in Washington State include:

- School-based health centers
- Spokane school district mental health school treatment model
- DASA-funded prevention/intervention specialists in schools

<u>B. Priority Two</u>: Policies, funding and practices should be advanced that work to bring services to people where they live.

Description: Examples of home based programs include:

- Nurse Family Partnerships
- PEARLS: outreach, screening and depression treatment for elderly
- CAPA Attachment volunteers: outreach, screening and support to homeless teen moms with newborns (Spokane)

<u>C. Priority Three</u>: Policies, funding and practices should be advanced that engage people with supports and services as they participate in life activities of the community.

Description: School-Based Health Center (SBHC) programs are the most often cited example of this strategy. Specific efforts include those developed in the Seattle School District. Another example is the school treatment model in the Spokane School district that provides care to Medicaid-eligible students within a

[15] The Mental Health Transformation Project is currently funding a social marketing campaign to address recovery and reduce the impacts of stigma.

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separate facility. The program has been shown to be effective in reducing the need for psychiatric hospitalization.

Services and supports are best delivered in community setting that already engage individuals and families. Commonly references locations for service integration, including mental health screening, intervention and treatment include: primary medical care centers; child care centers; senior centers; schools; universities; community centers; and, churches. These practices include population-based support services that emphasize mental wellness and reduce incidence of stress and isolation.

Often referred to as a "coordinated care" approach, this broad policy includes efforts to bring mental health clinicians in direct contact with individuals in need of services at commonly visited locations. Health clinics with trained psychology staff or mental health consultation efforts meet this definition. Para-professional and peer support staff can also improve access which leads to early identification of mental health problems, and prompt interventions.

D. Priority Four: Blend or braid treatment funding for treatment and support services for persons with co-occurring disorders and eliminate duplicative or conflicting regulations within the DASA and MHD service systems.

Description: This strategy specifically addresses challenges faced by individuals with co-occurring disorders who often find themselves eligible for one set of service, but not others. The strategy addresses the need for flexible funding, and a seamless transition to other services, and supports that are preventive in nature, rather than crisis-oriented.

- Flexible funding and seamless transition to other services, and supports that are preventative in nature, rather than crisis oriented
- Cross-system co-location of counselors

E. Additional Policy Recommendations:

Also presented to the TWG in June 2008 were a number of additional policy recommendations that Summit participants also ranked as important:

- **Holistic Care—**This policy approach focuses on care for the whole child beginning at an early age and the emphasis is on educations and health. It means services with an increased focus on family mental health and integrated family support services in early childhood settings. Other practice examples include promotion of "first relationships" and group-

based parent training. Holistic care is best defined in this context as involving whole families rather than focusing on the individual. Children are better treated in the context of the family and school system. In particular, very young children demonstrating attachment disorders need to receive care for their parent of guardian in order to recover from symptoms and future problems.

- **Social/Emotional Learning Standards—**This policy approach addresses basic education requirement for academic standards and elevate social and emotional competencies. One state, Illinois, has a policy model that was referenced in the feedback. As a strategy, social/emotional learning deploys a risk/protective factor model of creating resiliency in children during their education.

- **Trauma-Informed Care—**This policy approach emerges from the initial work by Anda[16] on Adverse Childhood Experiences Survey (ACES) which found a relationship between early childhood trauma and later mental health problems and symptoms. Trauma-informed care refers to both clinical practices and system training and awareness. In our state, educators are embracing trauma-informed care approaches in understanding classroom behavior and effective responses, both in the classroom and in referral strategies. Existing school resources, such as school nurses, school counselors or school social workers, are both limited and not always equipped or empowered to address mental health treatment needs, including screening and referral. Trauma-informed approaches give classroom teachers the tools and training necessary to assist children that create disruptions to learning.

- **Financing for Prevention with Aging Populations—**This policy statement calls for an examination of funding (Medicaid/senior services citizens ACT/Older Americans Act) for different types of outreach/in-home services and recommends greater flexibility in supporting such services. The policy includes recommendations for older adult parity within other mental health groups and creating a funding stream through the Senior Citizens Services Act (SCSA) to utilize evidence based prevention and early intervention programs such as PEARLS and the Geriatric Regional Assessment Team (GRAT).

- **Reduction of Child Poverty**—The strategy identifies a high level outcome for reducing poverty and is aligned with other advocacy activities. No specific practices or programs were provided in the recommendation.

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[16] Adverse Childhood Experiences Survey (ACES)—www.acestudy.org for more information
Chapman DP, Dube SR, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes.*Psychiatric Annals*. 2007;37:359-364.

- **Create funding and support for coordinated school/health programs, including behavioral health*.*** This policy statement is focused on coordination policies that link education programs and schools with health service organization, including behavioral health. The strategy is distinct from the integrated school health recommendation because its focus is not to provide in-school services, but to create community level practices that assure effective screening and referral services from schools to providers. The Centers for Disease Control (CDC) advances a program called the Coordinated School Health Program (CSHP). CSHP has eight components that include counseling and psychological services. The strategy is both a set of polices and practices at the school building level, as well as curricula-guided instruction. While the strategy is focused on overall health, the inclusion of mental health care creates support for the strategy among stakeholders. Coordinated approaches are less intensive than integrated approaches, and require multiple partners at the community level. Coordinated health in schools is a whole community model and would not necessarily substitute for integrated service models. However, there is some disagreement regarding school integrated care models; some districts are not prepared to advance integrated care. Coordinated health and the design developed at the CDC are an excellent starting point.

2. Prevention Structural Strategies –Polling Outcomes from Summit

Interestingly, on a number of items, polling votes were split among participants. For these strategies, unlike the 'clear winners' in the priority lists above, these strategies were often less clear to all participants, and were perceived as more bureaucratic, academic or structural, according to feedback in the 'Your Notes' sheets. These included the following strategies:

(Note: vote of 1 or 2 indicates "Not Important", while a vote of 10 indicates, "Very Important")

Strategy	% Voted "1 or 2"	% Voted "10"	Mean Score
Cost benefit analysis of existing prevention efforts	21%	18%	6.0
Commission a task group for developing clear outcomes; identifying measurable indicators	13%	21%	5.8
Create a baseline set of logic models for all programs	20%	9%	5.0

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Commission research project On risk & protective factors in Mental health	18%	12%	5.4
Consider amendments to age of Consent laws that bring consistency to systems providing services	33%	16%	4.2
Create a state level cabinet agency to advise on prevention	23%	19%	5.2

One strategy that seemed to clearly have considerable support among participants, although it did not rise to the top, was "Enhancing (an) existing structure to serve as an advisory effort to advance a public health approach to mental health." Nineteen percent voted this as 'very important' (10 of 10 score), with 21% voting it important (8 of 10 score). However, 9% voted it as 'not important' so the overall mean score was 6.6, which was not enough to bring it into one of the top three tiers of priorities.

3. Feedback from Participants about the Summit Day

The final polling activity of the Summit Day was a short series of questions about participants' personal experiences of the Summit, as well as their desire to work on future prevention-related initiatives. The following is a short summary of responses:

- 86% of Summit participants agreed or strongly agreed that they felt they had an opportunity to be heard during the day.
- 88% of participants agreed or strongly agreed that they found their table discussions to be helpful and though-provoking.
- Having participated in the Summit process, 79% expressed an interest in continuing to be very involved or somewhat involved. Of the remaining 21%, 18% expressed a desire to continue to be informed about future actions related to prevention initiatives.

Participants were also asked to turn in their thoughts on a "Your Notes" page that was provided in their Summit packets. MHTP collected more than 110 feedback pages at the end of the conference day, which were later data-entered into an excel spreadsheet for thematic analysis.

Comments from the "Your Notes" pages indicated that most participants responded positively to the opportunity to meet and discuss Prevention efforts. A large number responded that they wished they'd had more time to converse with their table mates. Some enjoyed the polling process, while others found it

cumbersome and unclear, especially as the day wore on. Many commented upon their appreciation of the Keynote Speaker's presentation (Kathryn Power from SAMHSA) and requested access to it. Though there were specific concerns and differences that they wrote about best strategies, participants at the Summit generally agreed upon the need to work together and across the lifespan in order to move a Prevention agenda forward.

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D. After the Summit & Next Steps

As with any policy development process, efforts are ongoing. The two-year process and summit results provide more clarity, broader partnerships and a starting point for action.

1. What work has been done since the Prevention Summit?

Based on the priorities that came to the forefront during the Prevention Summit in May 2008, the Prevention Action Group (PAG) brought forward the recommendations from the Summit to the June 2008 Transformation Work Group (TWG) for approval. The TWG met in Spokane, where David Brenna (MHTP) and Craig McLaughlin (SBOH) gave a presentation on the accomplishments of the Summit and the prioritization of strategies adopted as a result of the polling that took place.

At TWG meetings in June, the TWG reviewed areas where more work was needed to meet their original goals. Looking at the Prevention Advisory Group's recommendations, the TWG response was generally supportive, though concerns were expressed about whether the TWG was in a position to move forward such a large initiative given the other areas of focus in the "White Space" committees. This was discussed at length by members of the TWG, and no consensus was reached about future activities, though the TWG did agree that the PAG should continue with its current prevention efforts.

From June through November 2008, the PAG met four times[17]. At those meetings, the focus was on moving the prevention goals into action plans for the 2009 fiscal year. At the same time, TWG 'White Space" committees were meeting to set their own goals and action plans, in anticipation of the budgetary selection process for the next fiscal year.

In October 2008, the MHTP convened multiple meetings of the TWG White Space Committees. In these meetings, participants (drawn mostly from the TWG, but also from other organizations) worked to define priorities for each committee, develop project descriptions, and seek funding, including, three recommended projects from the PAG.

During December 2008, and January 2009, the MHTP/TWG funded selected proposed projects, including many that have a prevention/early-intervention/mental wellness focus. Finally, a Prevention Advisory Group meeting

[17] PAG met on 6/4, 8/6, 9/3, and 11/5/08. There were no July, October or December meetings in 2008.

was held on February 18, 2009 to explore the future work and focus of the committee.

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Appendix A—Summit Timeline

12/07: -Prevention Report Completed (12/31/07) by State Board of Health
-Feedback to Report Themes requested (thru 4/15/08)
1/08: -On-going meetings with organizations

2/08: -Contract with WIMHRT for registration/coordination begins
-Summit logistics group forms & begins to meet regularly
-Summit Planning Team (SPT) meeting
-Venue confirmed/contract/deposit

3/08: -3/10—Pre-Registration Opens
-3/21—General Registration Opens
-Summit Planning Team meeting
-WIMHRT contracted to work with SBOH on Thematic analysis of feedback

4/08: -Speakers & Agenda confirmed
-Registration on-going (reminder emails)
-Community meetings: Benton-Franklin, Walla Walla, Cowlitz & Spokane Counties
-Final Agenda & materials approved
-4/15—Deadline for feedback on Report Themes
-Thematic summit meeting held
-TWG meeting held
-Registration closed when full/wait list established

5/08: -Community Meeting (5/1)-Whatcom County
-Meeting with Electronic Meeting Services
-Meeting with Venue to review logistics
-Printing & packet assembly
-Final email to Participants with Packet review info
-Facilitators' training in Tacoma
-May 13th, 2008—Prevention Summit
-Information posted to website on results from Prevention Summit/emails

6/08: -Follow-up meeting with Summit logistics team
-Follow-up meeting with Prevention Action Group
-Data entry of "Your Notes" feedback from Summit
-Web articles about Summit /request for feedback on Mental Wellness Campaign
-PowerPoint presentation for TWG meeting on 6/27 on Next Steps

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Appendix B—Glossary of Abbreviations used in Report

ACES	Adverse Childhood Experience Study
CDC	Centers for Disease Control
CSHP	Coordinated School Health Program
DASA	Division of Alcohol & Substance Abuse
DEL	Department of Early Learning
DSHS	Department of Social & Health Services
FPC	Family Policy Council
GRAT	Geriatric Regional Assessment Team
MHD	Mental Health Division, DSHS
MHTP	Mental Health Transformation Project, Office of the Governor
IEP	Individualized Education Plan
PAG	Prevention Advisory Group
PEARLS	Program to Encourage Active, Rewarding Lives for Seniors
RFP	Request for Proposal
RSN	Regional Support Network
SAMHSA	Substance Abuse and Mental Health Services Adm. (Federal)
SBHC	School Based Health Centers
SBOH	State Board of Health
SPT	Summit Planning Team
SCSA	Senior Citizens Services Act
SPI	Superintendent of Public Instruction
TWG	Transformation Work Group
UW	University of Washington
WIMHRT	The Washington Institute for Mental Health, Research & Training

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Appendix C—

Themes and Policies Issue Guide for May 13, 2008 Prevention Policy Summit

Themes and Policies
Issue Guide for May 13, 2008
Prevention Policy Summit

The following information serves as a guide to participants at the May 13, 2008 Prevention Policy Summit. Participants are encouraged to begin with a careful review of the report "Mental Health – A Public Health Approach". In the report, fourteen themes emerged that were subsequently tested and reviewed by organizations representing service groups, consumers of care and families, educators and community leaders. Additionally, five community-level focus groups further refined the focus of the work. The original fourteen themes were reduced, based on feedback, to the nine themes below. One of the fourteen themes, cultural competence, was viewed as an embedded, over-arching principle for all policy and practice, and was included in the list of "common understandings" also contained in the report. Three of the fourteen themes, risk/protective factor assessment, mental health consultation and trauma informed models, were better understood as strategies or policies and are included in the policy statements. Two of the fourteen themes, both fiscal statements, were collapsed, for clearer decision-making into one theme.

1. Institutionalize communication and coordination towards common outcomes
2. Market mental wellness and reduce stigma
3. Increase funding flexibility and leverage existing funding sources
4. Screen at multiple points of entry
5. Provide care based on need
6. Engage people where they are
7. Ensure age-appropriate services are available
8. Support transitions across the lifespan
9. Increase and improve provider training

In the following pages, each theme heads a number of policy/practice recommendations identified in the multiple conversations and formal feedback received since the report was released in January, 2008. The response was overwhelming. For purposes of the Prevention Policy Summit, policy ideas or strategies were analyzed and organized into policy statements with multiple examples or descriptions. The policy statements are not

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the priority positions of the Transformation Project; rather they are the summary of issues presented for the summit. The lettered policy statements will be what participants will examine and prioritize on May 13, 2008.

Policies by Theme

(Note: *Indicates policy/strategy found in more than one theme)

Theme #1 - Institutionalize communication and coordination towards common outcomes

A. Create a state level cabinet agency for advising on Prevention. Establish requirements for defining outcomes, a research agenda, and supporting coordination/collaboration.

    1. Define common outcomes in measurable terms and collect data from all providers.
    2. Require those seeking public funding for programs to address how they propose to achieve the common outcomes as part of the application process/evaluation plan.
    3. Institute multi-system provider meetings (mental health, medical, other professional practice fields).
    4. Entity should not do funding, but focus on epidemiology, data, research and accountability.

B. Commission a multi-agency Task Group for developing clear Outcomes and identifying measurable indicators. Require all prevention funding contracts to address interventions that target Outcomes.

C. Create a baseline set of logic models for all the programs and groups so that the programs know where they have things in common, and with whom.

D. Commission research project on risk and protective factors in mental health.

    1. Statewide website for information and materials – clearinghouse of information and way to connect.
    2. Prepare annual trend report on key community indicators across multiple service systems.

E. Enhance an existing structure for prevention to serve as an advisory effort to advance a public health approach for mental health. Consider such organizations as the State Board of Health, Family Policy Council, WA Children's Trust and the Division of Alcohol and Substance Abuse (Prevention Office).

F. Develop a Trauma-Informed Care Model and require implementation in all services systems providing mental health care and/or education.*

G. Set policy goal of reduction of child poverty.

H. Advance efforts to improve coordination between providers while assuring protection of patient privacy.

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1. Examine barriers to service delivery and access.
2. Advance “medical home”-“health home” strategies.
3. Adopt policies for “coordinated school-health”
4. Statewide website for information and materials – clearinghouse of information and way to connect.
5. Prepare annual trend report on key community indicators across multiple service systems.

Theme #2 - Market Mental Wellness and Reduce Stigma

A. Create and support campaigns to market mental wellness.

   1. Create and support age-tailored and culturally-tailored campaigns on the importance of mental wellness for everyone, not just those with mental illness.
   2. Include a well articulated vision on the return on investment in mental wellness and mental illness prevention.
   3. Educate the public about early childhood development and the mental health needs of children birth to five. This includes education on the importance of parent mental health to child mental health.
   4. Educate the public on mental wellness in older adulthood.

B. Reduce stigma through social marketing.

   1. Develop a campaign to reduce stigma for older adults on mental illness and suicide and on interacting with other older adults who experience mental illness.
   2. Create and support campaigns that provide messages to the public on recovery from mental illness.

C. Educate the public on preparing for and coping with life transitions.

   1. Provide information on typical emotional responses to age-specific transitions, such as the transition to adulthood and the transition to retirement. Provide information on how to prepare for these changes and build social connections to support smooth transitions.
   2. Provide information on typical emotional responses to life transitions, such as loss of a job, birth of a child, death of a family member, marriage, or divorce. Provide information on ways to cope with these changes and when to seek help.

D. Encourage help-seeking behavior.

   1. Educate women and their partners on seeking help with postpartum mood disorders.
   2. Encourage older adults to seek help with emotional stress and educate providers and families on interventions to help older adults who experience emotional stress.
   3. Educate parents on when and how to seek help for themselves and their children.

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Social Marketing is designed to influence the behavior of members of the target audience for their own benefit and the benefit of society as a whole. The most well-known examples are the advertising campaigns aimed at tobacco-use prevention and cessation. Social marketing can be used to change the attitudes and behaviors of a nation, a local community, or a particular subpopulation.

Theme #3 - Increase funding flexibility and leverage existing funding sources

A. Policy should change financial structures and approaches to bring additional federal resources for more preventive care.

   1. Train providers and primary care providers on billing procedures under the federal EPSDT program, permitting children and families access to care not directed by Medicaid/state waiver rules and access to care standards.*
   2. Explore expansion of Medicare services for seniors to cover screening, diagnosis and treatment as medically necessary services.
   3. IDEA and CAPTA: Two options each state is allowed to do. Under Part C the state can choose to extend the family model of services up to age 6.
   4. Advocate extending EPSDT and funding to Medicaid-eligible adults.

B. State incentive funds should be authorized to enhance, by 10%, local or agency initiatives to blend or braid program funds in order to advance evidence or promising practices using multiple sources of funding, including private funding.

   1. Pursue private-public partnerships that will provide quality care at reasonable prices.
   2. Pursue collaborative funding efforts among types of providers.
   3. Funding flexibility with chemical dependency services.
   4. Allow purchasing services in a preventative comprehensive manner as opposed to the current system of providing short-term services when people are in crisis.

C. Create Executive/Legislative task force to consider state plan waiver removing distinctions between Medicaid services for mental health and physical health.

D. Consider additional recipients and expand prevention/early intervention funds identified in the Children's Mental Health System law (HB 1088).

   5. Provide additional funding to serve non-Medicaid clients.

E. Prepare financing strategy for preventive services in anticipation of aging populations.

   1. Diverse funding (Medicaid/senior services citizens ACT/Older Americans Act) for different types of outreach/in-home services.
   2. Older adult parity within other mental health groups.
   3. Create a funding stream through the Senior Citizens Services Act (SCSA) to utilize evidence based prevention and early intervention programs such as PEARLS and GRAT.

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F. Blend or braid treatment funding for persons with co-occurring disorders and eliminate duplicative or conflicting regulations with in the DASA and MHD service systems.

G. Enhance mental health parity for all ages and all services, including preventive care and care for parents of children with social and emotional disorders.

H. Conduct cost-benefit analysis of existing prevention efforts.

Theme #4 - Screen at multiple points of entry

A. Screen for mental health issues across medical settings.

1. Implement universal Postpartum Depression Screening by doctors who treat mothers of young children up to 1 year. Recommended by AMA, but implemented by few doctors in Washington.
2. Incorporate mental health in well child screens and integrate across all physical health care systems
3. Screen whole family for infant mental health 0-5.
4. Help children's doctors and other health providers support parents and connect families with effective programs.
5. Medical clinics that have a MH/CD person on-site.
6. Accessible transition-age youth health clinics with MH assessment skills to reduce stigma of going to a "mental health clinic".
7. Include the larger medical community – medical providers on a larger scale, not just Medicaid providers.

B. Screen for mental health issues within educational centers across the lifespan.
1. Head start & early head start. (all children)
2. Elementary Schools
3. High Schools
4. Colleges and universities. (offering mix of therapy and med management)

C. Screen for both Substance Abuse and Mental Illness in traditional mental health settings.
1. Blend CD/MH services together for elders.

D. Mental health screening in lifespan-appropriate activity centers.
1. Project Connect (volunteer peer counseling providing in-home support and assessment) (Clallam Cty)
2. Gatekeeper Program (outreach program in Spokane County)
3. COPES Assessment
4. Senior Information and Referral
5. Welcome Baby/Well Baby
6. Criminal Justice Centers
7. Immigration Centers
8. Faith-Based Centers
9. GRAT (Geriatric Regional Assessment Team)

Theme #5 - Provide care based on need

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A. Create Executive/Legislative task force to consider state plan waiver removing distinctions between Medicaid services for mental health and physical health.*
    1. Move away from DSM criteria for access.
    2. Alter or eliminate Access to Care Standards

B. Train providers and primary care providers on billing procedures under the federal Early Periodic Screening, Diagnostic and Treatment (EPSDT) program, permitting children and families access to care not directed by Medicaid/state waiver rules and access to care standards.*

C. Explore and fund multiple promising/evidence-based practices that can be provided without Diagnostic Standards Manual (DSM) diagnosis requirements and prior to crisis.
    1. Warm-lines
    2. Intense individual therapy.
    3. Flexibility in state regulation of alternative care models.
    4. Individual therapy for transition-aged youth.
    5. Center for Career Alternatives
    6. Functional Family Therapy
    7. Aggression Replacement Therapy
    8. Medication management with a structured interaction (TA Youth)
    9. Project Connect (volunteer peer counseling providing in-home support and assessment) (Clallam County)
    10. Gatekeeper Program (outreach program in Spokane County)
    11. Implement PEARLS statewide. (treatment for depression in the home)
    12. IMPACT (links primary care doctor and MHP)
    13. The Incredible Years prevention program

D. Implement therapeutic child care funding available through Medicaid.

E. Identify service structures supporting the mental health needs of all special populations.
    1. Support services for Fetal Alcohol Spectrum Disorder
    2. Support services for children with autism.
    3. Integrate present systems of care that identify and support children exposed to domestic or community violence with the child care community.

F. Consider amendments to age of consent laws that bring consistency to systems providing services.

G. Establish a lower access to care criteria so that people can access support services without needing to be "ill".
    1. Move away from DSM criteria for access; expand from "delays in progress" to also include at-risk kids or kids with less severe problems.
    2. Qualify kids who don't have a learning disability.
    3. The day a child turns 3, they lose all early intervention providers so have to start all new relationships. Now law allows you to go to age 6.

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4. Changes to access to care standards to support dyadic and family treatment.

Theme #6 - Ensure age-appropriate services are available

A. Promote the implementation and state-wide dissemination of evidenced-based practices.

    1. Program of Assertive Community Treatment (PACT)
    2. Supported Employment
    3. Family Psychoeducation
    4. Integrated Dual Disorder Treatment
    5. Dialectical Behavioral Therapy
    6. Functional Family Therapy
    7. Aggression Replacement Therapy
    8. MultiSystemic Therapy
    9. Geriatric Regional Assessment Team (GRAT)
    10. Children's EBP's
    11. Steps toward effective, enjoyable parenting (STEEP)
    12. Parents as Teachers
    13. Nurse-Family Partnership
    14. Parent-Child Home program.
    15. Healthy Families America.

B. Ensure all age-appropriate services are culturally-competent, population-based, and trauma-informed rather than income-based.

    1. Develop a Trauma-Informed Model and require implementation in all services systems providing mental health care and/or education.*

C. Expand emphasis on alternative treatments possibly in non-traditional mental health treatment settings and build consistently across the state.

    1. Peer counseling
    2. Project Connect (older adult peer counseling in the home)
    3. Need infrastructure for training parents to be mentors and to help their kids and other kids.
    4. Center for Career Alternatives
    5. Supported Employment/Vocational Services
    6. Pioneer Human Services – focuses on work projects as "normalizing" pathway to life.
    7. Places for young people to volunteer.
    8. Clubhouses
    9. Drop-in centers for youth (Lambert House)
    10. Adult day centers
    11. Senior centers
    12. Head Start
    13. Childcare centers
    14. Establish Co-Occurring Treatment Programs

D. Expand holistic care for children and families.

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1. Care for the whole child – at young age, not possible to separate education from health.
2. Increase focus on family mental health – can't separate children from family.
3. Integrate family support services into early childhood settings.
4. Promoting First Relationships.
5. Group-based parent training.

E. Create funding and support for coordinated school/health programs, including behavioral health.*

F. Create funding and support for integrated mental health services within schools.*
   1. School-Based Health Centers
   2. School treatment programs

<u>Theme #7 - Engage people where they are</u>

A. Engage people with supports and services as they participate in life activities of the community.

1. Child Care Centers
2. Senior Centers
3. Schools
4. Universities
5. Community Centers
6. Recreational Programs
7. Libraries
8. Churches

B. Serve people where they live.

1. Home Visitation Programs significantly reduce risk of child maltreatment.
2. Young children must be met in the context of their family environment, not just childcare.
3. Gatekeeper Program (outreach program in Spokane County)
4. Implement PEARLS statewide. (treatment for depression in the home)

C. Medical clinics will have Mental Health/Chemical Dependency professionals available either on-site or as consultation.

1. IMPACT (links primary care doctor and MHP)
2. Every visit to a physician's office should include a simple screening for depression.
3. Colleges and universities with therapists and med management.
4. Telepsychiatry consultation to medical settings.

D. Create funding and support for coordinated school/health programs, including behavioral health. *

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1. Use principals for family support.
2. Teen health centers in schools (school age)
3. Kelso program in Seattle, Renton school district (school age)
4. Readiness to Learn (school age)

E. Create funding and support for integrated mental health care in schools.*

1. Expand school-based mental health centers to K-12
2. More integrated rehab services.

F. Ensure provision of outreach that targets needs and is not stigmatizing.

1. Circle of Success
2. Welcome Baby Programs

G. Develop social/emotional learning standards for K12 education.

<u>Theme #8 - Support transitions across the lifespan</u>

A. Support Age-related Transitions

1. Provide adequate support for those entering retirement to remain physically active and socially engaged. This can be done through elder-friendly communities and community-based programs.
2. Young children need to develop adequate social and emotional skills to successfully transition into school. There are programs that provide such services to at-risk children, such as Part C of the IDEA and Head Start programs.
3. Youth and young adults need services designed to help them transition into adult systems and adult responsibilities. One example program is the Options Program in Washington, which used the Partnerships for Youth Transitions grant from SAHMSA.
4. Institutionalize continuity between age-related systems, such as child mental health services and adult mental health services, to minimize disruptions.

B. Support Stressful Transitions to Minimize Negative Impact

1. New parents need to be provided with support and education on early childhood development through a variety sources. Nurse home visiting programs and programs that do universal outreach through maternity wards have had success in providing support and education. New parents who struggle with mental illness are especially in need of support.
2. Older adults need adequate support as they transition through loss of loved ones, through physical illness, and into institutions. Support groups in senior centers are one way to provide this support to prevent crises during transitions.

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3. Support programs for family members who become caregivers for older adults can prevent depression in caregivers and premature institutionalization for older adults.

C. Support Transitions Related to Crises

1. Ensure that resources are readily available to prevent crises from escalating. Examples of prevention strategies are warm lines and respite or hospital diversion beds. Peer support is an effective tool to deescalate a growing crises.
2. Provide adequate services for individuals to successfully transition into stable, less stressful situations; for example, out of hospitals, jails, and homelessness. Programs that can be used to support these transitions are hospital-to-home support programs, transitional housing that accepts individuals with high-level needs, and supported employment programs.
3. Provide adequate support to family members affected by crises; for example, provide therapeutic programs for children and their incarcerated parents.

<u>Theme #9 - Increase and improve provider training</u>

A. Trauma-Informed training for all providers, all point of service centers.

1. Domestic violence (child/family/partner)
2. Foster Care trauma
3. Systemic trauma (state hospital/prisons, etc.)
4. Poverty
5. Impact of trauma on childhood development.

B. Train providers on developmentally appropriate assessment of children and older adults.

1. Ensure provision of social-emotional, behavioral assessment before medications prescribed to children.
2. Ensure provision of age appropriate assessments focusing on relationships among family members & identify targets of intervention.
3. Provide consultation to infant mental health providers. (0-5)
4. Nature of adolescent developmental process
5. Older adults and aging

C. Develop consultations and/or cross trainings among all providers (medical, schools, social services).

5. Telepsychiatry.
6. Mental Health Consultants (across the lifespan) for primary care settings.
7. Cross training between geriatric mental health specialists and aging resource specialists including early detection training for generalist aging services staff.
8. Domestic violence system and mental health/substance use providers.
5. Cross systems professional development – on social and emotional learning for 0-5 year olds.

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6. Train additional mental health providers in early childhood systems and working with young children.
7. Use model in which private agency provides training & consultation to community agencies to create a shared language and understanding of infant/child mental health.
8. Offer family services to childcare settings.

D. Prepare caregivers/childcare providers for understanding the unique needs of children/older adults affected by mental illness and for appropriately intervening with mental illness related behaviors.

1. Adjust caregiver curricula to include mental health/mental illness education.
2. Gentle Care Model (teaches about how to work with dementia)
3. Collaborate with existing efforts to expand resources and support for informal caregivers (family members, neighbors).
4. Fund ongoing relationship-based consultation and training for child-care providers, and public health nurses working with child care providers.
5. Statewide mental health consultation to child care and child welfare program.
6. Include family, friends, and neighbors in educating child care providers.
7. Childcare more than a place for a kid to go during the day – social emotional needs met as well.

E. Create funding and support for coordinated school/health programs, including behavioral health.*

F. Focus policies on current education system for future professionals.

1. Encourage development of combined aging and mental health graduate school studies.
2. Educate medical students about mental illness in older adults.
3. Retain geriatric mental health expertise.
4. More geriatric mental health specialists. (Loan forgiveness, financial incentives to attract re: American Geriatrics Society)
5. Program at UW that teaches people how to change their behavior instead of expecting an older person to change theirs.
6. Train additional mental health providers, who are culturally competent and representative of diverse communities, in early childhood systems and working with young children.
7. Work with CCRNR, WAEYC, STARS program, & AARP to work mental health into early childhood accreditation programs.
8. Childcare providers across the classes need to be engaged, influence the system, not just individual trainings.
9. Educating the educators – schools that are sensitive to trauma.

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Appendix D—Summary of Data from Summit Polling[18]

Which age group are you representing here today?

Early Childhood	21%
School-Aged	19%
Youth-in-Transition	18%
Adult	29%
Older Adult	13%

Note: The following questions are answered using this scale scores and represent the overall audience participation 'score' unless otherwise noted:

1 (not/lesser important)………..5 (neutral)……………10 (very/more important)

1. "Moving forward together…where do we focus our energy over the next couple of years?"

Increase funding flexibility & leverage sources	5.57
Market mental wellness & reduce stigma	4.79
Engage people where they are	4.20
Ensure age-appropriate services	4.14
Institutionalize communication & coordination towards Common outcomes	3.45
Provide care based on need	3.42
Screen at multiple points of entry	2.51
Support transitions across the lifespan	2.06

2. "What would be the most important strategies to make progress on FOR YOUR POPULATION over the next couple of years?"

(by age group polling results)

[18] Based upon final results submitted by Electronic Meeting Services for May 13th, 2008 electronic polling system (ARS—Audience Response System). Excerpted from PowerPoint presentation; not all questions are reflected here. For complete results: http://mhtransformation.wa.gov/ppt/MHTG/SummitVoting.pps

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Early Childhood Priorities

Serve people in home	5.22
Holistic care	4.98
Reduce child poverty goal	2.90
Promote Evidence Based Practices	2.80
Expand Funds for HB 1088[19]	2.46
Leverage federal funds	2.10
Incentives for local flexibility	1.85
Outreach strategies	1.12
Lower ACS[20] criteria	0.80
Therapeutic child care	0.80

School Aged Priorities

Integrated school/health	6.31
Social-emotional learning standards	5.14
Coordinated school/health programs	4.80
Campaign to market mental wellness	2.74
Lower ACS criteria	1.77
Expand funds for HB 1088	1.77
Pre-crisis service structure	1.74
Incentives for local flexibility	1.06
Outreach strategies	0.49
MH & SA consultation in health clinics	0.46

Youth-In-Transition Priorities

Engage in life activities in community	4.00
Develop a trauma-informed model	3.44
Integrated school/health	3.28
Pre-crisis service structure	2.97
Outreach strategies	2.91
Reduce stigma campaign	2.81
Expand funds for HB 1088	2.06
Education on life transitions	1.72
Lower ACS criteria	1.66
Campaign to market mental wellness	1.41

[19] House Bill 1088—Child Mental Health
[20] ACS= Access to Care Standards (age limit)

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Adult Priorities

Blend drug/alcohol and MH	3.84
Campaign to market mental wellness	3.51
Develop a trauma-informed model	3.33
Pre-crisis service structure	3.00
Non-traditional alternative treatments	2.86
Leverage federal funds	2.71
Lower ACS criteria	2.25
MH & SA consultation & health clinics	1.90
Incentives for local flexibility	1.53
MH parity enhancement	0.53

Older Adult Priorities

Serve people in-home	6.42
Plan for aging populations	5.38
Engage in life activities in community	3.08
Encourage help-seeking behavior	2.54
MH & SA consultation in health clinics	2.15
Campaign to market mental wellness	2.08
Pre-crisis service structure	1.69
Education on life transitions	1.31
Reduce stigma campaign	1.04
State Medicaid examination	0.69

3. What would be the most important strategies to make progress on as SOMETHING TOGETHER over the next couple of years?

Campaign to market mental wellness	5.26
Holistic Care	3.34
Engage in life activities in community	3.23
Develop a trauma-informed model	2.81
Incentives for local flexibility	2.71
Serve people in-home	2.57
Leverage federal funds	2.23
Blend drug/alcohol and MH	1.65
Encourage help-seeking behavior	1.55
MH & SA consultation in health clinics	1.01

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Feedback on Summit Day Activities (from polling responses at end of the day)

Note: These items use the following scale:
1=Strongly disagree
2=Disagree
3=Agree
4=Strongly Agree

1. I have had the opportunity to be heard:

Strongly agree	46%
Agree	40%
Disagree	4%
Strongly disagree	9%

2. The discussions at my table were helpful/thought-provoking:

Strongly agree	41%
Agree	47%
Disagree	8%
Strongly disagree	4%

3. Having participated in this step of the process, I am…

Very interested in being involved as the process continues	45%
Willing to be involved	34%
Would like to be kept informed but not involved	18%
Not interested in being involved	2%

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Appendix E—Contact Process: Notification & Registration for the Prevention Summit

After initial contacts had been made by Summit Planning Team (SPT) members to the Tier 1 (Legislators & their staff) & Tier 2 ('Crucial Stakeholders') agencies, organizations and individuals, the MHTP staff requested contact information (in the form of email addresses, primarily) for any interested individual in order to create a Tier 3 email list. A large database of contacts was assembled to send out the Prevention Summit registration information to all three Tiers. In addition, general announcements/ notifications were sent out approximately every other week by email, and those receiving the emails were invited to forward them to any additional interested parties.

The Tier 1 individuals were sent a 'pre-registration' invitation letter from MHTP Director Ken Stark, encouraging and inviting them to register early during two weeks before the General registration opened. General registration opened in late-March, with the available seats filling much earlier than anticipated, and closed by mid-April. Interest in attending the Summit resulted in increasing the number of seats by 20; even so, there was a wait list of over 25 individuals by the time the Summit day arrived.

Using the MHTP website, individuals registered online for the Summit. As there was no cost to attend the Summit itself, the only costs associated were with overnight accommodations and travel to the Summit. The MHTP set aside scholarship funds for up to 30 consumers and their families. This allowed a wider-level of participation for consumers from all over the state, who came to participate on the day of the Summit.
One of the crucial elements that the Summit Planning Team and MHTP staff identified as a barrier to success in moving forward Prevention efforts is the lack of communication and coordination between agencies and individuals working in different areas of the 'lifespan.' In order to break down this barrier, it was decided that during the Summit, seating at tables would be pre-assigned with an effort made to 'mix up' the groups at the tables. In addition, it was important to be sure that there was roughly equal representation from each of the five 'age' groups at the Summit itself, so during the online registration process, registrants were required to indicate which 'age group' they would be representing during the Summit day:[21]

Age Groups:
Early Childhood (0-5)
School-Aged
Youth-In-Transition

[21] With the exception of legislators or their staff, who were not required to indicate a specific age group.

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Adult
Older Adult

Based on the above self-identified life span groups, participants were seated at the Summit in tables intermixed with different life span representatives.

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