



Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

Transformation Transfer Initiative

Fiscal Year 2008 through
FY2013 Projects

Overview

NASMHPD

Transformation Transfer Initiative Summary of Projects

Whole Health/Integration

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Congratulations to the Transformation Transfer Initiative (TTI) Awardees of Fiscal Years 2008, 2009, 2010, 2011, 2012 and 2013! Together, they represent 40 states and territories and 69 projects that have improved the behavioral health of millions of Americans.

Each state and territory has provided great leadership and effort to disseminate models of excellence and guidance to state and local systems on adopting consumer-driven and recovery-oriented practices that have successfully improved the landscape of American healthcare. Through utilization of flexible “tipping point” resources to behavioral health communities, the TTI initiatives have shown clear evidence of success through the years, as well as sustainable, positive impact on state behavioral health systems. TTI programs demonstrate that goals and accomplishments can be achieved while leveraging existing resources. Each of the initiatives embodies a high level of expertise, resourcefulness, and innovation to address the significant behavioral health needs of Americans and to provide effective responses that are unique to each state.

SAMHSA will continue to support efforts such as the TTI that promote positive system change in states and local communities and encourage partnership, sharing of ideas and resources, and facilitates peer-to-peer technical assistance to accomplish measurable goals. SAMHSA is proud to have partnered in these successful projects and we look forward to continue to effectively address the behavioral health needs of the American people.



Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services

Introduction

“Never in the history of America have we known so much about mental health and how to enable people with mental illnesses to live, work, learn, and participate fully in the community. Recovery from mental illnesses is now a realistic hope. Yet, much of what we know is not accessible to the people who need it the most. Today, we are on the threshold of achieving the promise of transforming mental health care in America. Government – Federal, State, and local – and thousands of organizations in the private sector are joining together to transform the mental health service delivery system across the Nation.”

This vision statement, put forth in the Substance Abuse and Mental Health Services Administration (SAMHSA) report *Transforming Mental Health Care in America - Federal Action Agenda: First Steps*, describes very clearly the reality of today’s public mental health system and calls attention to the opportunities we have, by working together, to improve the lives of Americans with mental illness and substance use disorders. Changing systems with bureaucratic infrastructures to be recovery and outcome-oriented, however, takes investment, hard work and the ability to bring the right players to the table. States, as the largest payers of mental health services, are in a key position to lead and influence systems change with all stakeholders.

In 2007 SAMHSA’s Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI) to assist in this essential transformative work. It sought to provide – on a competitive basis – funding awards to states, the District of Columbia, and all territories, that had not had the opportunity to participate in the Mental Health Transformation State Incentive Grant (T-SIG) program. Under the first year of the TTI (FY2008), CMHS awarded contracts of \$105,000 each to ten States and the Commonwealth of Puerto Rico. Under the second year of the TTI (FY2009), CMHS awarded contracts of \$221,000 each to eleven States. Under the third year of the TTI (FY2010), CMHS awarded contracts of \$221,000 each to nine States; four states from FY08 received an award of \$110,500. In FY2011, there were twelve awards of \$221,000 each. And in FY2012 and FY 2013, CMHS awarded contracts of \$221,000 to an additional eleven states. All sixty-nine projects sought to identify and adopt transformation initiatives and activities that were implemented either through new initiatives or expansion of initiatives already underway, all rooted in quality systems change. Some states elected to advance multiple projects.

This important project has given these States the opportunity to increase efforts in transforming their state behavioral health delivery system to be more consumer and family driven and to break down the silos of state government that impede recovery and resiliency. These States also used their funding to leverage private and public resources to make current initiatives richer and more effective, and in many cases to provide the tipping point to transformation success.

This overview document highlights some of the successful outcomes for all sixty-nine projects. If you would like more specific detail, in-state contact information is provided on each project page. Also feel free to contact NASMHPD’s TTI Project Manager with questions as well at:

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Alabama



FY2008 TTI PROJECT:

Coordination of public mental health and primary care through one large Adult Psychiatric Conference followed by regional roundtable discussions between family practice physicians and mental health clinicians to develop regional plans of action.

KEY OUTCOMES:

- A statewide “Psychiatric Institute” focusing on the integration of physical and behavioral health was held on April 11-13, 2008 in Orange Beach, Alabama with over 150 participants including psychiatrists, primary care physicians, nurse practitioners, and policy makers from four partnering state agencies.
- Responding to the evaluation, 85% of attending primary care physicians said they would like to attend again next year if offered and 95% indicated that the training was relevant to their practice/work.
- The statewide conference was followed by 10 regional roundtables to create local partnerships between primary care physicians and mental health professionals.
- Approximately 187 people attended the roundtables throughout the state. This total includes 27 physicians, 26 primary care providers, 56 community mental health center representatives, 25 representatives from advocate groups, and 10 consumers.
- Responding to the roundtable evaluation, 95% of physicians said that the roundtable was worth their time and that they met someone from the local area that they did not know.
- The Alabama Primary Health Care Association was a co-sponsor of these meetings and was pivotal in the planning and execution of regional roundtables, they also included a mental health track at their annual statewide conference.
- Leveraged resources from a Bristol-Myers Squibb Foundation grant to the Alabama “blackbelt” region to improve the overall health of these 12 very poor and rural counties in Alabama.

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Alabama



FY2010 TTI PROJECT:

Improve collaboration with primary care providers through: 1) local planning grants to support collaboration between Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs), 2) convening expert panels to address barriers and challenges to collaboration from the physician's perspective, and 3) a joint meeting between pediatricians and public mental health center psychiatrists to address improved collaboration.

KEY OUTCOMES:

- A survey was developed with the input of the Department of Mental Health Medical Director, Richard Powers, MD, and the Alabama Medicaid Agency Medical Director, Robert Moon, MD. The Alabama Primary Health Care Association created the survey instrument and sent it to CMHCs (12 responses), Hospital Emergency Departments (6 responses), and FQHCs (8 responses) for completion by their respective medical staff. There were positive responses to the concept of integration while primary care physicians were more positive about the use of telemedicine.
- Two expert panels were convened with the first on February 22, 2010, in Birmingham and the second on March 22, 2010, in Evergreen. Primary care physicians in hospitals, Public Health, and FQHCs were represented as were public sector psychiatrists. Dr. Moon and Dr. Powers attended and presented at both sessions. At each meeting, the results of the survey were shared along with the findings from the regional roundtable meetings supported by the first Transformation Transfer Initiative grant in 2008. The common messages from all of these sources was the need for more effective communication and working relationships between primary and mental health providers with integration being a well-received concept, the potential benefits of telemedicine, the need for more primary care physicians and psychiatrists, and the need for more on-going continuing education between psychiatrists and primary care physicians.
- Planning for funding six local planning grants began in December, 2009. The purpose of the grants was to support in-depth local planning that would result in a plan for improved collaboration and would also position the local coalition to apply for the next round of Substance Abuse and Mental Health Services Primary and Behavioral Healthcare Integration grants. A draft Request for Proposals (RFP) that was circulated to national experts contributed significantly to the knowledge base for the individuals participating and their respective agencies. Through the expert panels, individual practitioners both gained knowledge and developed an appreciation for the challenges facing their counterparts in primary and mental health care and shared their knowledge to inform the planning process for integrated services. The Child and Adolescent Psychiatric Institute provided a forum for pediatricians and psychiatrists to learn about best practices and to inform state agencies about their respective concerns when attempting to access each other's services. One of the predominant themes from the six local planning grant reports was an improved mutual understanding of the regulatory and fiscal parameters within which CMHCs and FQHCs operate.

- State-level Interagency relationships were expanded and strengthened beyond the scope of the specific activities supported by the grant. The Department of Mental Health (DMH) and the Medicaid Agency have a long-standing strong working relationship. The direct involvement of key Medicaid staff in the activities supported by the grant is a reflection of their commitment to improving collaboration between primary and mental health care. Dr. Moon from Medicaid was directly involved in planning and implementing the grant.
- Through Dr. Moon's leadership, Medicaid established regular monthly meetings with DMH to address parity and implementation of the Affordable Care Act. These meetings also involve representatives from the Substance Abuse Services Division, the Department of Public Health, the Department of Human Resources, and the Department of Youth Services. Medicaid also issued an RFP for three medical home pilot projects based on the work done in North Carolina. As a result of the Department's ongoing dialogue with Dr. Moon and other key staff, Medicaid required that the local mental health center be on the Board of Directors for the medical home pilot projects. Medicaid will take the lead on submitting an application for Health Homes for Enrollees with Chronic Conditions. Discussion is underway regarding a possible application for Medicaid Emergency Psychiatric Demonstration grant. Medicaid is seeking clarification on some of the regulatory language before committing to an application. The regular meetings with Medicaid have also provided a forum to discuss the Department's plans for a 1915(i) state plan amendment.
- One of the issues identified by the expert panels and the local grantees is how to support interagency collaboration through billing practices. The Department and Medicaid developed a joint policy statement clarifying billing through FQHCs for mental health services and promoting the concept of Interagency collaboration between FQHCS and CMHCs to effectively use the Medicaid Rehab Option.
- The Alabama Primary Health Care Association (APHCA) has been an active partner in grant implementation and in promoting improved collaboration between FQHCs and CMHCs. The APHCA annual conference included a track on integration of mental health and primary care. The local planning grants supported and enhanced collaborative efforts between CMHCs and FQHCs.
- The following quotations from mental health center executive directors reflect the influence of this grant:

"I just returned from an excellent meeting with the CEO of the local FQHC and we have finally started a good dialogue about how we may be able to work together in the future. There apparently were some issues between our organizations 30 years ago that led him to keep his distance but I think we are on track to mending those fences ... which will ultimately enhance the lives of those we mutually serve. Thanks for keeping the issue of integrated care before us!"

"... just wanted to say thank you for getting the issues of FQHC's and CMHC's on our radar screen. I appreciate you bringing it to the council and encouraging us to go to the Primary Health Care conference. I know I still have a lot to learn. But, I was able to shoot off an email even while we were in Mobile to the folks in our area who might be involved in applying for an FQ. Turns out the timing was perfect because they are applying and will now include us in the loop. I had a great and reassuring conversation with East Alabama Medical Center yesterday who assured me they want us involved and have no intention of creating a duplicate "mini-mental health center" inside the FQ without us. I would have never even known to ask if you hadn't kept it in front of us."
- In summary, the modest amount of funding provided through this TTI grant supported concrete steps to enhance interagency collaboration to the goal of better integrating primary and mental health care. Improved knowledge contributed to improved interagency relationships which extended well beyond the specific agencies and individuals involved in grant Implementation.

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Alabama



FY2012 TTI PROJECT:

Leadership Forums and other activities to prepare for healthcare reform

KEY OUTCOMES:

Alabama proposed the following four major components that provided an opportunity for all of Alabama's mental illness and substance abuse providers to gain clear understanding of how healthcare reform will change the delivery and financing of behavioral health services. The focus was to stress to providers the importance of adopting a recovery orientation system of care and provider integrated care. These activities were selected for support with the input from the following state level partners: Alabama Medicaid Agency; Department of Public Health, Alabama Hospital Association; National Alliance for the Mentally II; the Alabama Council of Community Mental Health Boards; FORMLL (the SA statewide consumer advocacy organization); Wings (the MI statewide consumer advocacy organization); and the Southern Coast Addiction Technology Transfer Center.

Leadership Forums: The focus of the Leadership Forums was to provide an understanding of the components of healthcare reform and integrated care, how reform will drive change for providers, and reinforce the urgency with which the agencies need to adapt service and business models to respond to alternative financing strategies offered through healthcare reform. Healthcare Reform was presented as a series of opportunities for providers to recognize that change is imminent and that forward thinking providers who manage the change will have greater opportunities to maintain the financial support needed to fulfill their missions. Each Forum was educational and experiential, using topics selected by providers and AL-DMH to allow for in-depth discussions. Workshops focused on target populations, alternative service approaches, and/or business models that present concerns and challenges to the providers, Alabama or other stakeholders.

ADMH partnered with the Southern Coast Addiction Treatment Center to host the first Leadership Forum November 15-16, 2011 for executive directors of mental health and substance abuse services. This Alabama-paid leadership forum served as the basis for the subsequent three TTI forums.

The first of the three TTI Leadership Forums was conducted by David Mee-Lee, MD on April 24-25, 2012 in Eufaula, Alabama. Dr. Mee-Lee presented on "Transforming Services and Systems" and discussed that before integration with primary care takes place, it is essential that mental health and substance abuse services are truly integrated. His workshop assisted addiction and mental health clinicians in improving clinical skills to serve clients with co-occurring disorders. It also built on participants' knowledge about co-occurring disorders (COD) to practice and enhance their clinical skills in assessing and engaging people, and in designing and delivering appropriate treatment services. This training also focused on how systems need to transform to support clinical skills and develop a flexible and integrated system for COD. This session: 1) Identified definitions and dilemmas in assessment and treatment in co-occurring disorders; 2) Demonstrated clinical skills needed to improve services in daily clinical practice; 3) Applied engagement and treatment strategies to develop an integrated service plan and meet the client's individual needs and readiness for change; and 4) discussed systems changes necessary to promote integrated services for people with co-occurring disorders.

The second TTI Leadership Forum was conducted by David Lloyd on August 16-17, 2012 in Florence, Alabama. Mr. Lloyd presented on "Maximizing Readiness for Healthcare Reform". This Leadership Summit focused on key factors that

influence an organization's readiness for healthcare reform. Participants completed the *Healthcare Reform Readiness Assessment Survey* (from The National Council/MTM) and engaged in dialogues to address the findings and identify potential solutions. Topics included:

- The top challenges organizations face as they prepare for the changing health care environment and solutions that have been implemented nationally to address similar challenges;
- The components of an accountable care practice model that can assist with developing solutions to daily operational challenges;
- How open/same day access to treatment helps engage clients/families in care;
- The outcomes achieved by other community behavioral healthcare organizations nationally who have utilized Accountable Care Service Delivery principles; and
- The Rapid Cycle Change management model including how to develop a "good idea" into an implementable solution recommendation.

The third TTI Leadership Forum, initially postponed due ADMH closing two state psychiatric hospitals, is scheduled to occur in the late fall 2013.

Integration of Data: The MH and SA divisions have operated on separate data systems. Alabama is in the process of enhancing its IT capabilities to be able to co-mingle the information from the existing MH and SA platforms into a data warehouse infrastructure to allow for cohesive and logical reporting across systems. The overall cost for this project is estimated to be \$200,000. TTI funded the \$80,000 initial design phase of the project and consulting resources, as well as some of the initial programming necessary to create the infrastructure ADMH will need going forward. DMH also contracted with an outside consultant to give access to state-of-the-art best practices and analysis in its implementation. DMH is also exploring data element that will support the Olmstead TA that occurred August 23-24, 2012 by Vijay Ganju.

Infrastructure for Self Directed Care: DMH and other stakeholders worked diligently with the Alabama Medicaid Agency on the Money Follows the Person grant. DMH worked directly with Medicaid in this application of how this will incorporate MI and SA populations and determining the funding vehicle for that. DMH and other stakeholders are working on an ACT 2 Waiver State Plan Amendment that will address MI and SA consumers in nursing home care. Also, DMH is working with Medicaid on a 1915i SPA that would incorporate SOC services. DMH also worked with Medicaid on the 2703 Health Home State Plan Amendment that was approved by CMS in May 2013. DMH also worked with Medicaid on the submission of an 1115 Concept Paper that was submitted to CMS in May 2013. If approved by CMS, DMH has offered its expertise in crafting the behavioral health components of the 1115 State Plan Amendment.

Peer Support: Prior to the merging of the Mental Illness and Substance Abuse divisions, both divisions had been focusing on and making peer support services a top priority. Alabama currently has MI and SA peer specialist within the communities and at state hospitals. However, the two groups have not focused on specialty populations such as co-occurring disorders, African Americans, or criminal offenders with serious mental illness. ADMH ensured that the training focused on the development of a diverse group of peer specialists. TTI allowed Alabama to train additional peer specialists to address the lack of diversity within our existing peer support specialists. It also strengthened the partnership with Alabama Medicaid in the process of moving Peer Support Services into a reimbursable service which would leverage the ability to sustain this vital service and assist in transforming the importance of peer services in the continuum of care for our consumers. Mike Autrey, Director of Office of Consumer Relations, conducted this training in August 2012. Alabama also worked with FORMLL (the SA statewide consumer advocacy network) who put a proposal forward to complete a second Peer Support Specialist training with the focus of this grant. This training was conducted in October 2012.

Future Activities: The third TTI Leadership Forum, initially postponed due ADMH closing two state psychiatric hospitals, is schedule to occur in the late fall 2013.

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Alaska



FY2010 TTI PROJECT:

The Alaska Psychiatric Institute's (API) Telebehavioral Health Open Access Clinic commenced January 2010 with the goal of providing immediate access to psychiatric, psychological, and behavioral health services for Alaskans living in rural and remote-rural locations throughout the state.

KEY OUTCOMES:

- As a result of our growth under SAMHSA's TTI grant, API's Telebehavioral Health program currently provides services to approximately 22 locations across Alaska. Of these, two are urban, five are rural, and 15 are remote-rural (off the road system and accessible only by airplane or boat). Based solely on our present contracted sites, the total population of Alaskans who have direct access to our psychiatric and psychological services is approximately 28,000. In addition, the Open Access Clinic is capable of providing these services statewide, filling a much needed gap in service access in Alaska because video-teleconferencing capability exists in most areas of the state. The growth of the program over the past year is indicative of the service needs of rural and remote-rural Alaska and suggests that the program is an overwhelming success. The program proved so viable that continued growth is expected over the next year and beyond.
- The goal of the Open Access Clinic was to provide same-day access to psychiatric and behavioral health assessment and treatment to rural and remote-rural Alaskans. This goal has been met; immediate state-wide access to psychiatric and psychological services has been available and widely accessed during the past year. The Open Access clinic consisted of two differing service models. The first model involved immediate access to services for sites that were already served by API's telebehavioral health program. The result was more rapid access to recurrent appointments and a dramatically increased ability to provide program services for emergent cases. The second model involved same day access to program services for sites that did not have an existing relationship with API's telebehavioral health program, via the use of a one-page fee-for-service agreement. As a result of this second model, providers and their patients (typically from small clinics) were able to immediately access psychiatric and behavioral health services on an as-needed, one-time basis. Providers indicated that they were quite pleased with the option of as-needed access. SAMHSA's TTI grant allowed us to develop and maintain a full time equivalent psychiatric provider as the program grew.
- During this start-up period we performed 494 psychiatric encounters that included 165 individual patients. Of 165 patients, 77 were males and 88 females.
- We provided highly skilled adult and child psychiatry that encompassed evidenced based and best

practices. Services including psychiatric evaluations and treatment. We were able to provide child psychiatry through a VTC link to Children's Hospital in Seattle, with a University of Washington faculty child psychiatrist; adult psychiatry with in-house psychiatrists including an addictions specialist and an advanced nurse practitioner. In referring to the telebehavioral health program a mental health clinician from a remote village stated, "This is by far away the very best service that we have been able to provide for our clients." Another provider stated "The quick time frame to connect with you guys is wonderful".

- We learned that the ability of the psychiatric provider to be tolerant, patient, and flexible was the most critical factor in the success of our program. For example, rural Alaska has a shortage of medical and behavioral health providers and often the existing behavioral health clinicians are inexperienced. Couple this with clients presenting with some of the most severe behavioral health and substance abuse problems in the country. For example, the clients we served described a history of multiple psychological traumas and reported multiple village suicides that included relatives and friends. Village cluster suicides are a tragic reality in rural Alaska. In light of these factors, it became clear to us that it was unreasonable to expect rural providers to fax a completed mental health assessment, the patient's relevant medical records or a listing of the patient's prescriptions prior to the appointment given the lack of personnel and the time they devote to day-to-day crises. We learned that our providers must understand that the patient may be late or connectivity problems could delay the appointment. Significant cultural differences exist that must be acknowledged and respected. For example, village culture is not fast paced, timely, or pressured thus our providers could not expect patients to always be on time for appointments.
- We were attentive to metabolic problems, especially for patients taking medications that cause weight gain and metabolic syndrome. Our psychiatrists ordered tests and referred patients to their medical providers to monitor the problems. We encouraged partner sites to purchase a scale and a blood pressure cuff so we could monitor BMI.
- We provided licensure supervision, consultation, and a safe avenue for remote providers to share their challenges and secondary trauma experiences. According to one mental health clinician "You guys have been my anchor".
- Over the past year, API has increasingly utilized the Open Access infrastructure to conduct a number of live discharge planning sessions throughout Alaska. These sessions allowed hospitalized patients and their API providers to connect with family members and service providers from the patient's home community or new setting (e.g., residential treatment facility or long-term assisted living facility) for continuity of care, service linkage, and daily living arrangements. All parties involved routinely cite live discharge planning as a successful and valued tool in transitioning hospitalized individuals back into their home communities or to new care settings. For example, partner-site patients participated in live discharge planning and attended their follow-up appointment back at home.

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Arizona



FY2010 TTI PROJECT:

Implemented a peer-based whole health program in the two largest metropolitan areas in Arizona, Maricopa and Pima Counties, to transform the behavioral health system into one that applies a holistic approach to health to increase longevity and quality of life, increase coordination of care between primary care and behavioral health, and increase participation in recovery through medical autonomy.

KEY OUTCOMES:

Pima County: Health and Wellness Center - Camp Wellness

The goal of Camp Wellness is to improve the health of persons with Serious Mental Illnesses (SMI) through 8 weeks of intensive health related education, skills training and peer support. Camp Wellness was founded through various partnerships, such as with the University of Arizona and several health & fitness centers. Camp Wellness is a place where individuals with an SMI can have a health assessment; develop health goals; increase health literacy; learn about diet and exercise; work with a mentor to learn how to shop and eat healthy; participate in relaxation classes and smoking cessation groups/classes; and learn proper use of fitness equipment and develop an exercise regimen.

Maricopa County: “For the Health of it” program

In Maricopa County, a peer-based whole health program was developed with the goal to improve whole health in the behavioral health consumer. Once trained, peer and family support staff provide an array of interventions and supports within each of the outpatient clinics, including but not limited to diet education and fitness activities; empowering individuals when communicating with their Primary Care Physicians; stress reduction groups and activities; sleep hygiene groups; and diabetes and oral health education. This program was designed to put the participant in the lead role of their individual Whole Health Plan.

Outcomes and Achievements:

Pima County: Health and Wellness Center - Camp Wellness

TTI funds were used to open Camp Wellness and successfully complete camps – including evaluation practices. Significant improvements were observed in the quality of life and health outcomes, including in the six minute walk test, the waist circumference and weight loss measurements. Analysis of the program’s impact beyond the initial eight week intervention and the participant’s maintenance of learned healthy practices will be conducted in the fall of 2011.

An important component of this program is to ensure that students apply what they learn and maintain their lifestyle changes. This has been accomplished through the work by the grant-funded Health Mentor, who works primarily with Camp alumni to ensure they maintain healthy lifestyles beyond their participation in the 8-week program. The Health Mentor continues to meet alumni at all local branches of the YMCA, and works with alumni who have had their Y passes revoked (due to lack of use) by offering them the chance to develop an individualized plan of supported physical activity to earn their pass back.

Another achievement is a stable pipeline of students. This has been achieved primarily through a TTI grant funded position which conducts marketing and promotional activities for Camp Wellness including presentations at service

providers' staff meetings, recruitment tables at providers' lobbies and distribution of posters and educational materials at providers' facilities. Having a position devoted to marketing dramatically increased referrals and resulted in increased enrollment and participation.

A video and website were developed to promote Camp Wellness and offer educational and informational resources to Camp students. Both video and website are vital components of recruitment presentations to service providers' staff and members. Camp marketing materials include the website address so members and providers can quickly download applications, learn more about the program and staff, etc.

Maricopa County: "For the Health of it" program

TTI funds were used to develop infrastructure for this program including training of Peer and Family Health Mentors, development of training materials for future mentors, design of supporting materials for program participants, and establishing evaluation and data collection.

Seventy-five peers were trained in whole health peer support by Larry Fricks and Ike Powell from Appalachian Consulting Group. This training has paid many dividends in terms of improved health outcomes. Based on Peer Support Whole Health developed by the Appalachian Consulting Group and the Georgia Mental Health Consumer Network, the Peer Support Whole Health Journal – "For the Health of It!" was designed and printed for use at all participating clinics. This is a 42 page journal for members to track their progress as they participate. It currently helps participants to: take ownership of their individual Whole Health Plan; develop and maintain efforts in reaching their goal(s); and document measurable results of the program.

The existing "Passport to Care" was redesigned and printed for use in this program and is being used at all participating clinics. This is a tool that looks like an actual passport and fits in your back pocket, is a ten-page "how to guide" for members, their families, and peers to start a dialogue with his or her medical doctor. It also contains information to access medical insurance and information about medications.

Data reporting and analysis tools were designed to ensure accurate and consistent measurement of outcomes among all participating clinics. At the clinic level, data collection takes place once a week during Whole Health group sessions. The collection method encompasses six measurable outcomes: Weight; Body Mass Index; Blood Pressure; Smoking Cessation; Increased Walking Distance; and Improved Sleep. The completed data sheets are submitted to the TTI Data Analyst on a monthly basis and entered into the Whole Health Database for tracking and reporting.

The most rewarding achievement is the positive impact in our members. From April 2010 to March 2011, there were a total of 659 encounters at 13 clinics with a total of 131 participants. Approximately 25 of these individuals reduced their high blood pressure to within normal range while participating in the program.

Remarks:

Learning from the past year has enabled Arizona to make improvements and explore ways to develop practices for integrated care in Arizona. A blueprint for implementing the Maricopa Whole Health Initiative has been in discussion and 14 essential elements identified for this integration model. Camp Wellness is gaining recognition outside Arizona as a model for integrated care. All of the TTI grant-funded positions mentioned above have been essential in improving recruitment, retention, community integration for students and alumni of Camp Wellness and establishing evaluation practices at both programs. Going forward, these positions will be retained and funded by the contractors and partners. Arizona also has the infrastructure in place for billing and encountering health promotion, peer support, skills training and transportation services so that they are reimbursable through Medicaid. The programs continue to create new partnerships, including one with the Arizona Smokers' Helpline (ASHLine). In addition, with oral health being a key component of each project, the State of Arizona has signed a MOU with the Arizona School of Dentistry to place whole health peer specialists at the school and its clinic to assist and educate Dental Students.

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Arizona



FY 2012 TTI PROJECT:

Training trainers to teach peer-support specialists about chronic disease self-management planning

KEY OUTCOMES:

The Arizona Department of Health Services Division of Behavioral Health Services (ADHS/DBHS) initiated a work-force development program in 2012 to train the behavioral health peer-support specialists, peers and their family members to self-manage chronic illnesses, with priority given to those with SMI. Self-management programs help individuals gain self-confidence in their ability to control symptoms and manage their chronic diseases. Objectives of the TTI project were:

- 1) To increase self-management of chronic illnesses among Arizona peer-based workforce, peers and their family members (with focus on population with SMI).
- 2) Create the process and mechanisms to identify and refer peers into workshops and an educational module to train providers in recruitment and referral.

Why a Chronic Disease Self-Management Program in Arizona?

Studies have shown that people with mental illness have higher standardized mortality rates than the general population from chronic illnesses. For example, they are 2.7 times more likely to die from diabetes than the general population. For cardiovascular disease this rate is 2.3 times and for respiratory disease this is 3.2 times. We also know that at least 75% of individuals with a serious mental illness (SMI) have a chronic medical illness. Medical illnesses are more likely to go undiagnosed or misdiagnosed in individuals with SMI. Compared with the general population, individuals with SMI engage in fewer health promoting behaviors; are less physically active than the general population; are 50% more likely to be overweight; are more likely to take medications that can induce insulin resistance; and smoke cigarettes far more than the general population. To address these disparities and improve the overall quality of life of people with serious mental illness in the public behavioral health system, ADHS/DBHS is transforming the way services are delivered into an integrated health approach. One important part of health integration is educating the behavioral health service recipient and the peer-based workforce in chronic disease self-management. Self-management programs help individuals gain self-confidence in their ability to control symptoms and manage the progression of several long-term and chronic age-related illnesses. Stanford University School of Medicine's "Chronic Disease Self-Management Program" significantly increases the self-confidence of adults when it comes to their health and managing their chronic illnesses.

Baseline

At the time this program officially began, in April 2012, there were 54 facilitators able to provide the CDSMP workshops through the behavioral health system in Arizona..

Current Status & Plans for the Future

As of May 2013, various key pieces have been accomplished including program planning, infrastructure development, and roll-out of the workforce trainings as well as several six-week workshops.

Planning:

- Project plan was developed and has been used in the implementation with minor adjustments.
- A diagram was developed to provide a visual of this program. It has been used during meetings with stakeholders to discuss the overall initiative.

- Two categories of trainers have been trained – master trainers and lay leader trainers. Master trainers allow Arizona to train additional trainers as Arizona sees fit; lay leader trainers teach the 6-week sessions to peers and stakeholders statewide.

Recruitment and Referral Infrastructure:

- Informational materials were produced and used to promote (recruit) target candidates to become Healthy Living CDSMP Lay Leaders (facilitators).
- A recruitment and promotions plan was developed and implemented to recruit candidates statewide.
- An online application specifically for this program, referred to as “the DBHS scholarship for healthy living lay leaders”, was developed. Over 90 applications were received overall, and after review 72 applicants were found to be eligible. Of those 72, 60 were selected and 53 trainers ultimately completed the 5 day course which permitted them to become trainers.
- A tracking system for the six-week workshop registration was developed.
- A data-entry system was developed for the six-week workshops. This system helps track information about workshop participants including numbers of participants who entered the workshop versus those who completed the workshop, attendance records, in-class surveys, post-class surveys, evaluation information, as well as demographic information.

Trainings:

- A Healthy Living (CDSMP) Master Training was held August 20-24, 2012 in Phoenix. Two master trainers emerged, and they ensure project sustainability as they will become advisors to the program in addition to their master training responsibilities which include conduct trainings of lay leaders, monitor lay leaders trained for fidelity to the program, coach and mentor trained lay leaders.
- Healthy Living (CDSMP) Leader Trainings occurred throughout Arizona to accommodate the DBHS scholarship recipients. These trainings occurred statewide, including at Apache Junction, Tucson, Show Low, Casa Grande, Sierra Vista, Cottonwood, Kingman, West Valley and Phoenix.

Workshops:

- The six-week Healthy Living (CDSMP) workshops have begun to roll-out by some of the recently certified Lay Leader facilitators as well as other Lay Leader facilitators not certified under this program but who have become available to this program through partnerships.
- To date, twelve six-week workshops have been completed that were fully facilitated by scholarship recipients, with 68% of the students completing all six workshops (nationally this rate is 70%).
- Three more of these workshops are currently underway and will continue throughout the year as these new facilitators become more experienced.

Licensure:

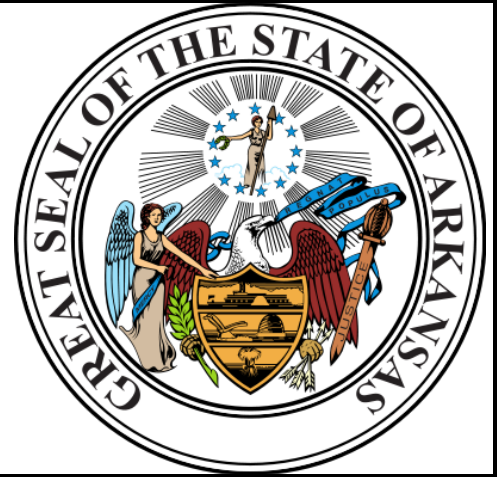
- ADHS/DBHS has become licensed by Stanford University to conduct the CDSMP six-week workshops both in English and Spanish.

Arizona expects that this program will continue to see success as the timing and the environment for this kind of program in our state is very beneficial. Behavioral health service providers are showing increased interest in having our workforce trained and certified to provide the six-week workshops at their employer sites and to be able to offer CDSMP as part of the peer support specialist services. Arizona expects to be able to increase the workforce trained (and the number of workshops offered) beyond the TTI-grant period due to the infrastructure we have developed that not only includes online systems but also various key partnerships that will help us propagate the program and reach our overall objectives.

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Arkansas



FY2010 TTI PROJECT:

Consumer empowerment through the creation/strengthening of a statewide consumer network.

KEY OUTCOMES:

The flexibility of this grant to tailor it to the specific needs of the State has made this an extremely effective grant. With the funds provided, Arkansas has made significant progress toward transforming its mental health system. The work initiated through the grant will continue even after the grant ends through state and private funding – such as through combining several funding streams to bring a second round of leadership training and train-the-trainer programs to the State. A second consumer conference is now in the planning stages, and private fund raising activities are underway. The tracking of local consumer councils through the Division of Behavioral Health Services contracts and annual reporting requirement will assure continued efforts and attention. Possible changes in Medicaid to fund peer supports will provide even more momentum for system changes toward recovery.

Outcomes Accomplished:

1. An active consumer council in each of the State's fourteen Community Mental Health Centers and three Specialty Clinics

Consumer councils now currently exist, or are in the formation stage, in all of the CMHCs and Specialty Clinics. Consumer council representatives are in contact with Division of Behavioral Health staff and Mental Health Council staff regarding the continual evolution of these councils. DBHS has modified CMHC and specialty clinic contracts to require them to report annually on their consumer councils including average attendance, meeting schedule, method of selection of consumer council leaders, communication pathways to and from the Center's Board of Directors, and policy changes based on consumer input.

2. First statewide Consumer Conference

A statewide consumer conference was held November 9th – 10th in the capital city of Little Rock. Approximately 200 people attended. All CMHCs and two of the three specialty clinics were in attendance. Melinda Davis spoke on the formation of the Advocacy Initiative Network of Maine. Dr. Dan Fisher spoke of his recovery journey and its impact on his current professional and personal life. David Granirer provided a lively comedy show "Stand Up For Mental Health". Local speakers presented on the history of the consumer

movement in Arkansas, legislative advocacy, voice and choice, growing and nourishing your network, psychiatric advanced directives, trauma-informed care, and collaborative planning. Time was allotted for regional contacts and planning for next steps.

3. At least one regional meeting in the five regions of the State to include representatives from behavioral and physical health, rehabilitation, higher education, local policymakers, and other entities as appropriate

Six regional meetings were held; five regions were initially planned but transportation issues for one larger CMHC necessitated a sixth meeting. Each regional meeting had a different mix of community partners, including social security, community colleges, physical health agencies, rehabilitation agencies, department of human services, advocacy staff, department of corrections, area agency on aging, prosecuting attorney's office staff – victim witness program, and housing authority. Consumers were able to meet and talk with other consumers and community partners. Next steps discussed included future regional meetings.

4. A strong foundation of recovery principles and commitment by consumers and providers leading to concrete steps toward a recovery-based behavioral health system

Recovery concepts were discussed at each venue. Consumers, providers and community partners are much more knowledgeable about recovery. This process must continue so that all consumers and providers are not only aware of, but are providing and participating in recovery-focused activities and treatment. DHS has established a "Recovery Oriented System of Care" Committee made up of numerous divisions including Behavioral Health, Medicaid, Developmental Disabilities, Aging and Adult Services. This committee is expanding on some of the lessons learned through the consumer movement.

5. A strong state-wide consumer voice

The consumer voice in Arkansas has gained significant strength over the past year. The TTI grant has provided the foundation for significant "grass roots" advocacy by behavioral health consumers. The Mental Health Council of Arkansas coordinated a "Hill Day" for behavioral health to highlight relevant issues during the recent legislative session. 191 consumers participated, including at a House committee meeting and were recognized by the Chair as special guests. This grass roots participation in the legislative process served to empower the consumers and helped them to realize the true voice they have in the process.

6. Evaluation surveys from each regional meeting to determine service gaps or areas for growth and coordination

Evaluation surveys were obtained from participants in all of the regional meetings. Information obtained from these surveys, and other consumer groups, has served as a guide for current recommendations on the development of a 1915(i) state plan amendment to offer services noted as lacking such as supported employment and peer support services.

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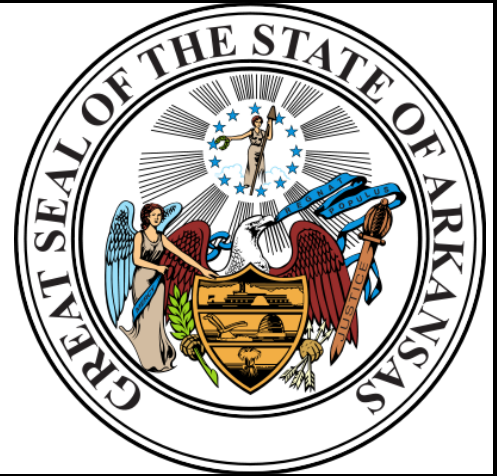
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Arkansas



FY2012 TTI PROJECT:

Consumer empowerment through strengthening of a statewide consumer network and statewide outreach

KEY OUTCOMES:

Began a Core Consumer Group monthly teleconference among staff of the CMHCs, consumer members of the councils, Division Advocate, and Staff at the Mental Health Council. This meeting is used to coordinate initiatives and to elicit and give support for strengthening the councils. This core group was essential in coordinating the May 11 Mental Health Awareness day and participation at the Mental Health Institute in August. Presently this group is part of the input, planning and support of the 3rd annual Consumer Counts Conference. This core group is increasing its members and will continue to be an intricate part of the incentives set to be coordinated by its members. Even after well over a year of meetings the monthly meetings remain very well attended.

Established a Leadership Academy/Train the Trainer work study support group council. Held at the Division of Behavioral Health. The council meets weekly to study the curriculum of the Leadership Academy. The participants initially reported that they didn't feel competent to present the materials from just attending the 3 day train the trainer training. Having this regular group meeting has met the participants' need to get more familiar with the materials. This enables them to be a local resource for others as they prepare to engage the consumer councils throughout the state.

Key Activities:

Mental Health Awareness Day Rally, May 11, 2012.

- Monthly Consumer Council Conference Calls were held to discuss Mental Health Awareness Month proclamations in local areas and at State level. Public Service Announcement for Mental Health Awareness Month was edited, completed and began running May 8th. There were 75 spots devoted to the PSA. It has been posted on websites and Facebook.
- Advertising on city buses with stills from the PSA were produced.
- Mental Health Awareness rally was held at the State Capitol and attended by over 400 people (including 250+ consumers) including representatives from Consumer Councils from around the state. Speakers included the Governor of the State of Arkansas, the Director of the Division of Behavioral Health, a Consumer Advocate leader. Consumer Councils displayed banners that they designed. Lunch was served to all attendees.

Legislative Outreach Day. March 7, 2013.

- 152 attendees, including 83 consumers.
- Letter campaign by consumers to legislators regarding healthcare reform and Medicaid reform.

Rally for Mental Health Reform. May 9, 2013.

- Also held in 2012.
- Held on front steps of Arkansas Capital.
- Accompanied by Governor Proclamation.
- Multiple mayors and other government officials in attendance.
- Significant media coverage both years.

Projected next steps

- The Mental Health Council of Arkansas will host a third annual Consumer Counts Conference (annual attendance is roughly 250 consumers) on November 26-27. Members from each consumer council group will be invited to attend. The state council group will meet again to further discuss and plan what supports each council’s growth and ways to communicate more efficiently with each other. Larry Fricks, Peer Services Vice President DBSA, has been scheduled to be keynote speaker and will also make time available to meet with CMHC staff members for a Q&A session in order to clarify peer support specialist roles and provide resources for further learning on the subject.
- The Consumer Advocate will continue to meet weekly with the Leadership Academy/Train the Trainer work group to strategize next steps for consumer engagements\trainings.
- Consumer advocate will continue to meet with Consumer Councils.
- An information curriculum tool kit will be developed to help support, guide and smooth over some of the consistent challenges the council groups have been experiencing.
- Continue to plan for Leadership Academy classes on a regional level.
- Continue technical assistance and consultation with consumer councils statewide to assist in further development of the local councils.
- Continue to meet with CMHC and Clinic staff, Leadership Academy and Train the Trainer graduates to facilitate council development and coalition building.
- Consumer Advocate continues to meet with agency leadership from sites to discuss sustainability of Consumer Councils.
- Collaboration with AR Department of Health Smoking Cessation continued and beginning to establish support groups for peers at CMHs.
- Mental First Aid training – to be held in four regions throughout the state.
- Conducting regional Arkansas consumer leadership classes of 8-10 consumers per class.

Challenges:

Communication network between councils groups fragmented. Many agencies have silo clinics which make meeting together a challenge. Local resources for consumers are limited or nonexistent.

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Colorado



FY2009 TTI PROJECT:

Assistance to the Governor's Behavioral Health Cabinet in facilitating the integration of Colorado's public behavioral health system. This project will establish a planning and implementation process for this transformation that includes the Behavioral Health Cabinet (Corrections, Medicaid, Human Services, Employment, Local Affairs, Public Health, and Public Safety), and a Behavioral Health Transformation Council comprised of departmental staff, consumers and stakeholders.

KEY OUTCOMES:

- Over 75 regional forums conducted in cities across the state and via videoconferencing, to solicit input to the planning and implementation process, were attended by more than 550 Coloradans. The following groups were involved in the planning and participation of these forums: (1) Consumers, (2) Parent/Caregivers, (3) Adult Family Members, (4) Youth, (5) BH Providers, (6) Law Enforcement / Adult Corrections, (7) Juvenile Justice / Child Welfare / Schools, (8) Primary Care / Public Health, (9) Community / Business / Advocacy Leaders.
- A statewide Behavioral Health Transformation Council was developed to inform and advise the Governor's Behavioral Health Cabinet. Membership includes over twenty-five entities representing Consumers and Families, Providers, Advocacy, State Agencies, and non-behavioral health stakeholders. This group is developing specific implementation plans in four key areas: under 21/prevention; criminal justice; continuity of care; and sustainability.
- Legislation is being drafted for the next legislative session to codify the TTI work and outcomes. In addition, an Executive Order from the Governor as well as a Chief Justice Directive from the Judicial Branch are being considered to model collective leadership concerning behavioral health issues among the three branches of government.
- Input from the Governor's Behavioral Health Cabinet, which meets bimonthly, has contributed towards the protection of the Division of Behavioral Health's budget (Mental Health and Substance Abuse) despite overall cuts to state agencies totaling \$1.4 billion.
- Work continues on developing a plan to secure funding, staff, and other supports necessary to sustain the planning and implementation process established by the Behavioral Health Cabinet.

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Colorado



FY2012 TTI PROJECT:

Supported Employment

KEY OUTCOMES:

Colorado's TTI project focused on expanding employment opportunities for consumers with serious mental illness (SMI). To achieve this, the Office of Behavioral Health (OBH) pursued a two-pronged approach that included creating a marketing strategy, materials, and implementing a training and support system for evidence based supported employment programs. The development of a Metro-Denver Employers' Council was considered as a mechanism to inform employers about the mental health consumer workforce, identify employment opportunities, engage employers in providing training and orientation to consumers on basic job skills and expectations, and market the program's success. However, as efforts to develop this council progressed, it became clear that other marketing approaches would be more beneficial, especially given the interest in Colorado to expand supported employment to other more rural parts of the State.

The support system for employment programs was developed with guidance from the Dartmouth Psychiatric Research Center (PRC) and refined through trainings provided to the employment staff at three Community Mental Health Centers (CMHCs) on implementation and ongoing support of the Individual Placement and Support (IPS) model of supported employment. This evidence-based practice has shown consistently positive outcomes and is currently being delivered in three CMHCs in the Denver/Boulder area: Mental Health Center of Denver (MHCD); Jefferson Center for Mental Health (JCMH); and Mental Health Partners (MHP). In addition to providing assistance to the supported employment programs in metro Denver/Boulder, the resources provided by this grant also provided initial funds to support the expansion of supported employment to three to five of Colorado's rural and frontier regions. To accomplish these goals, the OBH worked with the Western Interstate Commission for Higher Education (WICHE), which has expertise in public mental health programs and services, job development and marketing.

This project effort worked synergistically with another grant-funded project. In September, 2010, the Colorado Office of Behavioral Health was awarded a five year Mental Health Transformation Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the grant is to transform Colorado's community mental health system by expanding and enhancing evidence-based supported employment and education services for individuals with serious mental illnesses using the evidence-based IPS model. The TTI project provided an important adjunct by expanding the base of available employment opportunities in the Denver area through the development and distribution of marketing materials. The IPS Trainer worked extensively with employment staff at the three centers to develop a training model aimed at increasing the effectiveness of the programs that could be used for new adopters in other regions of the state. Over time, these efforts have the potential of increasing the number of consumers served through the Wellness and Recovery for Thousands through Employment and Education (WRKE) project, as well as offering consumers increased choice and a better job match, which could ultimately extend the duration of employment and increase job satisfaction.

The Office of Behavioral Health continues to explore the potential of partnering with the Johnson & Johnson-Dartmouth Mental Health Program. The program's purpose is to increase access to evidence based

IPS supported employment services. This program emphasizes collaboration between the state's vocational rehabilitation program and the mental health authority and provides ongoing technical assistance and consultation. Should this partnership occur, it will provide additional resources to expand supported employment in Colorado.

TTI Activities & Accomplishments:

Supported Employment Program Marketing Development

- Prior to starting initial drafts of the SE marketing materials (brochure, website, DVD), employment staff from MHCD, JCMH and MHP was asked for input regarding preferences, needs, target audience, etc. Those suggestions were incorporated with agency observations and Dartmouth information to produce the most efficient marketing message for Colorado. In addition, approval was received from Dartmouth PRC for use of their IPS materials in new Colorado SE marketing and implementation materials.
- A comprehensive Supported Employment guide was developed with tools and information to help Colorado mental health centers with new IPS programs, as well as to help enhance existing programs. The guide was compiled with materials from Dartmouth PRC, along with a “Colorado Implementation Lessons” section, which identifies specific challenges and lessons learned from the three CMHCs that are currently practicing IPS. The guide was produced on an electronic zip drive, and 20 copies were duplicated for distribution to interested CMHCs throughout the State.
- A marketing brochure promoting Colorado's Supported Employment Program was written and produced in coordination with WICHE's graphic design staff. The four-color, tri-fold brochure highlights the benefits of the SE program to both job seekers and employers, with a focus on key SE principles. One thousand copies are available for distribution to target industry employers, Chambers of Commerce, CMHCs, consumers, and other stakeholders throughout the State.
- A total of 250 marketing DVDs have been produced. They include video and other relevant materials from Dartmouth PRC, as well as local information. Video clips of local consumers were collected by sharing resources from the local mental health centers and DVR. The DVDs are being used as a supplement to the marketing brochure and in presentations to target employers or Chambers of Commerce.
- Based on local observations, knowledge of the local market and specific recommendations from MHCD, JCMH and MHP employment staff, a list of target employers has been compiled to use in marketing efforts. In an effort to expand recognition and support for the SE program throughout the State, the list is primarily focused on Colorado-based businesses, as well as larger chains with multiple locations.
- A webpage on the OBH website dedicated to supported employment has been developed to disseminate information to stakeholders. The webpage has a link to the participating local CMHCs, Colorado DVR, as well as the Dartmouth IPS website. The webpage address is: <http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251631987055>
- A full-day supported employment training occurred in Durango, CO in October 2012 as part of the expansion of activities into other parts of Colorado.
- Job development trainings occurred at the MHCD and JCMH.

Workforce Development

- Following the IPS training course at Dartmouth Psychiatric Research Center (PRC) in January, 2012, initial activities were focused on getting to know the three participating mental health centers at MHCD, JCMH and MHP and how the IPS model is interpreted and implemented at the local level. This included interviews with management and Supported Employment (SE) Supervisors at the three MHCs, as well as with leaders at OBH and OMNI.
- The CMHC's paperwork and practices were compared to the Dartmouth IPS procedures, and recommendations were made to each agency for improving documentation.
- Based on input from the three CMHCs, a “fundamental” IPS training program was developed to include all key principles and essential elements for practicing the IPS model, with room for tailoring the training to the

specific requests of each group. These training materials are the core for use in IPS training for expansion sites.

- Comprehensive, full-day IPS trainings were conducted with all three participating SE teams and supervisors. Training sessions on “helping clients with criminal histories” and “sales and developing employer relationships” received very positive feedback.
- Ongoing IPS support was provided throughout the year, primarily via email, to assist agency staff with specific questions regarding IPS Fidelity. For example, what specific forms are required to achieve good fidelity scores, how local employment rates compare to the national data collected by Dartmouth, where to find specific information on the Dartmouth website, etc.
- OBH attendance at the IPS train the trainer course at Dartmouth Psychiatric Research Center (PRC) occurred in February 2013. The DVR statewide supported employment coordinator was unable to attend due to illness, but will attend the next training at Dartmouth in August 2013. This will bring to three the number of Dartmouth trained IPS trainers in the state.

Challenges & Key Project Changes:

- When approaching the three CMHC employment teams regarding their employers, they were very protective of releasing-employer names and contact-information. Disclosure is a BIG-issue, especially for the newer programs at MHP and JCMH. Therefore, the original concept of compiling a database of current employers was changed to focus on identifying businesses that the CMHCs would want to target for marketing purposes, focusing on Colorado-based companies. Marketing materials are being mailed to these target businesses, with additional materials supplied to both participating and prospective mental health centers. Thus far, over 50 such employers have been identified. This includes recruiters and Chambers of Commerce.
- A survey of employers currently participating in supported employment was originally developed to solicit feedback on program performance and identify areas for improvement. However, after discussing this with the employment teams, the issue of disclosure was again raised. Consumers do not always want to their employers to know they are in treatment. Therefore, many employers don't know they have employees with SMI working for them. This creates a significant discrepancy when approaching employers for information; specialists manage their employer relationships on a case-by-case basis. Given this, it was determined that employer surveys would not provide sufficient data. The survey document was shared with the interested SE supervisors, to distribute and solicit feedback for their respective programs as they like.
- In addition, during the TTI Leadership and Sustainability Conference in August, Colorado attendees shared the challenges faced with the employer survey and Employers' Council. Feedback from other states acknowledged that this is not a Colorado-specific issue. They were encouraged to engage in other marketing activities to expand the reach of SE in the state.

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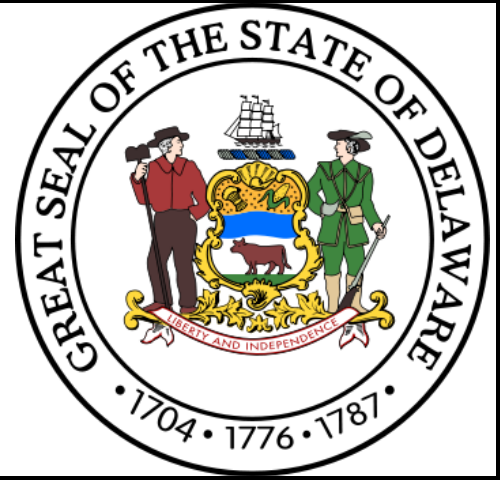
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Delaware



FY2011 TTI PROJECT:

Paving New Ground: Creating a Recovery-Oriented System

KEY OUTCOMES:

1. Provide support and direction to the “budding” Delaware state consumer network
 - Hired network executive director in March, 2012.
 - The group has developed goals and objectives in the framework of a strategic plan.
 - The state-wide consumer group is now incorporated. It is working on becoming a 501 (c) 3 non-profit organization. The Director of the Office of Consumer Affairs continues to attend each monthly meeting. A sub-committee met with Steve Dettwyler, Director of Community Services, and communicated their proposal for funding priorities, many of which are part of Delaware’s agreement with United States Department of Justice (USDOJ).
 - The peers Delaware hired under the trauma grant started to attend the meetings.
 - One member presented a letter to the governor about the list of consumers compiled by law enforcement to identify consumers who have been involuntarily civilly committed. As a result the commitment law is being rewritten to a 24 hour standard.
2. Build on the initial integration of the employed Peer Specialists at the state hospital to provide hospital onsite services as well as Bridge Peer services that follow individuals upon their discharge from the hospital to assist them in their re-entry, as well as to identify gaps in services.
 - These initial Peer Specialists have been hired and funded with existing, sustainable funds. With the complement of the TTI funds, the Peer Specialists will be able to further leverage their efforts.
 - Continued work on a community re-integration services program, which works with hospitals on re-integration into the community.
 - ACT teams revised so that they are truer to the ACT model. Delaware hopes to have 8 teams following the revision. Teams are also adding performance measures to ensure faithfulness.
 - Peer specialist training held June, 2012. 20 consumers, to be hired as peer specialists and who are volunteering at our consumer run peer center, attended. These individuals will become either peer support specialists in the hospital, bridge peer specialists in the hospital and community, and trauma peer specialists in the community. Stipends created to sustain them until Delaware’s H/R system can get them hired.
 - New inpatient peer specialists will be hired over time, and more bridge peer specialists will be hired immediately. Because of the demand for bridge peer specialists we know we need more soon. They work with individuals in our system as they transition from one level of care to another. Most of the demand is for hospital

The TTI award was instrumental for both improving the state system and for showing the recovery orientation demanded by the DOJ investigation.

patients that are being discharged to the community, supported by the Olmstead decision. The agreement with the USDOJ will result in many more peer specialists in our system. Delaware is working on a data system to help track and evaluate this program. The Bridge Peer Program currently has 7 bridge peers and 1 team leader. They are getting more and more referrals and consequently are going to increase the size of the staff. The U.S.D.O.J. is staying informed about workload and staffing to insure that Delaware will be able to discharge hospital clients and give each discharged person a peer specialist to help them integrate into the community.

3. Supported statewide conference, named: "Living out Loud: the Magic of Transformation". The conference was held on 9/9/11. Close to 350 consumers attended.

4. Developed and implemented performance measures for all DSAMH community contracts that clearly delineate the expectation for all providers, state or private, to employ consumers in key roles. This included meeting with the director of our quality performance and contract monitoring office to discuss how Delaware can make sure that peer specialists are treated as professionals. Have now hired 8 trauma peer specialists to work in clinics. They are state employees and will do work relevant to the related trauma grant. There are plans to hire 8 more who will work in case management agencies. Several other agencies have hired peer specialists on their own.

5. Delineated and implemented the expectation of Peer inclusion through the DSAMH licensing and certification Department. This includes embedding and distributing licensing and certification standards in all DSAMH programs, and monitoring that agencies follow these standards. One such example is meeting with all clinics so that they understand and implement standards regarding peer specialists, job responsibilities, and the need for clinical supervision.

6. Trained DSAMH staff on the importance of integrating Peers in all services DSAMH provides and eventually incorporate these understandings/expectations into their respective job descriptions. This goal was accomplished by specific trainings by Peers and senior DSAMH leaders conjointly and included the development of curriculum training and fully revised policies, procedures, and forms where necessary. Training was done in two half-day segments.

7. Created a Peer Run Art Resource Center Program called the *Creative Vision Factory*. The Art Program has been a long-term goal of the Division. TTI funds helped pay for a director for the Art Program and create an advisory board. Delaware will continue to contract with the director once this grant award ends.

SUMMARY

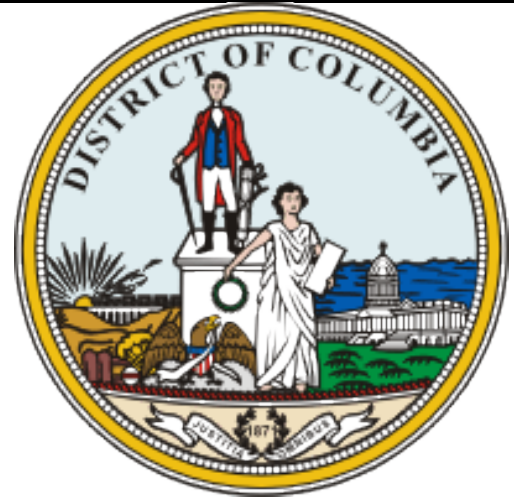
Delaware now has more than fifteen peer specialists working in three unique programs: the inpatient peer support specialists, the bridge peer program and trauma peer specialists. Delaware also has plans to hire up to eighteen more peer specialists. Delaware has combined funding from TTI and Trauma grants to meet the training needs and stipends to support the peer programs. Eventually through a combination of hiring state and private peer specialists, Delaware will have peer specialists in all of community and inpatient programs/agencies.

Statewide Delaware now has an Art Center, as well as several consumer resource centers run by consumers and funded by either the state or local outpatient agency. Delaware has a state-wide consumer network meeting monthly; our vision for that group is that it will become independent, involved in advocacy and running some programs such as the consumer satisfaction survey.

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District of Columbia



FY 2010 TTI PROJECT:

Improve access to primary health care for individuals with chronic mental illness by expanding an existing project to co-locate primary health care practitioners with community mental health providers and also by incorporating peer specialists as "health navigators" to help consumers to take advantage of primary health care services.

Activities:

- DMH originally planned to contract directly with two mental health clinics to expand the scope of the Chronic Care in Mental Health (CCI MH) project that was funded through a grant from the District's Department of Health (DOH). The DOH CCI MH project is managed by George Washington University School of Public Health (GWU) in collaboration with the Washington Hospital Center Diabetes Education Program (WHC). The focus of the CCI MH project is to develop models for how to best provide primary care to persons with diabetes and severe mental illness. WHC provides the nurse practitioners and the diabetes education, while GWU focuses on the project coordination and research aspects of the project.
- Although several mental health providers expressed interest in participating, only one submitted a proposal in response to the RFP and subsequently withdrew the proposal when they were unable to establish partnerships with a healthcare network to provide the physical health services. As a result, DMH worked with DOH to use the funds to expand the CCI MH program, with some funds going to GWU via a modification of the existing DOH grant agreement and the remainder going directly to WHC via sub-grant from DMH. The project expanded to include the mental health programs operated by Anchor Mental Health and the Trinity Square clinic which is affiliated with WHC.
- DMH also worked with GWU and WHC to develop and present a grand rounds style of training for psychiatrists and nursing personnel at each clinic site (four sites) and Saint Elizabeth's Hospital. Training was conducted on November 30, 2010 and December 1, 2010. Andrew Kolbasovsky, PsyD, MBA, who has implemented integrated care models in New York and published on the subject of integrating behavioral health and primary care, was the speaker. CEUs were offered for psychiatrists, nurses, social workers, licensed professional counselors and psychologists for the grand rounds presentation at Saint Elizabeth's Hospital. The training was well attended by program staff and also hospital staff. Suggestions for future training and activities that resulted from this training are described below.

Lessons Learned:

- Many mental health consumers in the District are "linked" to primary care services, although the collaboration between the mental health clinic and the primary care clinic is not consistent.
- One model does not work for every community-based provider in the District. The level of readiness among the District providers has varied widely. For example, one of the original sites (from the DOH Chronic Care Initiative grant) dropped out of the project in September because they felt the burdens of participating and referring consumers for the nurse practitioner to see were too great. However, the other original site has asked to expand the number of peer specialists working on the initiative (from two to three).
- Medicare reimburses for diabetes education, however, the District's Medicaid program does not. DMH will be working with the Department of Health Care Finance (DHCF) to try to address this issue.
- The District's Medicaid program does not reimburse nurse practitioners to draw blood for purposes of CLIA waived testing at off-site locations, such as mental health clinics. Instead, phlebotomists are used (which is actually more costly). DMH will be working with DHCF to try to address this issue.
- Training about physical health - diabetes education is needed for front-line staff.
- Peer specialists have been a great addition to the team and have been particularly helpful in coordinating and linking consumers to the diabetes education and wellness training conducted at the clinics.

Future Plans:

- Continue the project through the end of FY 2011 and evaluate progress in obtaining Medicaid reimbursement for diabetes education and blood draws by nurse practitioners.
- Complete implementation of peer specialist program by DMH which will facilitate Medicaid billing by peers participating in the CCI MH project.
- Offer Health Administration Responsibility Project (HARP) training for peer specialists.
- Offer additional training to frontline staff regarding management of physical health conditions and diabetes education.

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Florida



FY2008 TTI PROJECT:

Development of Recovery and Resiliency Task Forces in Florida's six regions.

KEY OUTCOMES:

- Development of a recovery and resiliency task force in all six regions.
- Twelve two-day recovery and resiliency trainings (two in each region) with over 500 consumers attending.
- A recovery and resiliency task force meeting in each region.
- A statewide advanced leadership training for 34 consumer leaders across Florida.
- Two Certified Peer Specialist Trainings producing fifty new Peer Support Specialists.
- A statewide Certified Peer Specialist Train-the-Trainer three-day training for fourteen participants, including one person from each region.
- A statewide peer support sustainability conference is being planned.

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Florida



FY2010 TTI PROJECT:

2059 participants attended six regional seminars on Trauma-Informed Care (TIC) throughout Florida.

KEY OUTCOMES:

Six regional seminars were held in Tallahassee, Jacksonville, Tampa, Orlando, Miami, and Boca Raton (one seminar in each of the Department's six administrative regions). Seminar participants included a broad range of stakeholders in Florida's mental health system, including mental health consumers, family members, advocates, executive and clinical staff of mental health provider agencies, other mental health professionals, staff of other social service and advocacy organizations, Department staff, and staff of other state agencies. A total of 2059 participants attended the six seminars.

The first day of each day-and-a-half seminar featured presentations provided mostly by staff of the National Center for Trauma-Informed Care (NCTIC): Tonier Cain, Dr. Joan Gillece, David Washington, and Dr. Tim Tunner. Additional presentations were provided by Dr. Shairi Turner, Deputy Secretary of the Florida Department of Health (DOH). These presentations covered the profound psychological and biological impact of traumatic experience and concrete strategies for implementing trauma-informed care. The seminar agenda was developed by the Department in consultation with NCTIC staff.

The second day of each seminar (a half-day), served as the initial meeting of local trauma informed care strategic planning workgroups. These groups include diverse mental health stakeholders and have begun meeting regularly since the seminars. These workgroups have been tasked with authoring strategic plans to implement trauma-informed care for their respective local areas. These plans will be reviewed by the circuit, regional, and central offices of the Department as a basis for potential policy changes and new, trauma-related initiatives.

The Department contracted with the Florida Peer Network (FPN) for outreach, participant registration, event planning, travel reimbursement processing, and related services. Headed by a mental health consumer and advocate, Executive Director Rose Delaney, FPN is the only statewide mental health advocacy organization in Florida that is controlled by mental health consumers. (FPN's bylaws require its board to include at least 51 % mental health consumers.) Placing a consumer-controlled entity in this key role emphasized the importance of consumer empowerment in trauma-informed care, and lent credibility to the outreach effort toward consumers, family members, and advocates.

A total of 2,059 participants attended the six regional seminars. Mental health and substance abuse providers were 27.4% (565) of the participants. This category includes executive and clinical staff of provider organizations, as well as clinicians in private practice.

Department of Children and Families staff were 11.2% (231) of the participants. This includes central office, regional, and circuit staff, as well as staff of state mental health treatment facilities. Department of Juvenile Justice staff were 26.8% (551) of the participants. Other government agency personnel were 2.4% (49) of the participants. State agencies represented included the Department of Health, the Department of Elder Affairs (DOEA), and the Agency for Health Care Administration).

Staff of Community Based Care providers (CBCs), which provide child protective services under contract with the Department, were 11.6% (238) of the participants. Judicial and criminal justice system personnel were 2.6% (54) of the participants. This includes judges, magistrates, law enforcement officers, and the staff of courts and of the offices of state attorneys and public defenders. Department of Education and school personnel were 0.9% (19) of the participants.

Staff of other private social service and advocacy organizations were 12% (247) of the participants. This includes mental health advocacy groups, children's advocacy groups, domestic violence shelters, assisted living facilities, and many other types of organizations.

New local strategic planning workgroups were launched at the seminars, collectively covering the entirety of the state. Each workgroup is responsible for creating a strategic plan for its own local area. Having benefited from the assistance of department and consumer facilitators at their initial meetings, these workgroups have now selected their own leaders and have begun meeting regularly (monthly, in most cases). Though twenty-two workgroups were originally planned, several groups consolidated with others in their area, yielding a final count of seventeen.

These workgroups include a diverse array of stakeholders in the mental health system, including consumers, advocates, professionals, and the executive staff of provider agencies. Each workgroup is intended to be highly autonomous and responsive to the needs of the local community. The workgroups have been encouraged, where appropriate, to merge with other, related workgroups, task forces, or similar groups. Workgroups are keeping minutes of their meetings and sharing these with the Department. All strategic plans were completed by March 1, 2011.

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Georgia



FY2009 TTI PROJECT:

Integrating whole health concepts into Georgia's Peer workforce with the development of peer support whole health services.

KEY OUTCOMES:

- Conducted Peer Support Whole Health Pilot Project Training (PSHW), in conjunction with Appalachian Consulting Group, on January 28 and 29, 2009 in Macon, Georgia. There were 33 training participants, including 18 Consumer Participants from the two Pilot Sites, 12 Certified Peer Specialists, and 3 APS Healthcare Employees.
- Eight Week Peer Specialist Whole Health (PSWH) training and programming occurred at two Peer Center Pilot Sites. The Training included consumer participants setting whole health goals, inclusion of these goals in their Individual Service/Recovery Plans and beginning work toward attainment of whole health goals.
- Worked with Wendy Tiegreen, DMHDDAD Medicaid Coordinator and key staff of APS Healthcare (DMHDDAD's external review organization), to conduct an audit of the progress notes charted on participants in the 8 week PSWH pilot study, as well as the detailed audit report, which is to discuss characteristics of notes that do or do not pass Medicaid criteria. This is a huge first step in Whole Health Peer Support being Medicaid billable in Georgia.
- Some of the critical points recognized within the audit findings include:
 - Whole health must be integrated into the entire behavioral health system.
 - Assessment forms must include information related to whole health.
 - Clinicians must be trained to integrate whole health goals into treatment service planning.
 - The pursuit of whole health and wellness should be incorporated into Behavioral Health care in a manner similar to employment, housing and meaningful community life.
- Five Regional (PSWH) Mental Health Provider meetings (with over 150 provider attending):
 - Region 1 – July 7, 2009 – Rome, GA
 - Region 2 – July 8, 2009 – Athens, GA
 - Region 3 – July 14, 2009- Atlanta, GA – The Carter Center
 - Region 4 – July 21, 2009 – Cordele, GA

Region 5 – July 23, 2009 – Savannah, GA

- Over 10% of Georgia's CPSs (63) participated in a total of three two-day PSWH training of trainers.
 - Conducted PSWH CPS Training at Callaway Gardens on May 27 and 28, 2009. Twenty CPSs and two older adults from the Fuqua Center on Late Life Depression completed the two-day training.
 - Conducted a TTI PSWH CPS Trainers Training at Simpsonwood on June 18 and 19; 19 CPSs and three older adults from the Fuqua Center on Late Life Depression completed the two-day training.
 - Conducted the TTI PSWH CPS Trainers Training at Epworth by the Sea on August 13 and 14, 2009; 19 CPSs and 2 older adults from the Fuqua Center on Late Life Depression completed the two- day training.

- Held the 18th Annual Georgia Mental Health Consumer Network Conference on August 18, 19 and 20, 2009 at Epworth by the Sea on St. Simon's Island, GA. Five hundred twenty-one consumers of mental health services attended, including the participants of the PSWH Pilot Project, who were provided scholarships. Included tasks were the preparation and distribution of Wellness Packs to all conference participants. For the first time in 16 years conference attendees voted affordable healthcare as one of the top five things needed for recovery from mental illness. Peer Support Whole Health services are a timely, person-centered and cost-effective component of affordable whole healthcare.

- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.

- Larry Fricks published an article in the National Council Newsletter highlighting Georgia's TTI Project.

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Georgia



FY2012 TTI PROJECT:

Peer supported whole health and wellness coaching

KEY OUTCOMES:

The Georgia Department of Behavioral Health (GDBHDD) worked with the Georgia Mental Health Consumer Network (GMHCN) to promote integrated primary and behavioral health by fostering Peer Support Whole Health and Wellness Coaching. Specifically, the project sought to enhance:

1. A health-competent Certified Peer Specialist (CPS) workforce (workforce readiness);
2. An accepting and ready provider network (provider readiness); and
3. A consumer base which is prepared to be supported by a CPS to create health goals (consumer readiness).

An additional, and crucial, outcome is the advancement of Georgia's application to CMS to allow for billing of peer support in a whole health setting. While this outcome is not specifically attributable to this TTI grant, it can be fairly said that Georgia's first TTI grant was the catalyst for the CMS application (i.e. it helped to create the vision) and that this TTI grant helped to create the curriculum and push the workforce development that provided the backbone and details for the successful CMS waiver decision. The state plan language is contained below.

Workforce Readiness.

In terms of the improvement of the workforce readiness of Georgia, connections made during Georgia's first TTI project were instrumental. In 2011 Georgia reached out to New Jersey and Peggy Swarbrick in order to access and start with New Jersey's whole health curriculum (advanced in NJ's 2009 TTI award) and to then modify it to Georgia's system and culture. To buttress that, Georgia reached out to the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) to receive technical assistance for a specialty credential for CPSs which would be used as the credential to bill Medicaid-reimbursed peer support whole health. This resulted in the Whole Health Action Management (WHAM) training and curriculum, and thus far 5 WHAM trainings with roughly 35 attendees per training have been held – 150 total (10% of the Georgia CPS workforce). Finally, Georgia again held a Health and Wellness Statewide Forum at the Carter Center (TTI has now supported 4 of these conferences) on May 21, 2013. There were 120 attendees, encompassing providers, peers and state representatives.

Provider Readiness.

In January 2013 training began with providers on the new service definition as well as potential frameworks for the service within providers' organizations. Attendance at this initial January training was strongly encouraged by GDBHDD Commissioner Berry, which resulted in a strong turnout of roughly 120 providers. Next, providers began training on the potential roles/skills/opportunities of using CPSs who will have the

additional specialty credential. These activities were followed by a one-pager ([attached below](#)) describing Peer Supported Whole Health and a monthly telephonic forum to discuss opportunities and implementation. Finally, in partnership with The Carter Center, an event trained a broad-based group of constituents on community readiness. Overall, as of February 2013, 42 sites have been certified to provide CPS whole health services pursuant to the CMS Service Definition.

Consumer Readiness.

Consumers were prepared via many of the tools described earlier, including the Health and Wellness Statewide Forum at the Carter Center, the same one-pager describing the new Medicaid option, and the annual GMHCN conference, encompassing 550 attendees, where consumers were trained on the concepts of the new peer supported whole health endeavor. Peers similarly learned about WHAM and a cookbook, which all attendees received, entitled *Healthy Eating on a Budget*.

State Plan Language on Whole Health Peer Support

This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists under the direct supervision of a behavioral health professional. Consumers actively participate in decision-making and program operation. Services are directed toward achievement of the specific goals defined by the individual and specified in the Individual Service Plan (ISP), and provided under the direct supervision of a Behavioral Health Professional. The interpersonal interactions and activities within the program are directed, supervised, guided and facilitated by the Behavioral Health Professional in such a way to create the therapeutic community or therapeutic effect required to achieve individual treatment goals. [Additionally, this service provides support and coaching interventions to individuals to promote recovery and healthy lifestyles and to reduce identifiable behavioral health & and physical health risks and increase healthy behaviors intended to prevent the onset of disease or lessen the impact of existing chronic health conditions by teaching more effective management techniques that focus on the individual’s self-management and decision making about healthy choices which ultimately extend the members’ lifespan.](#) These services may be provided in a clinic or outside the clinic setting in the community. Practitioners are required to hold current certification from the Georgia Certified Peer Support Project.

The “blue” activity above will be billed under the *Health and Wellness Supports (Behavioral Health Prevention Education Service (Delivery Of Services With Target Population To Affect Knowledge, Attitude And/Or Behavior)* HCPS code.

Georgia’s One Pager – distributed within the state

IN THE NEWS: Georgia’s Peer Support Expansion into Whole Health Coaches

On June 6, 2012, the Centers for Medicare and Medicaid Services (CMS) approved Georgia as the first state to have Medicaid-recognized whole health and wellness peer support provided by certified peer specialists (CPSs). Georgia’s newly approved Medicaid service will be delivered by peer support whole health and wellness coaches certified in Whole Health Action Management (WHAM), a training developed by CIHS that promotes outcomes of integrated health self-management and preventive resiliency.

The state plan includes the following CMS-approved definition elements.

Goal	<p>To ultimately extend the members’ lifespan by:</p> <ul style="list-style-type: none"> ● Promoting recovery, wellness, and healthy lifestyles ● Reducing identifiable behavioral health and physical health risks ● Increasing healthy behaviors intended to prevent disease onset ● Lessening the impact of existing chronic health conditions
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Interventions	<ul style="list-style-type: none"> • Supporting the individual in building skills that enable whole health improvements • Providing health support and coaching interventions about daily health choices • Promoting effective skills and techniques that focus on the individual’s wellness self-management and health decision making • Helping individuals set incremental wellness goals and providing ongoing support for the achievement of those goals
Technical Elements	<ul style="list-style-type: none"> • Requires professional supervision in accordance with CMS-SMDL #07-011 • Requires a related goal(s) on the official treatment (recovery) plan • Requires health-related certification • Uses the WHAM training, which provides CPSs with six major skills to: <ol style="list-style-type: none"> 1. Engage in person-centered planning to identify strengths and supports in 10 science-based whole health and resiliency factors 2. Support the person in writing a whole health goal based on personal motivation and person-centered planning 3. Support the person in creating and logging a weekly action plan 4. Facilitate WHAM peer support groups which create new health behaviors 5. Build the person’s Relaxation Response skills to manage stress 6. Build the person’s cognitive self-management skills to avoid negative thinking • Allows CPSs to provide the service with technical medical advice and referral support from behavioral health nurses, as necessary
Billing Detail	<ul style="list-style-type: none"> • HCPCS (Healthcare Common Procedure Coding System) Billing Code: Health and Wellness Supports, H0025 • Rate for 15 minute unit: Ranges from \$15.13 to \$24.36 depending on CPS experience/education and location of service

Health-Certified CPSs will receive medical technical support from registered nurses and are trained to work in both behavioral health and primary care settings.

In this same CMS-approved state plan, Georgia has also developed Medicaid-reimbursed peer support services specifically for addiction recovery. This allows Georgia to expand its behavioral health workforce by using certified addiction recovery empowerment specialists (CARES) that function as certified peer specialists. This new workforce will bill Medicaid for peer support, with the addition of a substance abuse modifier, using Georgia’s base peer support code. The service meets all of the CMS-SMDL #07-011 requirements for peer support. As this addiction recovery-specific workforce emerges, Georgia expects to also expand its whole health and wellness peer support through the use of CARES CPSs.

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Guam



2013 TTI PROJECTS:

(1) Self-directed care; (2) mental health first aid; (3) suicide prevention; (4) trauma informed care; and (5) enhanced collaboration among stakeholders.

KEY OUTCOMES:

Background and Overview of TTI Project Key Outcomes

The Guam Behavioral Health and Wellness Center (GBHWC) sought to build local capacity with the pool of locally-based trained trainers and improve services delivery by skilled services providers and consumer coaches/peer specialists. Five areas were to be addressed via this TTI project:

- 1) Develop and implement **self-directed care support** strategies that actively engage consumers and stakeholders in behavioral healthcare decisions;
- 2) Enhance **community awareness** of behavioral health issues and ways to provide immediate support to individuals in a behavioral health crisis, until appropriate professional treatment is received or until the crisis resolves through **Mental Health First Aid Training**;
- 3) Strengthen suicide prevention and early intervention trainings and practices among primary care providers through **Suicide Prevention Toolkit for Rural Primary Care Providers, Applied Suicide Intervention Skills Training (ASIST)** and **safeTALK** training;
- 4) Enhance **trauma-informed care** and evidence-based practices, skills and competence that support community integration and partnerships in prevention and recovery; and
- 5) **Strengthen collaborative partnerships** and formal Agreements among members of the Mental Health Planning Council, the Mental Health Advisory Council and the Governor's PEACE (Prevention Education and Community Empowerment) Council.

Guam has long lagged behind the rest of the United States in a number of critical areas.

- Suicide remains prevalent on Guam, with an average of 1 suicide death occurring every 2 weeks. In 2012, Guam has a suicide death rate of 15.6 per 100,000 inhabitants.
- Alcohol is implicated in almost one-fourth (24%) of suicide deaths in 2012. Almost 1 in 5 adults (2012) and 1 in 7 youth (2011) are binge drinkers in Guam. Binge drinking among Guam men is about 3 times higher than women in Guam (2012).
- 1 in 3 adults have tried using marijuana and 17% are current users (2012). Among youth, nearly 1 in 3 are current users of marijuana (2011).
- About 1 in 3 adults in Guam is a smoker (2012). Among youth, 1 in 5 smokes (2011). Guam's smoking rate is higher than the average smoking prevalence in the US States and Territories; this has remained unchanged since 2001.

Two TTI-funded trainings have been conducted thus far; a series of 2-hour **Suicide Prevention Toolkit for Primary Care Providers** training (with a training of trainers component), and a 2-day **Mental Health**

First Aid (MHFA) training. Both trainings were held in March, 2013 and were conducted by trainers selected by WICHE (Western Interstate College for Higher Education). Physicians, physician assistants, lab technicians, nurses, nurse aides and other Department of Public Health and Social Services (DPHSS) community health clinic staff on Guam attended the suicide prevention toolkit training. Behavioral health and primary health care services providers, law enforcement, youth services, educators, consumer advocates, persons in recovery and peer specialists/mentors completed the MHFA training.

With TTI's assistance, GBHWC was introduced to the New Hampshire NAMI who trains and certifies trainers in *Connect* for suicide postvention. Two trainers were brought to Guam with Garrett Lee Smith Memorial Grant funding (as part of Guam's *Focus on Life* efforts to stop suicide), to conduct a one-day community training followed by a two-day *Connect* training of trainers component for personnel in the education, behavioral health and law enforcement fields. Training statistics are as follows:

	Suicide Prevention Toolkit	MHFA	ASIST	safeTALK	Connect	KUTO Youth Helpline	Responsible (Alcohol) Beverage Service
# of Guam Certified Trainers	17	None	20	13	18	35	7
# Individuals Trained in the Community	72	38	1,596	775	155	22	37

The growing Guam-based cadre of certified trainers and instructors (and potentially within the broader Pacific Islands region) will serve as adjunct teaching staff for accredited courses that will be offered at the Guam Community College. Official discussions were held and recommendations made with the Pacific Behavioral Health Collaborating Council (PBHCC) for jointly developing and sustaining behavioral health training curriculum in the Pacific community colleges. PBHCC is a formalized partnership among the six U.S. Affiliated Pacific Island Jurisdictions: the Commonwealth of the Northern Mariana Islands; the Republic of Palau; the Federated States (Kosrae, Pohnpei, Yap and Chuuk) of Micronesia; the Republic of the Marshall Islands; American Samoa and Guam. PBHCC promotes sustainable, culturally appropriate services and capacity building systems, and advocates for behavioral health policies and systems improvement.

As a member of PBHCC, GBHWC fully supports the three strategic priorities that are to be developed: **Regional Collaboration** (Promoting partnerships with professional associations in the Pacific Region to improve overall health and wellness); **Workforce Development** (Coordinate training and trainer certification opportunities across the Pacific Region to include professional credentials in behavioral health); and **Cultural Competence** (Promote implementation of evidence-based practices with cultural adaptation).

College-linked or profession certification-linked pre-service and in-service behavioral health training and education will be accomplished as part of a sustainable, long-term goal. TTI supported the implementation and evaluation of sustainable, evidenced-based behavioral health prevention, early intervention, referrals for treatment and follow-up practices, policies and programs for the island, with a focus on cultural appropriateness, relevance and competence.

I. Lessons Learned

The following are some of the lessons learned upon which improvements will be made in the planning, coordination, implementation and evaluation of TTI-funded workforce development trainings:

- GBHWC's need to reassess and prioritize training needs among Guam's behavioral health services providers, particularly those employed in the Center;
- At the direction and authority of Guam's General Services Agency, GBHWC is strongly advised to

prepare an RFP or Bid for the solicitation of eligible professionals/vendors who would conduct behavioral health trainings on Guam; and

- Through the first series of trainings (Toolkit and MHFA), there was no opportunity provided for direct communications between Guam’s TTI team and the trainers selected by WICHE.

II. Projected Activities FY 2014

Based on the first year’s TTI coordination experience and lessons learned, the following are the projected activities and tasks that will be accomplished during FY 2014 (October 2013 thru September 2014):

- Re-Assess and Prioritize Behavioral Health Training Needs with GBHWC and Other Services Providers;
- Selection and Establishment of Multiple Vendor Agreements for the Conduct of Trainings; and
- Conduct and evaluate scheduled trainings.

III. Pacific Region Benefits of TTI Funding

As described above, where Guam has and will continue to benefit from TTI funding, so will the other U.S. affiliated Pacific Jurisdictions, by virtue of its established Pacific Behavioral Health Collaborating Council.

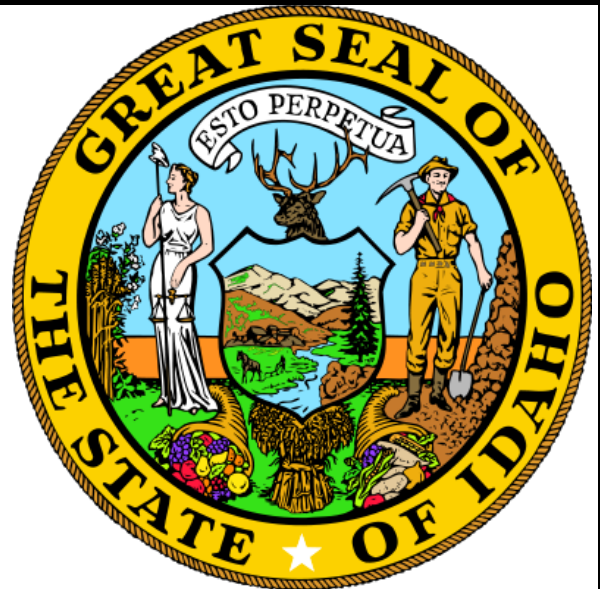
IV. Summary

The greatest prevention and treatment resources that exist on Guam are the people of the island with the diverse cultures, values and practices that are the strengths from which positive changes can be experienced and sustained. The 2013 Gathering of Pacific Islands for PEACE (GOPEACE) event is but one demonstration of this. This community event brought together increased and new representation of the different Pacific Island cultures and groups present on Guam. Over 200 youth and adults joined GOPEACE and united to *be part of the change* as one community for a healthier **One Nation**. This two-day gathering encouraged everyone to be part of a journey towards community healing and empowerment. As one faith-based leader expressed, *“Suicide and substance abuse affects many lives and it may be about us that we speak about, or our loved ones. As traumatic and life changing as these issues may be, we as Pacific Islanders have proven to be amazingly resilient. Our islands are prone to be in the path of many natural disasters that we have endured for many years, yet we are able to survive those storms. We can survive storms within because we are crafted to be survivors. It is essential for us to **listen and observe** what is going on with our families and in our communities. We must make a conscious effort to **think** about how our personal lives are impacted and what we **feel** when our cultural values are put to the test.”*

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Idaho



2011 TTI PROJECT:

Creation of a data warehouse to collect and process data from multiple state systems

KEY OUTCOMES:

INTRODUCTION:

Idaho's Transformation Transfer Initiative (TTI) project was centered around the development of a data warehouse built on a universal platform that allows multiple data system feeds. The vision is that at the end of the TTI project all State Behavioral Health Authority health records will be included in a single data-mart. This will allow for reporting across systems within the Division of Behavioral Health for the first time ever. Additionally, it will provide a springboard for providers, both public and private, to participate in the warehouse and the system-wide reporting structure.

BACKGROUND:

Idaho had already laid some of the groundwork before the TTI funding. A little more than a year ago, there was no reliable data system for the state-run community mental health clinics. Apart from a legacy billing system, data was collected manually on individual spreadsheets maintained in each of the state's seven administrative regions. On the inpatient side, the two state-run psychiatric hospitals operated stand-alone legacy systems that were no longer supported by the vendor.

Absent this project, Idaho would remain an ad-hoc data state, with no dashboards or other statewide data assessments.

With appropriations from the state legislature, DBH had begun working to standardize and make improvements to its data. Beginning in 2007, Idaho's two state psychiatric hospitals began the implementation of the Veterans Health Information Systems and Technology Architecture (VistA) Application. Both hospitals are now using modules of VistA and the implementation is nearing completion.

The Division modified the Web Infrastructure for Treatment Services (WITS) system for use in an adult outpatient mental health setting, and the state-run Regional Mental Health Centers began using WITS in October 2009 as both an electronic health records and clinical practice management system. The Division will also convert its children's mental health program to the WITS system from an existing legacy system over the next few months.

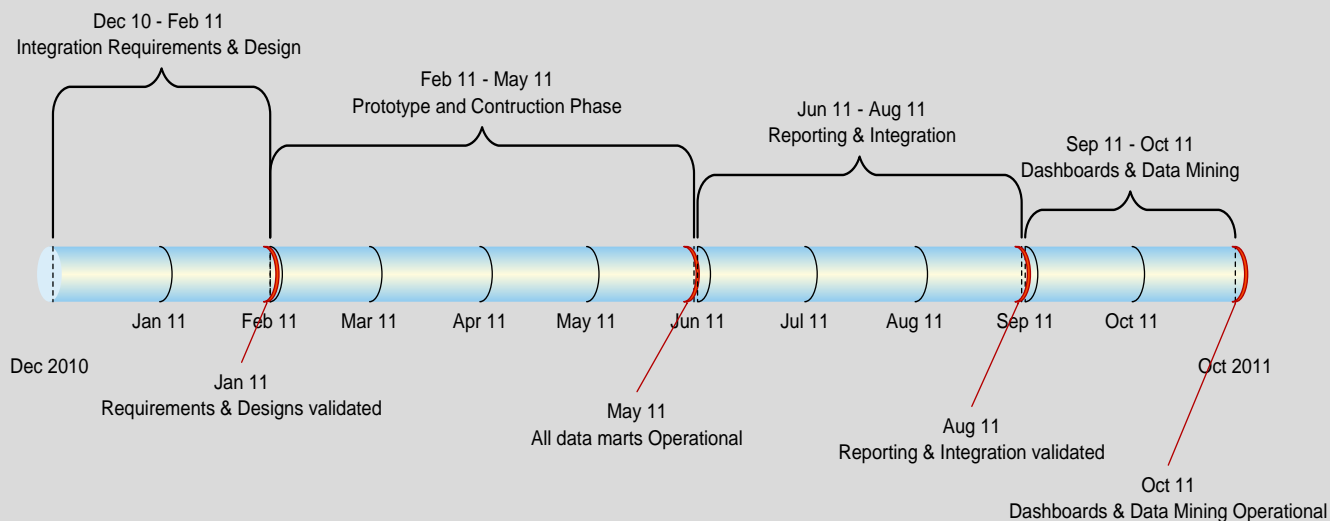
On the Substance Use Disorders (SUDS) side, the Division partnered with the Office of Drug Policy to connect WITS to a web-based version of the uniform assessment (the Global Appraisal of Individual Needs or GAIN-I) for use by all of the state's contracted network of substance abuse treatment providers. SUDS network providers use WITS to enter client encounter data and the network manager provides payment data from the network manager's legacy system.

Data from the above systems were not integrated. The manual compilation of data from these disparate systems inhibited the timely access to useful information. DBH began work to construct the Behavioral Health Integrated Data Warehouse (BHIDW). The warehouse is based on the HL7 format, which is being used nationwide with current data communication and health data networks and exchanges. Adopting this industry standard allowed DBH to import data from all source systems and provide for unambiguous data communication among programs, divisions, and agencies. The focus has been on storage of clean, transformed, and cataloged data that will be made available to managers, administrators, and other business professionals for data mining, online analytical processing, and decision support.

PROJECT PROGRESS:

The effort necessary to meet the projected timelines was short for an Information Technology project. The reality is that this project involved the development of four data warehouses into a single data-mart. In addition, the data systems used by the CMH program and the SUD historically contain all the necessary data for longitudinal reporting and therefore were necessarily included in the data warehouse. This model, in concept, allows queries across each of the warehouses/data sets.

The project was initiated with the development of a project team comprised of subject matter experts, management, information technology, programmers, and enterprise warehouse staff. The project team developed a project plan and associated timeline for milestones. See timeline below.



The development of the warehouse itself required additional work with vendors to provide regular, consistent transfers of data to a secure site. Those vendors include the Substance Abuse management services contractor, the WITS provider, and the VistA provider. It was also necessary to include Idaho’s Child Welfare agency as they own the system FOCUS system, which was the former case management information system for the CMH program.

The data warehouse has been completed, including all four information system’s individual marts. The data is currently being uploaded at least every two weeks or so if the host system has the capacity.

PROJECT GOALS:

1. Focus on indicators that provide the most useful clinical and operational data possible within the scope of the data currently available within DBH.
2. Implement “dashboards” that will graphically present key performance indicators to senior management on demand. In some ways this is the primary goal of the project.
3. Identify, develop and build reports that measure service outcomes, trends, exceptions, and performance versus goals.
4. Provide a common data model for all data of interest regardless of the source (e.g. WITS, VistA, outside agency), making it easier to report and analyze information than it would be if multiple systems were used to retrieve information.

5. Identify and resolve inconsistencies in data prior to loading data into the warehouse that simplifies reporting and analysis.
6. Complete the construction of the BHIDW composed of several data marts so it incorporates and integrates data from vendor-hosted and in-house information systems including (but not limited to) SUDS Program, Business Psychology Associates, Adult Mental Health Program, Children's Mental Health Program, State Hospital South, and State Hospital North. This process can also be used to incorporate appropriate data from other agencies (Medicaid MMIS, Department of Labor, Corrections, Juvenile Corrections, Tax Commission, Division of Financial Management, etc).

OUTCOMES TO DATE:

- Data dashboards for each program are available, are provided to senior leadership monthly, and are also posted on DBH's website for public viewing. Thus far managers have found the dashboards to be very helpful, but are also uncomfortable that the Commissioner and the public can view as well, especially when certain indicators (such as time spent with consumers, or direct client contact data) are abysmal.
- Data from these dashboards has already led to the appropriation of new funding for a fulltime FTE.
- There has been a resultant increase in trust in state leadership from key legislators.
- Data testing remains ongoing yet very time consuming.
- Meets the State's need for reliable, consolidated, unique and integrated analysis and reporting of its data at different levels of aggregation.
- Paves the way for other states that are interested in streamlining parallel data processes and disparate data sources and extracting outcomes and management data.
- Foundation for analyzing data from multiple sources to assess the efficacy of multi-agency services.
- Provides the necessary data to the State Mental Health Planning Council, consumers and family members to facilitate their monitoring the state MH system.
- Provides a foundation for implementation of Health Care Reform; especially the efficiencies achieved through comprehensive electronic health records.

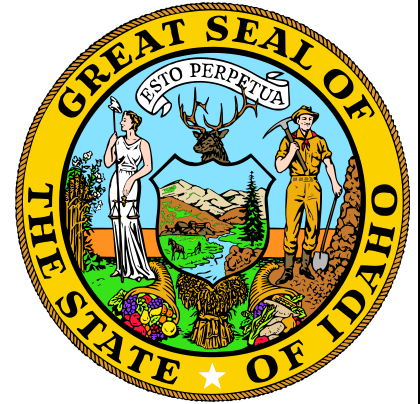
SUMMARY

The TTI project in Idaho assisted with the initial development of a multiple system data warehouse. The project team is still working on the hard coding of the newly created data dashboard. All in the DBH system now have the ability to feed the dashboard on a routine basis and it will soon be published to the external website and the internal SharePoint team site for the Division staff and management to utilize consistently. The TTI project moved Idaho forward dramatically in our ability to process and provide meaningful data.

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Idaho



2013 TTI PROJECT:

The collaboration of substance abuse and mental health services into recovery coaching and peer services

KEY OUTCOMES:

Idaho's project originally included: 1) a trauma focus toolkit, 2) an action plan toolkit for use by regional behavioral health boards, and 3) recovery coaching training for 25-50 individuals from Idaho. These activities evolved quite a bit during the course of the project due to the flexibility of the TTI award. The work with the action plan toolkit was cancelled due to the 2013 non-passage of legislation to transform Idaho's Behavioral Health system which delayed the formation of Regional Behavioral Health Boards.

The work on trauma was changed due to the substantial amounts of information already available. The Division of Behavioral Health (DBH) decided that rather than building a single toolkit, creating a website portal that can be continuously updated and improved would be more valuable for Idaho. Research and development work began in Spring 2013 toward building this web portal, and will continue again once responsibilities for recovery coaching and the recovery centers can be shifted to Recovery Idaho.

DBH thus moved strongly toward the recovery coaching aspect of the TTI award. Idaho has had peer specialist training for adults with mental health diagnoses in place since March 2009, but until the implementation of the TTI award project in 2013, there was no equivalent Idaho training program for adults in recovery from substance use disorders. A little over a year after beginning TTI work, this award had already allowed DBH to facilitate a number of trainings and establish recovery coaches in each of the seven regions of our state. Idaho also now has its own recovery coach trainers located around the state to support the sustainability of this effort, and is working toward certification for recovery coaches.

Connecticut Community for Addiction Recovery (CCAR) provided the initial Recovery Coach Academy in Idaho, and DBH continued its collaboration with CCAR in developing other elements of this project. In March 2014, CCAR returned to Idaho to facilitate a workshop that began the development process for Idaho's own Recovery Community Organization (RCO), named Recovery Idaho. That same month, DBH helped start conversations in several Idaho cities regarding the establishment of community-driven recovery centers.

Project Outcomes to Date

Recovery Coaching

Trainings: Idaho held its first Recovery Coach Academy May 20-25, 2013, led by CCAR trainers. At the end of the training, Idaho had its first group of 47 trained recovery coaches, including 15 individuals who went through additional hours of instruction to become Idaho recovery coach trainers.

The enthusiasm surrounding recovery coaching exploded in the months following the first Recovery Coach Academy. By September of 2013, DBH was working with Idaho's trainers to organize new trainings for individuals around the state. As of May 22, 2014, a total of 209 recovery coaches were trained in Idaho, with another training planned for August 2014. A treatment provider in region 7 holds ongoing recovery coach trainings for drug court graduates in eastern Idaho.

Idaho Trainers: In March of 2014, DBH brought CCAR back to Idaho for an additional session of Recovery Coach Academy "train the trainer." An additional 12 Idahoans received instruction in teaching the Recovery Coach Academy, bringing Idaho's number of recovery coach trainers to 25. That training was followed by a CCAR train the trainer session in "Ethical Considerations for Recovery Coaches." Twenty-one of Idaho's trainers can now also teach this ethical piece. A number of the Idaho trainers are state employees, which allows DBH to further support the trainings by allowing them to train using their work hours.

Certification: Training in Ethical Considerations for Recovery Coaches will be a required component of the curriculum to obtain a recovery coach certification in Idaho. In mid-February 2014, the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) agreed to offer a credential for individuals who would like to become certified recovery coaches. The work to finalize standards for the certification continues, but standards will include training in the Recovery Coach Academy, Ethical Considerations for Recovery Coaches, and other requirements of the International Certification and Reciprocity Consortium (IC&RC) and the IBADCC. While a process is currently in place to allow recovery coaches to be reimbursed if they are working with certain DBH populations through a state network treatment provider, the certification is a step toward Idaho recovery coaches being compensated through other agencies and potentially Medicaid. DBH has also created a Recovery Coach Provider Orientation presentation to be delivered for the first time on July 15, 2014. This training will educate providers and institutions on what a recovery coach does and what services they can provide.

Technology: Since Idaho is a large rural state, communication became a challenge. Regular conferences with both the trainers and coaches to talk about any challenges were ultimately supplemented by the website recoverycoaching.dhw.idaho.gov. This website has grown to include resources for recovery coaches, training materials and assistance for Idaho's trainers, an electronic training sign-up process, a training calendar, and space for personal stories of recovery to be shared. DBH also created a dedicated email address, recoverycoaching@dhw.idaho.gov. The site and email provide ways to distribute materials to all of the coaches. As a final technological enhancement, DBH created a private blog, recoverycoachingidaho.com, which is only open to recovery coaches. Replacing the old conference call system, this blog provides a place for coaches to post experiences and communicate with one another as well as representatives of DBH. Since the blog is private, coaches can receive invites to join after completing their initial training, and the information they share on the blog is only seen by fellow recovery coaches who may be able to provide help or advice. The blog got a slow start but grew in popularity during 2014.

Peer Specialists: Using TTI funding, DBH originally hired two certified peer specialists in March 2013 to assist with the TTI project. One of those peer specialists, who was involved in the first steps of establishing the recovery coach training, was hired directly out of DBH to fill a position as the Project Director for Idaho's Office of Consumer and Family Affairs' Idaho Peer Specialist Training Project.

Recovery Centers

In October 2013, four DBH staff, one of whom is a trainer for both recovery coaching and peer specialists, took a small group of state stakeholders to tour CCAR's community recovery centers in Connecticut. The group included two members of the Idaho Legislature who are in key positions for supporting recovery-related legislation; two county commissioners; two substance abuse treatment providers, one of whom

provides services in a tribal setting; the Behavioral Health Program Director for the Idaho Supreme Court; a budget analyst from Legislative Services; and the Idaho Department of Correction Reentry Director. The group got to see firsthand the success that CCAR has had with its volunteer-driven and community-based recovery centers. These centers are centrally located in their communities and provide services for people in recovery, their friends, families, and allies. The centers have information on local recovery support services like transportation and housing assistance, and can also provide classes to those in recovery to live clean and sober lives. Other components include computers with online access and phone banks so volunteers can connect with people in recovery who request support calls, as well as job search education and assistance.

After returning, DBH collaborated with the Canyon County Commissioner who toured the CCAR centers to organize a kickoff meeting in Caldwell, Idaho. The purpose of the meeting was to determine local interest and support for establishing a local recovery center. The meeting was attended by about 50 individuals, representing local providers of treatment and RSS services; people in recovery and their allies; staff from the Idaho Department of Correction, Idaho Department of Juvenile Corrections, Idaho Supreme Court and Legislative Services; probation and parole workers; recovery coaches; representatives of United Way; members of the faith-based community; and DBH staff. The meeting also drew several county commissioners who were ready see recovery centers developed in their communities. By the end of the meeting, a workgroup had been formed and is now meeting regularly to discuss the logistics of establishing a recovery center in Canyon County. This effort has the support of the Chairman of the Canyon County Commissioners and the mayor of Caldwell. The enthusiasm generated from the Canyon County meeting has resonated across the state with additional communities and counties expressing interest in learning more about recovery centers.

Recovery Idaho

A crucial component in the ongoing success of recovery coaching and local recovery centers will be the establishment of Idaho's flagship Recovery Community Organization (RCO), named Recovery Idaho. Idaho took its first steps toward establishing Recovery Idaho during the TTI project, inviting people from all seven regions of the state to participate in a workshop March 17-19, 2014, in Boise, Idaho. DBH used TTI funding to bring in Jim Wuelfing and Phil Valentine from CCAR to walk about 50 workshop attendees through the process that was used in establishing the RCO in Connecticut. The group determined the name, drafted a mission statement and core values, established a workgroup to finalize a mission statement and identified eight initial board members to continue the process toward becoming a 501 (c)(3) nonprofit. By April 2014, board members were meeting every two weeks via phone conference. Recovery Idaho has already received its first donations, and work is being done to finalize the 501 (c)(3) application.

- DBH used TTI funding to contract with the National Association of State Alcohol/Drug Abuse Directors (NASADAD) for the creation of a report, by the end of May, 2014, documenting the process of developing the RCO and recovery centers. This document will be used in Idaho as a reference on RCO development and as guidance for the creation of recovery centers.

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Illinois



FY2008 TTI PROJECT:

Create a co-occurring strategic plan and develop a criminal justice workgroup with regional sessions to develop regional system mapping to identify service gaps and barriers.

KEY OUTCOMES:

- Development of a statewide criminal justice transformation workgroup and five regional criminal justice transformation workgroups.
- Development of a statewide criminal justice transformation advisory council. This advisory council's first meeting began the planning process for five regional workshops to begin a regional mapping process. It was attended by executives of three partnering agencies (Substance Abuse, Corrections, Mental Health), the Cook County State's Attorney's Office, the Illinois Sheriff's Association, the Chicago Police Department, Illinois NAMI, Illinois MHA, four CMHC's, University of Illinois, Illinois Criminal Justice Information Authority, Corporation for Supportive Housing, an Appellate Judge, and *five Chief Judges from across the state*.
- The Illinois Judges Council, as an official partner of this project, authored and sent out the invitations for the five regional workshops to boost attendance.
- The five regional workshops, responsible for the regional mapping process and action plan, met over the summer. These workshops produced the following:
 - Identification of the interception points within the criminal justice system where individuals with mental illness and co-morbid substance use disorders can be provided with services and interventions;
 - Description of the service delivery process that supports the recovery of individuals with mental illness and co-morbid substance use problems intercepted in the criminal justice system;
 - Identification of best practices and promising initiatives that address the needs of individuals with mental illness and co-morbid substance use problems;
 - Identification of gaps in service and barriers to service delivery;
 - Development of work plans for each of the five regions; and
 - A statewide mapping report and three-year integration plan is expected by late fall.

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Illinois



FY2010 TTI PROJECTS:

1) Implementation of a statewide mental health justice and advisory group; 2) Piloting an integrated mental health court database; 3) Implementation of a mental health and justice consumer conference.

Statewide Mental Health and Justice Advisory Group Strategic Planning:

- Completed TTI strategic planning process and identified priority initiatives for MHJ transformation for the next two years.
- Completed Strategic Planning Report.
- Completed Medicaid application training for 150 provider staff and DMH social work staff working with justice involved consumers.
- Expanded JDL to Macon County, with four more counties targeted for expansions in the next year (Kane, Mclean, Sangamon, and Vermillion).
- Identified start-up support for an Illinois Mental Health and Justice Center of Excellence.
- ***Issues/Concerns/Sustainability:*** Sustaining MHJ actions and initiatives after the final expenditure of TTI award funds. The Illinois Criminal Justice Information Authority will provide funding for two years for a Mental Health and Justice Center of Excellence COE. This will allow time to identify and pursue other funding mechanisms to sustain the initiative.

Integrated Database Pilots:

- Completed the process of piloting the Integrated Mental Health Court Database. Data was collected on 463 past and current participants at both pilot sites in Cook and Winnebago County. The chief pilot finding was that effectively capturing comprehensive participant data is impacted by the cohesiveness of the Mental Health Court Team in providing and sharing information. The pilot in Winnebago County showed more effective results in this respect as the data entry person has more efficient access to participant information. Both sites showed that the database is an effective tool for capturing information in a uniform but flexible manner.
- ***Issues/Concerns/Sustainability:*** Both sites will continue to use the Integrated Database. The database will be made available to other jurisdictions with mental health court programs through continued involvement with the Mental Health Court Association and other activities involving the judiciary. The database will be provided to any mental health court at no charge.

Mental Health and Justice Consumer Conference:

- Tonier Cain, nationally recognized consumer expert on Trauma and Recovery provided keynote address at the DMH Region III and IV recovery conference.
- Tonier Cain, nationally recognized consumer expert on Trauma and Recovery provided keynote address at the Mental Health Court Association and Mental Health and Justice Statewide Conference in DuPage Illinois.
- Identified priority consumer recommendations for TTI strategic plan. Highest priority was identified as expanding peer to peer support services in Illinois.
- The TTI consumer consultant, Mrs. Frances Priester, provided peer to peer support to 21 recovery specialists and their supervisors working with local jails and court systems in their community in Macon, McLean, and Sangamon counties.
- ***Issues/Concern/Sustainability:*** Funding and resources are needed to expand MHJ peer to peer support initiatives. Any remaining TTI funds will be used to train additional peer to peer support staff in Illinois counties and regions.
- ***Overall Transformation Impact of Focus Area Outcomes***
The Transformation Transfer Initiative has been instrumental in facilitating regional and statewide collaboration on Mental Health and Justice Issues in Illinois. Most noteworthy in the collaboration was the involvement of judiciary in providing leadership for regional and statewide planning. Despite an ongoing severe state budget crisis and continual cutbacks in mental health services in the community, the TTI partners and stakeholders continue to forge ahead with planning, problem solving, and initiative development. Although the TTI process identified more issues and service needs than it could ever fix in our current economic climate, it did raise the level of awareness of the needs of justice involved consumers. Also as important to transformation was the initiation of strategies through the TTI process that could become system wide approaches such as peer to peer support, and the development of a Mental Health and Justice Center of Excellence that can continue to support regional and statewide initiatives with consultation, training, technical assistance, and information dissemination.

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Illinois



FY2013 TTI PROJECTS:

The 2013 TTI award directly addresses several critical issues that include information tracking in problem solving courts, the statewide forensic waiting list for DMH hospital admissions, the enhancement of community provider and DMH hospital workers therapeutic skills towards more effectiveness in their work with justice involved consumers and patients, and the development of information sharing between the Illinois Division of Mental Health and the Illinois Department of Corrections.

KEY OUTCOMES:

Transformation Focus Area 1 Final Outcomes: *Strengthened sequential intercept 3 service delivery by providing a Behavioral Health and Justice Integrated Database (BHJID). Developed the modified database with input from problem solving court programs, provide incentives to enter legacy data, and beta test at Illinois court sites with several different problem solving courts. Also incorporated new federal guidelines for problem solving courts.*

- Contracted with information technology specialists to develop BHJID.
- Completed meeting of selected problem solving court information technology specialists to formulate modifications of existing mental health court database.
- Completed meeting with judiciary to provide input to BHJID.
- Completed promotion of BHJID in Chief Justices Conference and Illinois Annual Problem Solving Court Conference.
- The Behavioral Health and Justice Integrated Database (BHJID) has been completed and is available for Illinois problem courts and other diversion programs.

Issues/Concerns/Sustainability: The TTI funds covered the complete cost of database modifications. The database will be available for use by Illinois problem solving courts at no charge. The Illinois Division of Mental Health will continue to provide limited IT support to users of the database.

Transformation Focus Area 2 Final Outcomes: *Strengthened sequential intercept 3 by providing joint training of regional court leadership and DMH forensic hospital staff that will help improve their shared response to the management of forensic referrals.*

- Contracted with the Illinois Center of Excellence for Behavioral Health and Justice to develop, plan, and assist in the implementation of 4 regional forensic workshops.
- Three Regional Judiciary Forensic Trainings have been completed to enhance collaborative relationships between Illinois courts and the Illinois Division of Mental Health Forensic Hospital sites. Participation included over 160 attendees. The trainings addressed admission and discharge issues, statutory and procedural education of forensic system partners, and identification of regional

diversion strategies.

- One outcome of Regional Judiciary Trainings is a statewide Symposium for forensic examiner's that is scheduled for September 26, 2014. The goal of this symposium is to train court examiners on the forensic evaluation process and provide information regarding DMH resources for forensic treatment.

Issues/Concerns/Sustainability: The TTI funds covered the complete cost of regional forensic workshops. DMH forensic leadership and staff will continue to collaborate with county courts and work towards implementing recommendations from workshops.

Transformation Focus Area 3 Final Outcomes: *Strengthened sequential intercept 5 by developing residential staff's skills in addressing the clinical and recovery needs of justice involved consumers upon discharge to the community.*

- The training the trainer process has been completed for two (out of four) trainees in evidenced based Moral Reconciliation Therapy (MRT). While achieving certification, these trainees provided MRT facilitator training to sixty community service providers and DMH hospital staff working with forensic and justice involved populations.
- The projected date for the completion of certification training for the remaining two 'training the trainer' trainees is September 2014. Training of thirty community provider staff will be conducted in September of 2014 as part of the final phase of the MRT trainer certification process for the remaining two trainees.

- Completion of training for 40 additional community residential service staff to conduct MRT group services is projected for completion by February 2015 using the four newly certified MRT trainers.

Issues/Concerns/Sustainability: The TTI funds will cover the complete cost of training four certified trainers and 60 community and hospital staff. This project will provide ongoing training resources for an evidenced based treatment practice that can be integrated into services for justice involved individuals throughout Illinois.

Transformation Focus Area 4 Final Outcomes: *With the recent legislative approval of Affordable Care Act (ACA) in Illinois, three additional initiatives will involve, 1) support of the development of mental health data sharing and Medicaid pre-enrollment between the Department of Corrections (IDOC) and County Jail sites participating in the DMH Jail Data Link (JDL) Program, 2) collaboration with a key agency on Medicaid pre -enrollment of jail detainees with serious mental illness, and 3) Development of a consumer conference to educate justice involved consumers access to Medicaid benefits under ACA.*

- Completed and continuing meetings with the Chief Deputy for the Illinois Department of Corrections IDOC, and selected county jails with Jail data Links programs regarding information sharing that will support the access of benefits to individuals with behavioral health disorders that are being discharged from county jails.
- A technological data link process has been initiated to share mental health information between the Illinois Division of Mental Health (DMH) and the Illinois Department of Correction (IDOC) via a computer based cross match of all individuals residing in IDOC with DMH outpatient and inpatient case files.
- DMH is collaborating with two consumer advocacy agencies to provide regional training conferences for justice involved consumers regarding access to Medicaid benefits under ACA. The conferences dates are projected for November 4, 2014.
- Planning is underway between DMH and a key provider that has facilitated the enrollment of over 1500 detainees at Cook County Jail to identify Illinois jail sites outside of Cook County that are

amenable to training on Medicaid pre-enrollment of detainees.

Overall Transformation Impact of Focus Area Outcomes

The Transformation Transfer Initiative awards have been instrumental in facilitating regional and statewide system building for forensic and mental health and justice services and initiatives in Illinois. It has continued to support collaboration with system partners, including Illinois judiciary, in transformation efforts. The 2013 TTI award directly addresses several critical issues in Illinois that include information tracking in problem solving courts, the statewide forensic waiting list for DMH hospital admissions, the enhancement of community provider and DMH hospital workers therapeutic skills towards more effectiveness in their work with justice involved consumers and patients, and facilitation of justice involved consumers access to health benefits.

Despite an ongoing severe state budget crisis and historical cutbacks in mental health services in the community, the TTI award in Illinois will accomplish additional specific important outcomes over the next six months. These outcomes will include the following based on available TTI funds:

- Two additional MRT Trainers will complete their training process by September 2014 and will be certified as trainers for evidenced based Moral Reconciliation Therapy. Illinois will have four certified MRT instructors.
- Forty community service provider staff will be trained by February 2015 to facilitate MRT groups in community programs that work with forensic and justice involved populations.
- A Forensic Examiners Symposium is scheduled for September 26, 2014 as an outcome of the statewide regional training process.
- An Illinois Forensic and Mental Health and Justice Conference is being planned in 2014 for the Spring of 2015. Topics will include presentations from national experts on forensic law, The Affordable Care Act and Assistance to Justice Involved Consumers, and Behavioral Health Care and Community Recovery of Detained and Incarcerated Individuals.
- Regional training will be scheduled in Region 1 with key Cook County Judiciary to continue the enhancement of collaborative relationships between Illinois courts and Illinois Division of Mental Health Forensic Hospital sites.

In addition to these specific outcomes the TTI award is supporting collaborative efforts between DMH and IDOC around planning for information sharing. The discussions being held between these two Illinois system partners have implications for assisting the access to healthcare benefits for correctional inmates and jail detainees under the Affordable Care Act Medicaid expansion in Illinois.

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Indiana



FY2010 TTI PROJECT:

Increased and improved recovery based care at the community level by (i) providing community mental health centers (CMHCs) and state operated psychiatric hospitals needed training for transformation initiatives and align them to a recovery-based philosophy and model clinical care and (ii) a media campaign designed to increase recovery awareness.

KEY OUTCOMES:

- Thirty-four training and technical assistance recovery/transformation activities were funded by TTI.
- Approximately 3,000 participants involved.
- Training breakdown included sessions on:
 - 135 people were trained on recovery based care
 - 329 people received MRO manual training
 - 187 individuals were trained on assessing and treating individuals with co-occurring disorders
 - 3 webinars, with 1383 participants, were held on prior approval processes
 - 303 people were trained on new performance expectations for recovery outcomes
 - Three peer webinars were held on (i) using peers to engage reluctant clients; (ii) role of the certified recovery specialist; and (iii) how to integrate certified recovery specialists into a clinical team
 - 123 people watched a webinar on states of change and person-centered treatment planning
 - 8 videoconferences are being held for providers who are struggling to implement recovery based care
- Regional training presentation subjects included:
 - Recovery based care - all levels of provider staff, consumers and families
 - MRO manual training - all levels of provider staff
 - Education and discussion regarding the transformation initiatives and recovery based care - consumers/families and community stakeholders
 - Assessing and treating individuals with co-occurring disorders - staff from DMHA funded providers, consumers and families
 - Prior Approval system processes (Expectations/utilization) - all levels of provider staff
 - Recovery Outcomes: new performance expectations - all levels of provider staff (webinar)
- Seven Regional Town Hall meetings were conducted with 294 individuals participating including consumers, persons in recovery, family members, providers, policy makers and advocates.

- A statewide media campaign, conducted in partnership with Mental health America, assisted in the creation of various products and a speakers bureau.
- SAMHSA's "What a Difference a Friend Makes" PSA was aired 646 times across the state.
- "What a Difference a Friend Makes" Community Tool Kit was developed for distribution to various organizations across Indiana. Organizations receiving this toolkit include:

Lions' Clubs	NASW Indiana
Future Farmers of America	Indiana Psychiatric Society
Rotary Clubs	American Psychiatric Nurses Association
Junior League	Indiana
American Legion	Charitable News
Public Broadcasting	DBSA
PTA	Key Consumer Organization
Indiana Psychological Association	NAMI Indiana
- 2,889 brochures and "What a Difference a Friend Makes" materials were distributed.
- DMHA conducted surveys to assess readiness of behavioral health providers to implement recovery oriented care. Surveys were completed in March/April 2009 and February 2011 (pre/post TTI). Of the providers who completed both the Pre/Post Provider Readiness Assessment, over 2/3 indicated they had made overall improvement in implementation of recovery oriented principles for consumer services. This improvement was found in all three domains:
 - Recovery
 - Person-Centered Planning
 - Recovery Support Services
- Three surveys were used to assess needs and gaps. Information gleaned from the surveys was used to guide decision making for TTI funded training/TA topics.
- Other activities supported by the TTI funds include:
 - Development and maintenance of a FAQ
 - Development and maintenance of a training website to facilitate registration, share information, and host presentations/materials
- Numerous presentations were developed and delivered to various community stakeholders:
 - Consumer/family groups
 - Legislative groups
 - Behavioral health providers

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Indiana



FY2013 TTI PROJECT:

Indiana's TTI project was designed to develop a framework for promoting the implementation of best practice(s) integrated primary and behavioral health care across Indiana

KEY OUTCOMES:

Strategies and activities were identified through the work of an existing integration stakeholder task force with representation from a broad array of agencies and vested groups including: four SAMHSA integration grant awardees and the Screening Brief Intervention Referral Treatment (SBIRT) implementation partners, NAMI, KEY Consumers, Indiana Primary Health Care Association, Indiana Council of Community Mental Health Centers, Primary Care Physicians, FQHCs, CHC, CMHCs and addiction providers. Based on a gap/barrier assessment survey completed by the stakeholder taskforce, five subcommittees were formed: Training/Education, Data/Technology, Funding/Reimbursement, Policy Development, and Health Homes/Care Coordination. The stakeholder task force was created through and is led by a partnership between the Indiana Family and Social Service Administration (FSSA), Division of Mental Health and Addiction (DMHA) and Office of Medicaid Policy and Planning (OMPP), and the Indiana State Department of Health (ISDH). TTI dollars were used to fund a variety of activities and functions, which have been instrumental in moving Indiana toward formalizing integrated primary and behavioral health care (IPBHC). DMHA used TTI funds to contract with a training/TA vendor Affiliate Service Providers of Indiana (ASPIN), to coordinate and facilitate IPBHC Training/TA events, develop certification process for Community Health Worker (CHW)/Certified Recovery Specialist (CRS) including curriculum, tests, train the trainer events, and develop and maintain a website and a learning management system. In addition, using TTI funds, DMHA created a dedicated staff position to focus exclusively on TTI IPBHC activities.

KEY TTI FUNDED ACTIVITIES

TTI funded activities include: 1) Planned and facilitated eight Training and Technical Assistance events; 2) Development of a 21 module curriculum to cross train and certify Community Health Workers (CHW) and Certified Recovery Specialists (CRS), competency testing, and a train the trainer event to implement the curriculum; 3) Development and maintenance of the Indianaintegration.org website and Learning Management System; and 4) Hired a dedicated staff person to facilitate and coordinate TTI funded activities, develop, implement and analyze a baseline survey and write a strategic plan to formalize IPBHC in Indiana.

1) TTI funds were used to plan and deliver eight training events, including pre/post testing to assess increased levels of knowledge, program evaluations, and recommendations to identify additional training and/or resources needed to bring Integrated Primary and Behavioral Health Care (IPBHC) to scale in Indiana. Each training event targeted professionals working in primary care and/or behavioral health settings as well as consumer and advocacy groups. Training sessions included three full day train the trainer events, a TA event follow up conference call, and 3 two hour webinars. All webinars allowed for 100 participants while full day training events allowed for 25 participants. *Completed five (5) IPBHC Training and TA events as of September 13, 2013- total 150 participants. *Scheduled for completion in by Oct 2, 2013- Two IPBHC webinars and one CHW/CRS train the trainer event- anticipating 170-200 participants. Projected total number trained with TTI funded trainings - 330 -360 individuals.

To ensure sustainability and growth **ALL** Train the Trainer Training events included training materials (manual and CD) and resources for participants to use as trainers to conduct additional trainings across the state moving forward. The train the trainer events included a *Cross-training CHW/CRSs* event (event was a collaboration with ISDH).

- CHW/CRS Certification Grandfathering – Limited time option for current practicing CHWs or CRSs throughout the State.
- Moving forward, those wishing to be state-certified CHW/CRSs will complete a specific training program and certification testing. It is understood that there are many training options available; however, the unique training program is recognized by the state due to its inclusion of both health and behavioral health in the curriculum and competency test.
- New 1915(i) Behavioral and Primary Healthcare Coordination program State Plan Amendment submitted and Indiana is awaiting CMS approval, which includes DMHA and ISDH certified CHW/CRS credential as eligible for reimbursement for select service activities within their scope of practice.

2) Developed a 21 module CHW/CRS cross training curriculum, certification test(s), and a TTI funded train the trainer event (Sept 19, 2013) which included training materials and resources for ten trainers to use to cross train individuals moving forward. TTI contracted vendor (ASPIN) collaborated with DMHA, ISDH, consumer/family CHW/CRS advocacy organizations and stakeholders to facilitate the development of the train the trainer curriculum used to certify and cross train individuals to become certified as either or both, Community Health Workers and/or Certified Recovery Specialists.

3) Established indianaintegration.org to house IPBHC information, education and resource materials and links. In addition, the website is used to announce, share and promote TTI and IPBHC events, activities and resources across the state. The website is the TTI event registration access point that is used to raise awareness of IPCBH and educate site visitors. Over a six-month period (between March 2013 and August 2013) of website usage, there was an average of 136 unique visitors and 423 website visits per month.

4) Developed and hired a dedicated IPBHC contract staff position who facilitated and coordinated TTI funded activities, developed, implemented and analyzed a baseline survey, facilitated development of guiding principles and core components, facilitated collaborative relationships and meetings with stakeholders and IPBHC committees, and is utilizing work completed with TTI funds to develop a strategic plan for formalizing IPBHC. TTI funds helped support bringing Kathy Reynolds to Indiana for a TA session on exploring options for formalizing integrated care.

5) Other activities included (a) a presentation at the Indiana Annual Recovery Month Symposium (INARMS) Conference; (b) Webinar presented by Integrated Health Solutions at the National Council for Behavioral Health - *Using data to measure Integrated Care*; (c) a roundtable discussion with Indiana SAMHSA Primary Care and Behavioral Health Integration Grantee Recipients; (d) Submission of policy consideration to Medicaid (OMPP) which focused on SBIRT reimbursement for mid-level practitioners; (e) Completed Draft and currently vetting Strategic Plan to formalize primary and behavioral health in Indiana; and (f) a *Primary and Behavioral Health Integration* presentation to: the Secretary of Indiana Family and Social Service Administration (FSSA), the Health Commissioner for the Indiana State Department of Health (ISDH), the Director for the Division of Mental Health and Addiction (DMHA), and the Office of Medicaid Policy and Planning.

LESSONS LEARNED

1) Gaining time, attention and engagement from our targeted primary care provider audience proved to be a challenge. Solutions to meet the challenge included embedding within their activities, working with the ISDH and Indiana Primary Health Care Association to explore opportunities to be involved with state/regional meetings.

2) Maintaining a project leader for a grant-funded period proved to be a challenge. Indiana would suggest requiring a written commitment from prospective short-term contractor applicants to better ensure the continuity of the project. Under more rigid funder's requirements, some of the proposed deliverables would not be met. However, the flexibility of the TTI funds will allow Indiana to use the funds to finish the strategic plan for formalizing integrated care. Indiana greatly appreciates this opportunity and will continue to build on the TTI funded activities to formalize integrated care which may include but not limited to developing behavioral health focused health homes.

3) Expert technical assistance was brought into the state to assist Indiana to work to explore options to develop a formalization mechanism. While this was helpful, maintaining overall buy-in to keep as priority agenda item was at times challenging due to changes in staff, administrations, and agency reorganizations that created competing priorities. The TA helped us get into the details of formalizing integrated care, and helped us to adapt to the changing environment, better define our roles, and prioritize goals. This was accomplished through cross agency meetings where all partners candidly discussed shared goals, roles, and expectations. In hindsight, creating a cross agency written MOU, Charter, or agreement to solidify commitment and define roles upfront may have been helpful.

4) Getting multiple agency heads together in one room at the same time has proven very challenging. Developing a presentation and recommendations for the cross agency collaboration members to present to each agency head may be a strategy to consider to avoid long scheduling delays. However, it was beneficial for all partner agency leaders to come together.

Great Long Lasting Benefits from TTI Funds:

While IPBHC collaboration had formed prior to TTI funds being awarded, the funds provided opportunities for stakeholders to see their ideas and recommendations come to life. Bringing in national experts to provide education and training on IPBHC would not have occurred without TTI funds. Development of the CHW/CRS cross training would not have happened without TTI funds! In spite of a number of changes in state government taking place since December 2012, integration of primary and behavioral health care has stayed on agency leadership's radar. The TTI funded activities were constant reminders of the importance of the work to be done to move Indiana forward from good to great in achieving positive results in improving the overall health and well-being of Hoosiers. Activities to formalize IPBHC will continue in Indiana thanks to the jump-start TTI funds have provided.

Workforce development is a significant need and challenge which TTI funds allowed Indiana to begin addressing through training/TA, certification implementation for cross-trained CHW/CRS, resources to coordinate and engage of stakeholders to assist in the development and implementation of a formally recognized framework for Primary and Behavioral Health Care Integration. As of June 1st, a new 1915(i) Medicaid State Plan Home and Community Based program will have specific reimbursement opportunities for the individuals who are certified as CHW/CRS.

Next steps:

Indiana will continue the forward progress brought about by the TTI funded activities. Over the next year, the state plans to continue bringing integration of primary and behavioral health care to scale in Indiana with following activities: DMHA will become the new "owner" of the Indianaintegration.org website; contract with a vendor to manage the implementation of the CHW/CRS cross training initiative and certification process for CHWs and CRSs; finalize the strategic plan and framework to formalize integrated care; and begin formal planning and development meetings for implementing behavioral health focused Health Homes in Indiana.

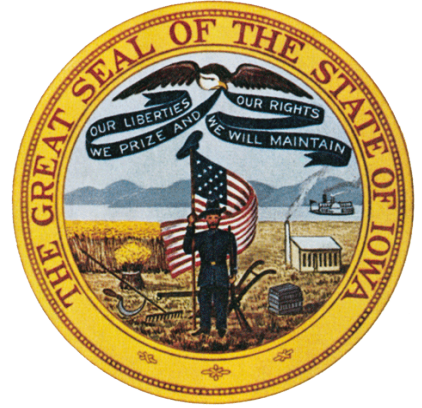
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Iowa



FY2008 TTI PROJECTS:

1. *Development of emergency mental health crisis services through Iowa's CMHCs; and*
2. *Improvement of their children's mental health system through CAFAS training.*

KEY OUTCOMES:

Development of emergency mental health crisis services through Iowa's CMHCs

- Development of an Acute Mental Health Systems Task Force.
- This project was instrumental in helping the state of Iowa in dealing with the horrific tornadoes and flooding in 2008. This successful assistance received significant attention at the Iowa legislature and secured the department \$1.5 million in new funds to continue to develop Emergency Mental Health services.
- Also in response to the natural disasters, TTI funds were used to provide Mental Health First Aid (MHFA) instructor training to 22 professionals who will train other professionals to use Mental Health First Aid across the state.
- With work from Mark Engelhardt of the University of South Florida, the Task Force developed new state standards for Emergency Mental Health (EMH) services, a statewide implementation plan for statewide delivery of EMH services, plus safety net services in acute mental health care.

Improvement of their children's mental health system through CAFAS training

- Dr. Kay Hodges, of the University of Michigan and the originator of the CAFAS ("Child & Adolescent Functional Assessment Scale") training, performed 'train the trainer' training to 39 mental health professionals from 34 CMHCs across Iowa to use the CAFAS and PECFAS ("Preschool and Early Childhood Functional Assessment Scale") assessment scales.
- Many Community Mental Health Centers purchased CAFAS software and licenses to enable computerized scoring of the CAFAS.
- The SMHA was also able to leverage the TTI grant to obtain \$500,000 of new funding from the Iowa Legislature to continue this training program beginning January 1, 2009.

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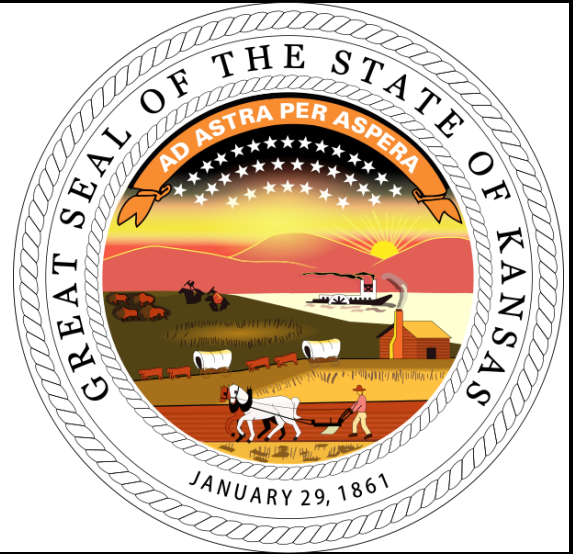
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Kansas



2011 TTI PROJECT:

Whole health initiative to improve health and wellness and coordination of physical and mental health treatment for persons with severe and persistent mental illness

KEY OUTCOMES:

The Kansas Department of Social and Rehabilitation Services (SRS) contracted with three agencies: Kansas Health Solutions (KHS), The Association of Community Mental Health Centers in Kansas (ACMHCK), and Breakthrough Club of Sedgwick County, a vocational and social program for person with mental illness. Through collaborating with these three agencies, Kansas planned to achieve the following goals:

- Improve health and wellness and coordination of physical and mental health treatment;
- Provide training and technical assistance to mental health treatment providers and peer support organizers; and
- Advance existing efforts in the development of an effective behavioral health home and care coordination model to inform policy decisions in Kansas.

Federal money had increased system preparedness re: whole health; has also increased managed care relations, acceptance and information exchanges.

In order to achieve these goals, SRS committed to the following tasks:

- Improving the coordination of physical and mental health care by building upon the existing efforts of KHS to develop an effective care coordination model in Kansas;
- Partnering with Breakthrough Club of Sedgwick County to provide training and technical assistance to community mental health centers and consumer run organizations to incorporate health and wellness activities;
- Collaborating with The Association of Community Mental Health Centers of Kansas' to research efforts to identify effective and efficient behavior health home services that can be included as part of the Kansas State Medicaid Plan for health homes;
- Partnering with Wichita State University (WSU) to ensure the coordination of physical and mental health care is delivered by trained practitioners. WSU to develop and implement an on-line training for practitioners; and
- Developing standards and guidelines in consultation with providers, consumers, and advocates. These standards and guidelines will serve as a framework for the coordination of physical and mental health treatment and provide a springboard for developing a Medicaid state plan.

Kansas Health Solutions

The first big event was held on January 27, 2011. KHS sponsored a Primary Care Integration pilot meeting in

Wichita. Presenters included representatives from the Cherokee Health Systems. Feedback from participants was very good. This was an opportunity for representatives from the integrated care pilots around Kansas to meet face to face and hear from Cherokee what success they had accomplished with integrating health care with mental health.

In collaboration with the Kansas Association for the Medically Underserved (KAMU), KHS has conducted monthly status meetings on the statewide primary care integrated pilot project. There are ten pilot sites around the state that involve CMHCs partnering with local health care providers and/or community health care clinics. KHS has developed a data system to track clients participating in the pilots. One of the tools used to track progress is the SF-12. Early data gleaned from the SF-12 indicated an 8% reduction or an average of \$37 a month less in medical expenditures per person.

KHS organized another statewide integrated health care symposium held September 27, 2011 in Wichita. This all day, professionally facilitated symposium included guest speakers from Missouri's Health Home initiative. Over 100 physical and behavioral health care providers, consumers and pilot participants attended.

Breakthrough Club of Sedgwick County

Breakthrough Club of Sedgwick County developed a 12 week program to encourage fitness and healthy eating called The H.E.A.L. Project. The H.E.A.L. project involves educating Breakthrough Club members on how to live a healthier life. The TTI funding was used to conduct eleven Train the Trainer sessions on the H.E.A.L. Project model. Members of Consumer Run Organizations and Community Mental Health staff were trained on the various aspects of the project and implemented a similar program upon the return to their home communities. Feedback has been very positive and the overall evaluation score from the participants was 4.74 out of 5. The participants walked away with specific plans and goals for their communities. Breakthrough Club has developed a manual for this training and shared it with NASMPHD.

Association of Community Mental Health Centers of Kansas

The ACMHCK has been conducting research, attending conferences, and participating in webinars on best practices currently being utilized for health homes. ACMHCK provided a final report to SRS with recommendations that can be included in the Kansas state Medicaid plan for health homes. Due to the TTI grant, CMHCs are also working towards this goal.

SRS expanded its agreement with ACMHCK and provided an orientation training to all 26 CMHC on how to integrate physical and mental health care. Because most of the effort to educate mental health providers on care integration has been focused on the targeted case managers, this training provided an opportunity for all CMHC staff – direct service and administrative staff to learn more about this exciting initiative taking off in Kansas.

Wichita State University

Wichita State University, a leveraged resource for the TTI grant, developed a Kansas specific Coordination of Care on-line training. The training went "live" on June 15, 2011. This training is required for all community mental health center targeted case managers to complete within 60 days of hire. From the time period of June 15-August 31, 2011, seven hundred thirty seven individuals completed the course. The feedback on this training has been very positive. The Wichita State curriculum has also been instrumental in the creation of a statewide train-the-trainer curriculum.

In retrospect, the TTI grant was the catalyst to better health and wellness collaboration statewide.

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Kentucky



FY2008 TTI PROJECTS:

- 1. Peer Support Initiative with State Medicaid Office; and*
- 2. Development of a Plan to Support High Fidelity Implementation of Wraparound.*

KEY OUTCOMES:

Peer Support Initiative with State Medicaid Office

- A Peer Support MOU with State Medicaid Office – as a result of which two pilot sites for Medicaid Peer Reimbursement have been established, with ability to bill soon.
- Development of a Peer Support Services Steering Team including consumers, family members, peer specialists, and representatives from the University of Kentucky, CMHCs, and state mental health, substance abuse and Medicaid agencies.
- Development of recovery curriculum for consumers, family members and clinical staff of the fourteen regional MHMR Boards.
- A statewide Recovery Forum which launched the recovery curriculum and attended by 82 consumers, as well as family members, clinicians, rehabilitation providers, educators, policy makers, and executive staff.
- Two statewide peer support trainings resulting in fifty additional trained peer specialists, giving Kentucky 155 total peer specialists.
- Three technical assistance teams were formed from members of the TTI Steering Team to support implementation of peer support services on a statewide basis.

Development of a Plan to Support High Fidelity Implementation of Wraparound

- Creation of State Wraparound Implementation Fidelity Team (the "SWIFT").
- Development of Implementation Plan for Wraparound using NIRN Implementation Drivers Framework.
- Development of cross-agency training curriculum for core components of wraparound facilitation.
- Development of training curriculum for coaches of wraparound facilitators, including mechanisms for fidelity monitoring.
- Assistance, participation, and expertise of Kentucky's statewide children's interagency council, which encompasses eleven other state agencies.

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Kentucky



2011 TTI PROJECT:

- 1) Service enhancement with the co-occurring providers through NIATx and mini-grants; and 2) facilitate the establishment of Double Trouble in Recovery groups*

KEY OUTCOMES:

Originally Kentucky was going to focus on two major efforts to further promote the integration of mental health and substance abuse services:

1. Utilizing a Steering Committee the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) planned to hold a series of regional forums to educate stakeholders on the impact of PPACA and to help guide “next steps” in furthering the integration of services.
2. Facilitate the establishment of Double Trouble in Recovery groups in a small number of Kentucky’s CMHC regions dependent on developing local interest. Double Trouble in Recovery groups are peer-to-peer groups that focus on people who have co-occurring mental health and substance use disorders.

There was a need to change #1 above due to a change in Kentucky’s mechanism on how it manages its Medicaid benefits. Kentucky promulgated an RFP for managed care contracts during this time and it was determined that having regional forums could jeopardize the procurement process by inadvertently providing erroneous or selective information. Consequently, the forums were cancelled and the TTI project, with permission from NASMHPD, focused more intensely on service enhancement with the co-occurring providers.

It cannot be emphasized enough that the way these funds have been distributed to the state is key to having a successful impact on service delivery for Kentucky. The flexibility of these funds allowed Kentucky to moderate the original plan, accrue the funds, modify contracts and continue with this part of the project in a fully planned and effective manner.

NIATx and mini-grants. This focus took the form of continuing DBHDID’s project that reviewed and assessed the CMHC’s capability to serve individuals with co-occurring disabilities by using the

DDCAT/DDMHT instrument (Dual Diagnosis Capability in Addiction Treatment/Dual Diagnosis Capability in Mental Health Treatment). The TTI funds were used to award a series of \$6000 mini-grants to providers that submitted an application to the Director's Office that identified a change leader, a set of objectives to improve measures in at least three dimensions on the instrument, and a set of rapid-cycle initiatives showing their progress. This process improvement project is using the NIATx format, which this Division has supported and used on targeted areas successfully in the past.

Ultimately, 11 of 14 CMHC's accepted the mini-grants. Acceptance of the mini-grant means that a provider will be evaluated under the NIATx model – a process improvement model originally designed to improve access, retention and penetration rates with substance abuse services. By referencing the scores from the Dual Diagnosis Capability instruments the CMHCs used the mini-grant funds and the process improvement process to target improvements in services. Projects to improve scores were suggested by CMHCs, and ideas were cross-shared on monthly conference calls.

On May 1st, all CMHCs met to present their finished projects. Thereafter additional improvement projects will be self-funded by providers, who are generally excited by the results and improvements and have really “taken the bull by the horns.” All 11 participating CMHCs are expected to continue their participation in the self-funded portion of the project.

Double Trouble in Recovery.

Double Trouble in Recovery is a Twelve Step program for men and women to share their experiences, strengths and hopes with each other so that they may solve their common problems while helping others to recover from their particular addiction(s) and manage their mental disorder. The program is designed to meet the needs of the dually diagnosed, and is clearly for those having addictive substance problems as well as having been diagnosed with psychiatric disorders. Groups like Double Trouble in Recovery are incredibly important for people with co-occurring disorders as many substance abuse only support groups, such as Alcoholics Anonymous, can frown upon certain mental health medications. For example, anti-depressants are the drug of choice for some people in substance abuse programs and are sometimes perceived as an excuse or enabling. But in the mental health world, these drugs are frequently a critical part of a person's care.

Peers took much of the lead in Kentucky, and the first group was started in Lexington. As news spread about the group the project spread statewide. Originally Kentucky hoped to establish three groups, but five have been established and plans are underway to start two more. As with all peer based groups, there will be an evolutionary maturation of groups and the individuals in them.

Kentucky also sent two staff to the training in South Carolina to facilitate the start-up of the Double Trouble in Recovery programs. They have identified training material for these groups, and these have been purchased and distributed to a large number of professionals and peer mentors who have been identified as individuals with an interest in DTR. Since these are peer-to-peer groups and DBHDID cannot pay the facilitators directly, TTI resources have been used to provide training and logistical support for that training.

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Kentucky



FY2012 TTI PROJECT:

Trauma Informed Care (TIC) Forums and Statewide Implementation Efforts

KEY OUTCOMES:

Purpose of Grant Funding: This project supported the initiation of statewide efforts in the implementation of trauma-informed care across the state, including: the formation of a statewide interagency Trauma-Informed Care Steering Committee; eight Regional Interagency Trauma-Informed Care Community Forums; and support to provide follow-up to the Regional Forum communities.

Trauma-informed Steering Committee: The purpose of this Committee was to provide information to agencies regarding federal and statewide trauma-informed care efforts in various agencies as well as gain feedback on future efforts to expand trauma-informed care across the state. The first Steering Committee meeting was held in March 2012. After the TTI grant ended, the Committee voted to continue to meet on a consistent basis and is presently being facilitated by the Department for Behavioral Health personnel. Committee participants include state level personnel from over 15 different agencies and groups. The Steering Committee has proven to be a great learning experience for all participants and has allowed many agencies and entities to learn about the “snippets” of trauma work that the others do.

Regional TIC Forums: The purpose of these Forums was to provide information to local communities about trauma and trauma-informed care and to guide a discussion around “Creating Cultures of Trauma-Informed Care”. DBH contracted with a national consultant through Community Connections in DC who guided us through this process and provided a speaker and the content for each Forum. Community partners were given information about trauma and trauma-informed care and were provided with the tools to guide them in developing strategic plans around trauma-informed care implementation.

All 14 community mental health centers (CMHCs) were eligible to apply to convene a Forum in their community. Funds were limited to implementation in 8 regions (although 2 non-funded regions attended the Forum of neighboring CMHCs). There were applications from 11 of the 14 CMHCs (one CMHC per region). CMHCs were required to invite local community partner leaders to attend and participate in this Forum. Participants were expected to include a small core team from their agency that could take the information gleaned and have the ability to facilitate change. The Regional Forums took place during the first two weeks of August 2012. There were over 441 participants and at least 57 different agencies and groups in attendance over the 8 Forums. All participating CMHCs were required to submit a Final Regional Forum Status Report that included a summary of the Forum and initial plans for future TIC efforts. CMHCs were also eligible for additional financial support upon completion of a TIC Work Plan submitted to DBH.

Follow-up Support for Trauma-Informed Care Efforts:

- 1) **Trauma-Informed Care Training for Trainers:** An overview of trauma-informed care is presented in a training for trainers format and provided to trainers within a variety of agencies. This training is held on a quarterly basis and is free to participants.
- 2) **Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative:** A 10 month training and coaching program (Nov. 2012 – August 2013) for 28 clinicians across the state. Priority was given to regions that held a Regional Forum. There were a large number of requests and a waiting list was created. Kentucky may hold a second training as a result.
- 3) **Ending Domestic Violence and Sexual Assault Conference (December 2012):** Scholarships were provided for the TIC Pre-Conference Institutes as well as the main conference. Janine D’Annibelle provided a Pre-Conference Institute on the “Neurobiology of Trauma”. Lori Beyer from Community Connections provided a Pre-Conference Institute on “Creating Cultures of Trauma-Informed Care”. A trauma track was also included in the workshop schedule.
- 4) **Community Connections Webinars:** DBH is collaborating with Community Connections to provide 4 different TIC related Webinars, that will also be archived for future use, to any interested KY provider on the topics of:
 - Trauma and Co-Occurring Mental Health and Substance Abuse
 - Trauma-Informed Skill-Building
 - Trauma-specific Services
 - Trauma Screenings and Assessments
- 5) **Louisville Childhood Trauma Symposium (May 17, 2013):** DBH is provided support to the Symposium for Plenary Speakers: Dr. Monique Marrow (National Child Traumatic Stress Network) and Dr. Christopher Mallett (Cleveland State University).
- 6) **Social Marketing Efforts:** A Kentucky TIC logo (below) was developed to support the branding of TIC in Kentucky – one of the lessons learned is that marketing is underappreciated and can be an essential part of outreach. TIC Posters were printed that highlight the Principles of TIC. DBH also collaborated with our Kentucky Federation partner (Kentucky Partnership for Families and Children) on a youth oriented music video related to trauma-informed care. DBH is also in the midst of finalizing a brochure that will provide more detail about TIC and what an agency can do to become more trauma-informed.



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Kentucky



FY2013 TTI PROJECT:

Evidence Based Screening for Children.

KEY OUTCOMES:

Overview

The purpose of the *Expanding Access to Evidence-Based Practices for Kentucky's Young Children in Child Care* TTI project was to implement evidence-based screening using the ASQ and ASQ-SE in six child care settings in Central Kentucky. Those children who screened positive in any of the developmental domain were referred for further assessment to the appropriate agency. Further, families in these child care settings had access to the evidence-based Nurturing Parenting Program, a 16-week parenting group, as well as one-on-one peer support, upon request. The six child care settings participating in the project were selected based on the high proportion of children and families receiving child care subsidy, an indicator of high need.

Key Outcomes

- The project implementation team convened monthly, and continues to do so.
- Preliminary results for implementation of ASQ-3 and ASQ: SE screening:
 - Thirteen staff from six centers were trained on May 23, 2013 in administration of the Ages and Stages Questionnaires, Third Edition and Social-Emotional edition (ASQ-3 and ASQ: SE), and on referral procedures for children for whom concerns were identified.
 - All centers except for Steppingstones of Berea have screened children and submitted data; Steppingstones has been contacted several times and reports being too busy with start of year to have begun screening, but plans to do so.
 - Preliminary screening results from May 23 to September 4, include:
 - 134 children screened
 - 134 children received ASQ-3 (results are being tallied)
 - 91 children received ASQ:SE; 72 passed; 2 referral status; 17 incomplete (post-screening referral status include referrals to First Steps [IDEA Part C], HANDS [first time parent home visiting program] Head Start, and Medical services)
 - Services prior to and after screening:

Service	Number of Children Receiving Service At Time of Screen	Number of Children Referred for Service Based on Screening
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Family member in Military	3	n/a (not assessed after screen)
Individual Family Service Plan	0	n/a
Individual Education Plan	0	n/a
HANDS (First time parent home visiting program)	0	2
First Steps (IDEA Part C)	3	8
Public School	2	1
Head Start	2	13
Medical Services (i.e., Physician, Specialty Medical Clinic)	3	3
Mental Health Services (i.e., Community Mental Health Center, Early Childhood Mental Health Program, KY IMPACT (targeted case management via wraparound process))	6	0 (One center indicated possible referral to ECMH Specialist but did not indicate such in referral stats; ECMH Specialist has contacted all centers)
Child Care Assistance Program (Subsidy)	66	7

- Preliminary results for implementation of Nurturing Parent Program:
 - Hosted a joint meeting of all Nurturing Parent Program group leaders and peer support specialists
 - Hosted two small site-team meetings with group leaders for implementation planning purposes
 - 15 child care providers trained in Nurturing Parent Program Community-Based Education curriculum
 - Marketing events held for the three child care centers hosting NPP in the fall
- Family Peer Support Service Provision:
 - 3 Peer Support Providers have been identified to serve the six child care centers

Lessons Learned

- Offering the Nurturing Parent Program Community-Based Education module was beneficial in that it equipped child care providers with information about the NPP to aid in recruitment efforts.
- Offering child care professional development hours was an effective incentive.

- Additional training and follow-up with centers is needed to ensure fidelity of ASQ-3/ASQ:SE-screening implementation and for referral procedures.
- Follow-up with centers for results of screening referrals to various agencies in KY would be beneficial.
- Providing additional incentives for centers that successfully screen children and make referrals for additional assessment as needed may increase participation.
- Recognizing centers in KY that implement screening and referral efforts with fidelity at an early childhood conference may increase project awareness and interest.

Projected Outcomes for Next 6 Months

- In the next 6 to 12 months, all participating centers will continue to screen and submit data. All centers agreed to screen children in spring 2014 at the least; some centers are conducting screenings each month. It is anticipated that some children will be referred for additional assessment and will receive needed services that would otherwise have been missed. In addition, it is anticipated that families will be more informed about the development of their children, and will more actively engage in activities with their children. Lastly, it is expected that center staff will more accurately notice children with potential delays and conduct screenings and referrals as needed.
- In the next 6 to 12 months, six, 16-week Nurturing Parent Program series will be offered; 3 in Fall 2013 and 3 in Spring 2014. It is projected that 30 families per group will participate. Ongoing online data collection will occur.
- It is projected that 10 families will access peer support services per each group.
- A final report will be disseminated to relevant stakeholders to promote dialogue about future replication of the model.

Accomplishments Not Possible without Federal Dollars

- The current federal investment has allowed for increased best practice through screening and education of families at six centers in central KY, supporting approximately 100 families and their teachers through these efforts. The portal for collecting and analyzing screening data has been upgraded based on user feedback. Reporting features have been developed and refined as well.
- Funds were used to purchase curricula and support group materials and to create and purchase marketing materials for the Nurturing Parent Program. Support and child care are being provided to families to increase participation in parenting groups.

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Louisiana



FY2009 TTI PROJECT:

Provide training, through the Early Childhood Supports and Services (ECSS) program, for public and private sector clinicians in specific EBPs in order to achieve improved clinical and functional outcomes in preschool children (birth through five years).

KEY OUTCOMES:

- Louisiana’s ECSS program was included in the “Roadmap to Economic Success” document that early childhood advocates will be supporting for additional funding during this upcoming legislative session for sustaining the work done under the TTI.
- Partnered with Tulane University to write and test the training manual and curriculum.
- OMH’s dialogue with its Medicaid office was successful in efforts to getting approval to bill for the PCIT (Parent-Child Interactive Treatment) component of the ECSS protocol; PCIT is an evidence-based treatment model; ECSS is anticipating approval to begin billing by July 1, 2010. This will greatly enhance Louisiana’s ability to sustain and expand the program statewide.
- OMH leveraged an additional \$1 million in TANF funds, for ECSS Program, effective this fiscal year.
- Initial Training and Booster Training is on track for December 2009 for child clinicians working in state mental health clinics and network partners working in other state/private agencies. The training is free to qualified clinicians statewide and will be followed by booster sessions over three months. This training will be provided by Tulane Department of Child Psychiatry.

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Louisiana



FY2013 TTI PROJECT:

Establishment of Louisiana's first mental health court (MHC) program that specialized in problem solving, using a collaborative team approach with judicial leadership

KEY OUTCOMES:

I. Overview and Key Outcomes

Collaborators representing the Lafayette Parish Sheriff's Office, the Louisiana Office of Behavioral Health, the Louisiana Department of Corrections, and other stakeholders, developed for the Lafayette Parish criminal justice system a proposed response which involves: (1) the diversion of individuals charged with probation and parole violators (and possibly misdemeanors) from jail time; and 2) the provision of re-entry services and treatment to appropriate offenders leaving the state prison system through "good time" and parole and returning to Lafayette. Louisiana also contracted with the LSU Office of Social Service Research and Development (OSSRD) to conduct an evaluation. The project was designed as a mental health court program that specialized in problem solving, using a collaborative team approach with judicial leadership. This project is of critical importance, as Louisiana has by some measures the highest incarceration rate in the world (in addition Louisiana has 1 social worker for every 1,000 inmates). We anticipate that the court will formally start activities in the Summer of 2014, and will initially handle probation and parole hearings.

The Lafayette Parish Sheriff's Office Community Resources Treatment Court (CRTC) was deemed to be an excellent site to implement this court-based intervention due to the success of the existing and well-established Community Resources Program (CRP), which is a community-based day reporting center and treatment organization. CRP is equipped with programs and qualified staff that provide treatment and facilitate employment and education opportunities with sufficient oversight and case management. The sheriff's office is currently the largest mental health provider in the parish and is working with Magellan to get reimbursement for certain services. It is hoped that the Court will assume some of these activities, as well as with activities such as counseling referrals and medication checks.

The key idea was to provide treatment in the community for offenders with serious mental illness (SMI) and co-occurring disorders. Not all offenders with mental health problems would be included in the CRTC, but rather a sub-population of those meeting the court's eligibility criteria. In Lafayette, criteria include male and female adults (18+ years), excluding those with sex offenses and violent charges. Those eligible must meet clinical criteria, which entail an Axis-I diagnosis: SMI or co-occurring (both SMI and drug) disorders.

There are various models of MHCs; however, they are basically conceptualized in two ways: 1) centralized within one problem solving court docket or 2) integrated into practices and procedures of the whole court jurisdiction. MHCs must have a functioning source organization to provide treatment. The CRTC process to

be evaluated is basically an emerging program of the CRP – Day Reporting Program – plus mental health treatment, under the jurisdiction of the court.

The proposed project aimed for individuals in CRTC to have specialized treatment for SMI and Co-occurring Disorders including individual and group mental health treatment from the CRP mental health professional, oversight by the CRTC designated case manager, specialized staff reviews, as well as other appropriate treatment as determined in tailored mental health treatment plans. When appearing before the court, the CRTC participants would be accompanied by a representative of CRP or its designee (such as a mental health professional in the corrections system), and CRP would provide the presiding judge with a report summarizing the participants' treatment progress. The presiding judge would have adequate information to provide sanctions and rewards, as deemed appropriate.

In summary, the Lafayette CRTC would: (a) Include those with co-occurring disorders in the existing treatment court; (b) Include those with SMI in the criminal dockets of the other judges; (c) Provide mental health treatment at CRP with judicial oversight; (d) Provide the means to treat the underlying mental health issues that may cause justice system involvement; and (e) Among other measures, the evaluation proposes to assess the impact of CRTC on incarceration, recidivism, and individual functioning (such as stable housing, education, and employment).

Current State of the Program

One of the key outcomes that has been accomplished is the near completion of a database used to collect demographic, treatment, and court records, which will provide quantitative data about treatment and outcomes. The web based data base has been developed and will be accessible pending resolution of several of the operational definitions of crimes that are included. Additionally, the treatment court has developed a preliminary manual of operations.

Over the course of 2013, the enrollment for CRTC has been extremely low. To date there have been about 4 individuals referred from the existing treatment court. All of these individuals had drug offenses; therefore, they all are categorized as offenders with co-occurring disorders. As of this report, there are 2 individuals in CRTC from the existing treatment court. No referrals have been sent from any other judge's docket.

The CRP team has closely monitored the low numbers and made a decision to "enroll" other individuals who are referred to the CRP Day Reporting program. These are individuals who were assessed at CRP as having mental health problems. As a result, an additional 10 individuals have received mental health treatment at CRP. At the CRP treatment facility, all mental health clients receive a tailored treatment consisting of individual counseling and participate in a mental health group that occurs 4 times per week. The mental health group includes dialectic behavior therapy, which incorporates social and coping skills training. The group work focuses on specific behavioral techniques to treat the clients' disabling mental health symptoms.

The only difference in the care of individuals referred from the court and those identified at Day Reporting is that the court referred clients must attend the existing treatment court every Thursday, and their mental health counselor meets with the judge in his chambers prior to court. The client attends court along with the mental health counselor and case manager. Those who are identified at CRP attend court as required by their case, and their judges are not aware of the specific mental health treatment.

The mental health staff reports that none of the clients who have been treated (either CRTC or those in Day Reporting) have re-offended. One individual was terminated from the program and returned to jail. One of the clients (referred by the judge) was moved from the mental health program to a substance abuse program.

Because of barriers to effective program implementation, the evaluation period has been extended from the

original six month period until the end of 2014.

II. Lessons Learned

During the development process, only one judge was an active participant. Because he was the substance abuse court judge, it was believed that adequate enrollees could be referred from the court. However, it soon became apparent that many of the offenders in substance abuse court did not have a co-occurring mental illness and thus were not eligible for the program. It was then recommended that the program expand to include referrals from all of the judges in the Lafayette judicial court district. The system of referrals from the court has not materialized beyond those individuals with co-occurring disorders in the existing treatment court. Upon reflection, the project might have been more successful in enrolling more participants if other judges, prosecutors, and defense attorneys were involved in the planning and development from the beginning in order to ensure buy-in and ownership of the program.

III. Where is the project going in the next 6-12 months and what are the anticipated outcomes?

Current data suggest that those clients with SMI and co-occurring disorders who receive mental health treatment are not reoffending. Reports from the mental health staff suggest that the requirement for clinician attendance at pre-court and court times is costly in terms of time. Additionally, if clients are stable and compliant with conditions of their tailored treatment plan, the best practices information suggests that weekly court attendance is not necessary. It appears that the drug court model, which is the experience of the court, is unduly influencing the requirement of weekly court attendance. The time requirements could negatively affect treatment if the case loads were large.

The Louisiana Supreme Court has also started working on a concurrent prototype court to mirror and supplement the TTI funded court. As was stated earlier the whole state is working on the incarceration rate.

IV. What has the federal investment provided? What could not have been accomplished without the federal dollars?

The federal investment has also encouraged a collaboration of the sheriff's office staff, mental health clinicians, and CRP staff members to be attentive to the details of the workings of the program. Examination has forced the team to continually problem solve. The mental health team has been communicating with the jail and court staff. It appears that the collaboration needs to be stronger among additional individuals, namely attorneys, prosecutors, and judges. Those providing mental health services are keenly aware of the evaluation and are keeping track of all data elements, which will be entered into the database.

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Maine



FY2010 TTI PROJECT:

The Office of Adult Mental Health Services worked with a group of consumers and providers to develop and implement a system of measures (in the form of a toolkit) focused on individual outcomes and recovery. The selected toolkit includes four measurement instruments: the OQ®, the Recovery Assessment Scale (RAS), the Data Infrastructure Grant Survey, and the LOCUS. The TTI grant also assisted Maine to define “recovery”, create a draft of “Recovery Guidelines for Mental Health”, develop a recovery-focused clinical training module for the administration of the toolkit, test Maine’s assumptions about whether the toolkit works to measure both individual and system outcomes, and create a training model for the implementation of the toolkit with providers and consumers.

KEY OUTCOMES:

- Maine established a work plan, hired two consumer groups to gather input for the recovery guidelines and develop recovery training as well as a consultant to produce a draft document incorporating all the feedback. Contracts were completed with the three pilot sites: Kennebec Behavioral Services, Common Ties, and CSI.
- OAMHS used the work from Connecticut as a basis for developing recovery guidelines for Maine. OAMHS conducted seven webinars based on each domain and included questions posted on the web for discussion as well as a power point for each webinar, collected input online, in written format and through discussion, and contracted with the Consumer Council of Maine to conduct a survey and focus groups. A final draft of the document will be circulated in the Summer of 2011.
- Maine created a Pilot Advisory Group that included representatives (consumers and staff) from each pilot site. Performed onsite training for one of the tools at each of the pilot agencies and used feedback from each training to improve the content.
- The recovery training effort was completed by June 2011. OAMHS contracted with a consumer group to develop the component based on the draft guidelines.
- OAMHS created a website on its main page and named it Recovery for Me. This site can be found at: <http://www.maine.gov/dhhs/mh/recovery/>.
- The pilots are just beginning to implement the RAS. Maine did, however, create focus groups that both discussed and took the RAS and are doing a community survey to gather input to norm the data.
- Maine has undertaken a pioneering effort to wed common measures associated with the recovery movement with well-recognized measures of outcome. More specifically, Maine partnered with the developers of the OQ®-45.2—the only system of outcome assessment recognized in SAMHSA’s National Registry of Evidence-based Programs and Practices—to simultaneously measure outcome and consumer recovery on two instruments: Corrigan’s Recovery Assessment Scale (RAS) and the NAMI Recovery Indicators (NRI).
- Maine is interested in not only tracking its services with respect to effectiveness on well-established

outcome measures of symptomatic improvement but also adding the voice of the consumer from a recovery perspective. In other words, to what extent are we adding value in the consumer's life by reducing troublesome symptoms **and** increasing the quality of their life on key dimensions of recovery? For this reason, Maine has been working to explore the relationship between recovery and outcomes with a psychometric examination. Data collection for this effort includes the use of consumer focused groups, a community collection of RAS data from residents of Maine and a collection of RAS and OQ Measures data by consumers receiving mental health services.

Lessons Learned:

- Electronically self administered tools using a laptop or net book are the way to go but this takes a tremendous investment of resources and close communication between technical and program people. The stakeholders (pilot site administrators, clinical supervisors, direct service staff, technical staff, consumers, and the state staff) must all receive steady support, communication, and training. With the assistance of the pilot agencies, good technical support was essential in assuring that the clinical tools were accessible to community integration workers in the field.
- A slow start with two case managers from each of the pilot sites as initial implementers was a great idea! Maine learned along the way and corrected its vision as needed. Maine has moved from 6 case managers to 60 over the course of the project and will be implementing another rollout this summer. Pilots may make more sense as a way to create system change than the full scale infrastructure changes that we have tried in the past. At the state level, we can have a new governor and a new commissioner every 4 years so large scale change can get caught up in the political structure. In addition, agencies are in great flux with mergers and potential Medicaid changes so asking a whole system to focus on change is very difficult.
- Using the recovery work from Connecticut was extremely helpful and efficient as Maine went about creating Recovery Guidelines. OAMHS tried a new model for gathering input through the use of webinars. This worked well in that OAMHS provided material ahead of time as a sort of study guide and then participants were free to use the questions to think about their input. It was still a long process...webinars over seven months....and was hard to maintain enthusiasm for the process over that long a time period. Maine did have some technical glitches but we did get more comfortable with the process, as did participants.
- The theory of the project was to equally involve consumers, providers, and state staff in the development of the recovery guidelines. In reality, many consumers and providers expressed skepticism about the actual implementation of the guidelines and were reluctant to spend time in the discussion or implementing items. OAMHS is mindful of the need for the Office to model the guidelines or explain why not.
- The Recovery Guidelines provide a discussion basis with other parts of the Department, especially as we look at Medicaid policy and a variety managed care initiatives.

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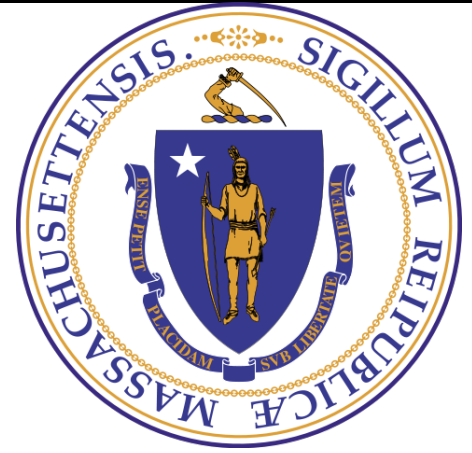
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Massachusetts



FY2010 TTI PROJECTS:

(1) a statewide training effort on person-centered planning; and (2) initiation of a program for a shared decision-making model to foster the reduction in the use of psychiatric medications.

KEY OUTCOMES:

Person Centered Planning

Massachusetts set the stage for the TTI grant through prior work such as the CMS Person Centered Planning (PCP) Implementation Grant. Upon receipt of the TTI grant, a PCP training team was convened and plans for the creation of a state-wide person-centered planning training curriculum and schedule of training sessions began. The team developed both an overview and a PCP facilitator training curriculum. The goal was to ensure that all individuals who are responsible for developing plans of care with DMH clients would be trained. The team worked with each of the state's geographic "Areas" to determine the manner, schedule and attendees for the trainings in each Area. Over the course of the grant, the training process and schedule and target audience has been continually modified based on the input from those trained, the Area staff and the training needs. DMH also determined that the curriculum designed for the community should be modified for the staff in DMH's inpatient facilities and DMH utilized the grant to begin to develop a modified curriculum and approach for these settings. *A hallmark of this project at all stages was the inclusion of peers in all aspects of its execution.*

Three presentations, offered across all six DMH Areas, were developed to implement the training:

- 1) An Overview of Person-Centered Planning – This was offered to the greatest number of staff as a basic introduction to PCP. Administrators, program evaluators, supervisors and all direct care staff including peer support staff were encouraged to attend.
- 2) PCP Facilitator Training – This training was offered to staff who were going to work directly with individuals in the development, documentation and implementation of treatment plans.
- 3) PCP Documentation Training – This session was designed to train staff to document the resultant treatment plans in such a way that would be true to the person-centered process and goals and preferences, etc. while still meeting the agency's requirements for licensing and billing.

Input was sought to ensure that these trainings built on current knowledge about PCP and matched local needs. They also gave the trainings a context and identified point people to ensure that the targeted staff attended. This insured that this initiative would be given due attention and not get lost in information overload.

The initial trainings are being followed up by post-TTI opportunities for consultation and technical assistance. These are not meant to reproduce the initial training, and would only be available to staff who were actively engaged in using PCP. The majority of the consultations have not yet taken place, although all are scheduled. As with the training, each area has chosen to take a slightly different path for the consultations - varying in number, participants, and focus.

The last component of the initiative is to develop a process to assist the DMH inpatient settings to shift to a more person-centered process for care planning in the inpatient setting and in planning for discharges. Beginning with

presentations to hospital leadership the PCP team has begun to assist inpatient leadership to form an applicable curriculum and a training plan. As with the other trainings, the hospitals plans are varied in their approach to bringing PCP to their facilities, some choosing to expose all staff to PCP principles, and others choosing to begin with specific units only. This work will also continue post-TTI.

Thus far, 20 training sessions were conducted in the community and 650 staff representing both state staff and vendor staff have been trained. This does not include the planned hospital trainings.

Shared Decision Making Medication Reduction (SDMMR)

SDMMR helps people to simplify, reduce, or eliminate their behavioral health medications. SDMMR partners with CommonGround©, an internet-based system that interfaces with an SDMMR-*employed* Peer Support Specialist trained in its use. CommonGround© enables people to arrive at their appointments prepared and ready to articulate and achieve recovery goals. Shared Decision Making (SDM) is defined as an interactive process in which providers and clients simultaneously participate in the decision-making process and negotiate a treatment plan to implement. SDM recognizes that both providers and clients have important knowledge to contribute to the decision making process.

CommonGround©, is a web-based application that helps people prepare to meet with their psychiatrists and arrive in the office ready to discuss the things that are important to *them*. When a client goes for a medication appointment, there are many issues that need to be discussed. However, the appointment is short, often only 15-20 minutes. It can be hard for a client to organize his/her thoughts, answer questions, ask their own questions, speak about concerns and make decisions in that brief period of time. CommonGround© helps the client prepare before their appointment, so that during the appointment he/she is ready to work with their doctor to collaboratively identify the best solutions/decisions for that person's treatment and recovery.

A Decision Support Center is located in the out-patient clinic that employs peer support specialist services as well as computer kiosks with CommonGround© software. The client can visit the Decision Support Center anytime - access is not restricted to appointment times with or without Peer Support Specialists assistance. The client sits at a computer station and logs into a secure, personal account to access the program. The CommonGround© program provides many tools for support – however, those critical to Shared Decision Making are: The Power Statement; Personal Medicine; Health Report; Information Treatment; and the Library.

Two clinics (one withdrew due to financial issues) with the CommonGround© program were chosen as the original sites for launching the SDMMR program. The approach built upon the CommonGround©, program by adding the medication reduction option to the recovery goals. These sites were selected because there was already buy-in and an investment in shared-decision-making tools. The plan was limited to two sites due to cost ambiguity and what would and would not be Medicaid-reimbursable at the outset.

Clients voluntarily participated when they were clinically and environmentally stable. Certain clients were excluded due to factors such as pregnancy, recent suicide attempts and pending criminal charges.

Due to implementation hurdles, evaluation data is not yet available (full data is only available for 8 clients). The program, however, will continue into the future using TTI and other funding. Hurdles included:

- Clinicians were reluctant to participate, despite training on SDMMR.
- Originally being limited to one insurance carrier (the pilot site now takes all forms of insurance).
- Delays in obtaining administrative (needed to compile evaluation materials) and billing support.
- Initial difficulties in obtaining volunteer clients, especially females and minorities.

Regardless of these difficulties, the SDMMR manual and other products have been finished and are available for use by DMH and other states.

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Massachusetts



FY2013 TTI PROJECTS:

Exploring the barriers and opportunities to encouraging culturally and linguistically understandable and relevant peer support and avenues to recovery within the Deaf community.

Groundwork - The importance of Deaf/hh (hard of hearing) culture for SMHA programs

This TTI project is unlike any other TTI project NASMHPD has assisted. To understand the experiences of people who are Deaf/hh you must understand the culture of the Deaf/hh community. Within the context of this project, some critical takeaways are:

- Mental health concepts such as recovery, trauma and peer support are not defined in the Deaf community as these are in the hearing world. Indeed within the Deaf/hh community these words have entirely different meanings.
- Understanding Deaf culture is essential. For example, for gatherings socializing at both the beginning and end is vital. The Story, the narrative, and the journey are a critical part of the recovery process. “*This is what I did to reclaim my identity*”; and this Story can frequently contain much more of the details, including trauma (frequently an immense part of the Story), than the hearing world may commonly talk about.
- Any planning and implementation of a project must account for the smallness of community – there will be complications with dual relationships and confidentiality.
- Interpreters are not a solution or a band aid. Direct communication is best. Understanding language is a subset of understanding Deaf culture. Ordinarily, when working with a different “language”, an interpreter is used to transfer knowledge. ASL, or other forms of similar communication, is not English. Within the Deaf/hh world, at least five different language subgroups exist: (1) English; (2) English/sign (overwhelmingly ASL); (3) Deaf, foreign language; (4) Deaf, foreign sign language, (5) expressive language - communication solely through visuals and gestures.
- Things the hearing community takes for granted need to be approached in an entirely different way for the Deaf/hh community. An example would be when the Massachusetts Department of Mental Health (DMH) attempted to advertise some of the meetings it was having. A poster that might work for the hearing population might be completely ineffectual for the Deaf/hh population. English words might be completely ineffective for many Deaf/hh, and more visually graphically oriented posters were frequently necessary.

KEY OUTCOMES:

Summary of The Process. DMH engaged a team including peer-run agencies, providers of Deaf and Hard of Hearing behavioral health services, and members of the Deaf community self-identified as having a mental illness and working on their recovery, to become the Steering Committee. The team brainstormed about where to engage the Deaf/hh community and how to engage participants. It was decided to use a popular Massachusetts specific yahoo distribution list as well as connect with professionals in the various agencies that have a high number of Deaf/hh clients. These included the Commission for The Deaf and Hard of Hearing; The Commission for Rehabilitation; the Deaf/hh Independent Living Services (DHHILS); The Deafblind Community Access Network; schools for Deaf/hh; the DMH operated state hospital with a specific Deaf service; and vendors that serve Deaf/hh clients.

The next step was to discuss the concepts of peer support and recovery and “unpack” the concept behind the words. There was a lot of discussion about the best way to convey these concepts. After deciding on key concepts, DMH generated a list of ways to use ASL to express the concept. The group agreed that in addition to using American Sign Language (ASL), Deaf culture requires the use of stories, pictures and role plays. Visual representation and stories are important in Deaf

culture. Deaf Peers were teamed up with a hearing peer specialist and worked in a different region of the state and connected with the agencies and Deaf individuals in that area. Additionally, the Deaf peers addressed a few statewide meetings of agency professional staff and had a table at a Deaf Health Fair and the Annual NAMI walk.

Summary of Activities To Date

- 2 Statewide presentations to staff and 2 events at which the project had an exhibit table.
- 38 forums across the state were facilitated. The number of Deaf/hh participants in each varied from 1 or 2 to a high of 18. These individuals included people who self- identified or were identified by staff as having a mental illness or emotional crisis. Others came as they were curious. Often in the course of the group, there was an understanding of what aspects did pertain to the person's life.
- The total number of Deaf/hh participants in the groups was 242. This is a duplicated count.
- 57 Deaf/HH and hearing/signing staff participated in the forums. Usually, these were separate meetings.
- DMH has used some of these funds to work with the peers and a film maker to film and edit their recovery stories and an example of a peer support group and a meeting showing Deaf/HH hearing working together with peers and will film something to address stigma/oppression. These are in various stages of editing and development.

Themes revealed by Activities to Date

Deaf/hh individuals may be first exposed to the concepts of peer support and recovery in one of two ways: through an interpreter at an event for hearing peers or through the Deaf community. If it is through an interpreter, the sign used and the cultural mediation provided will vary depending on the interpreter. ***In the Deaf community the words "peer support" and "recovery" are commonly used to convey various concepts, not the meaning understood in the hearing peer world.***

The ability to successfully convey these concepts was varied, in part due to language fluency. Some Deaf individuals are language dysfluent due to lack of exposure to language (ASL) at a critical development age and lack of opportunities to learn the language with other ASL users. Others who may have immigrated do not have ASL or English as their first language. Still others may have various learning issues due to poor educational opportunities and co-morbid conditions. Deaf peers had to be creative in using pictures and gestures and examples.

Peer support. While the concept was easily understood using a variety of signs, there was resistance to the idea. Participants did not readily accept the idea that another person with mental health issues could be helpful or trusted. There was great reluctance to share personal information or information that would make one vulnerable. Participants cited the smallness of the Deaf community and the concern that it is very difficult to keep anything confidential. Deaf members of the community are often in multiple roles, so one never knows what your relationship with another Deaf person may be or in what situations you may see them. Some of the successes in gaining acceptance of this idea were through the identification "in vivo" of peer support that occurred at some of the gatherings. Of course the other strategy was to use parallels in the Deaf community e.g. the relief one feels at learning about another Deaf person's experience of isolation in a hearing family or mainstream school. One useful example was that of a sports team to exemplify peer support. Also, an example that was effective was to describe peer support as the opposite of the workplace where there is a supervisor and a hierarchy description.

Mutuality in the hearing recovery world is the aspect of peer support that stresses that in a peer support relationship, the participants are equal and both give and get support. This was a tough concept among some groups. The history of Deaf individuals receiving services is to receive and be "done to"; there are not many opportunities to have learning exchanges, especially if one is not part of the larger Deaf community.

Trauma is a concept that is signed in many different ways and more commonly described as a specific event. The connection between a traumatic event or events and current issues is not as well understood in the Deaf world. The connection between trauma, triggers and physical responses is not common. Perhaps because the frustration and invalidation of ongoing and routine oppression in schools and services is so common, the line between the reality of life and something that is traumatic is not distinguished.

There is not an agreed upon way to sign or explain ***recovery***. Recovery is thought of in terms of recovery from a physical illness. There was resistance to the idea that people diagnosed with a mental illness could be "in recovery". A diagnosis is sometimes seen as a permanent label. Similarly, one peer reported that in the Deaf substance use world, even people who had years of sobriety were labeled as substance users for a long time after their sobriety.

Lessons Learned

1. The lack of information and knowledge about peer support and the hearing recovery movement was also not well understood by professional Deaf staff. There was not an openness to it or a value placed upon it, in some cases, at least not initially. Perhaps the project may have had an easier time if we held some community forums with professional staff first to educate about these concepts before outreaching to their clients.
2. The outreach and explanations would have been more effective if they had been done in ASL via YouTube videos attached to announcements on list serves or via Facebook, but there was some concern with the uncontrolled potential distribution of YouTube and Facebook connections.
3. The issue of isolation was prominent. People were starved for opportunities for communication and socialization. Interestingly, aloneness is identified as a common result of trauma.
4. After debate, it made sense to be inclusive and generic in our definition of who was targeted. As a result DMH included people with issues of substance use as well as isolation. Part of this was lessening the stigmatizing label of mental illness and also recognizing that many Deaf people avoid or cannot access mental health services. They may experience, however, the same impact on their lives as those who have used mental health services. Yet, we wanted those who did identify as a user of mental health services to feel comfortable in the group.
5. Sometimes the outreach was best accomplished in very small groups of 2, 3 or 4 or one-on-one.
6. The supervision/support provided by hearing peers was less helpful than anticipated. The hearing peers had varied exposure to ASL and Deaf culture and often did not feel comfortable providing feedback as they did not have enough knowledge to know if whatever they were commenting upon was part of Deaf culture. Of course, as always, communicating through interpreters was much less than ideal.

Challenges.

- a) **Communication.** As the steering committee included Deaf and hearing individuals, interpreters were required. Some meetings had to be cancelled due to a lack of interpreters. And when there were interpreters there the information was not equivalent for both parties which caused frustration. Using interpreters is also expensive, sometimes almost \$1000.00 for one meeting.
- b) **Stigma.** The stigma surrounding any diagnosis of mental illness or seeking mental health services is strong within the general Deaf community as well as among Deaf professionals. There are strong stereotypes and often an attitude of “let DMH take care of them” or feelings of discomfort in working with a person identified as having a mental illness or using mental health services. The peers were careful not to identify DMH on any materials.
- c) **Meetings.** Printed meeting announcements were a challenge. English words are not helpful. The meetings were described as “Deaf meet – ups” and social opportunities as well as opportunities to discuss issues with peers or informational meetings. It usually required several outreaches to establish a group and get to the information gathering/ education aspect of the work. It was important to provide people with options for meeting locations that protected their privacy. Groups should be held in a location not associated with DMH or sometimes an entirely separate space, not associated with Deaf services.

Conclusion. The impact of the funds has been substantial so far and will build. We were able to hire a number of Deaf peers to spread these concepts among the Deaf community and develop a foundation to build upon in the future. These individuals developed their presentation skills and their approaches to engaging others in this work.

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Michigan



FY2009 TTI PROJECT:

Integration of physical and mental health care in selected Community Mental Health Services Programs (CMHSPs) by providing a comprehensive peer-led whole health initiative.

KEY OUTCOMES:

- CMHSPs who received TTI funding hired Certified Peer Support Specialists (CPSS) to improve outcomes through health care integration. Some of the roles that peer specialists performed included working in hospital emergency rooms, assisting consumers in finding primary care providers, attending physician visits as health care navigators, and working with Federally Qualified Health Centers (FQHC) and CMHSP sites integrating health care.
- The Chronic Disease Self-Management Program, an evidence based practice model developed by Stanford University, was selected as the statewide health and wellness curriculum. The initiative in Michigan is called Personal Action Toward Health (PATH). PATH is a six-week workshop conducted in two and a half hour sessions in community settings. The success of the PATH workshop is based, in large part, on participant interactivity that includes problem-solving, decision-making, information sharing, and support for change. The Stanford model employs a train-the-trainer model, in which master trainers are trained by core Stanford staff, and then provide leader training for agencies and organizations that are interested in delivering the program in their communities.
- So far over one hundred CPSS in Michigan have attended leader training and are conducting classes in their communities. Twenty-four CPSS participated in master training with five individuals currently achieving Master Trainer status awarded by Stanford University. Approximately thirty PATH classes have been led by peers in fifteen CMHSPs across the state. By December of 2010 at least two CPSS will be trained at each of the Pre-paid Inpatient Health Plans (PIHP) who oversee the 46 CMHSPs as part of the 1915 (b)(c) Managed Care Specialty Services Waiver. In addition, 75% of consumer run programs will have two PATH leader trainers to run classes to support long term sustainability.
- Some of the PATH outcomes include: smoking cessation, weight loss, initiation of an exercise routine, decrease in stress, change in diet habits, improved blood sugar levels, decrease in cholesterol, attending free community health classes, and less visits with mental health and physical health providers.
- On June 22-24, 2009, Michigan held its first Statewide Peer Specialist Conference in Dearborn with over 450 CPSS in attendance.

- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.
- Some CMHSP health care coordination successes are:
 - Development of walk-in clinics for consumers. These clinics will allow consumers to see a doctor if they've missed an appointment, meet with a nurse and spend time learning about various health topics.
 - Some hospital Administrations are so pleased with the peer assigned to their Emergency Rooms that they have asked them to participate on their Recipient Rights Committee.
 - Memorandums of understanding and monthly meetings between FQHCs and behavioral health providers to develop the clinical screening/assessment/treatment protocols.
 - Declarations of an Organized Health Care System have been completed. These declarations will allow the Federally Qualified Health Clinics (FQHC) and CMHs to exchange information without a release. This declaration is in compliance with HIPAA regulations.

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Michigan



FY2012 TTI PROJECT:

Certified Peer Support Specialists in Federally Qualified Health Centers

KEY OUTCOMES:

This TTI grant has provided a significant opportunity to demonstrate the effectiveness of peer support specialists as health coaches and system's navigators in Federally Qualified Health Centers (FQHC). Two areas of the state in both urban and rural settings that serve a significant population of persons with serious mental illness and/or co-occurring chronic conditions were chosen as pilot sites. Mid Michigan Community Health Services in Houghton Lake and Hackley Community Care Center in Muskegon continue to participate in this innovative project.

Hackley Community Care Center is employing two (1.5 FTE) Certified Peer Support Specialists (CPSS) who have a serious mental illness, co-occurring MH and SUD conditions and multiple physical health conditions. Their history of receiving both physical and behavioral health care services at Hackley Community Care provides a strong peer to peer model to others who receive similar services at the FQHC. With their lived experience and shared journey of recovery they have made significant progress in working with others to improve their health and wellness as both role models and health coaches. They are providing a variety of health and wellness classes that promote self-management including Wellness Recovery Action Planning, Chronic Disease Self-Management Program, Whole Health Action Management, trauma informed care groups, mental illness anonymous, smoking cessation/tobacco recovery and classes focused on healthy living. In addition to their duties as peer health and wellness coaches they are following the TTI grant outcomes, outlined in the proposal, to assist individuals with health navigation. Some of the specific activities include working with and supporting a high risk population that have a history of not following through on medical and specialty service appointments. They have provided direct intervention and peer support including assistance with public transportation by providing 1:1 support for community mapping that may include bus tokens as needed. At the end of appointments the CPSS follow up and continue to provide peer support in relation to the identified health needs determined by the health care team and the individual using a person-centered planning process. The work that the CPSS are providing in the clinic has been supported and recognized by the medical staff as an enhancement to the medical services that are routinely provided. Primary Care Physicians and other medical staff have referred patients to the smoking cessation groups and provided information on the peer to peer model encouraging individuals to attend based on working with a person who has a shared journey of recovery. Several successful case examples have been documented in the areas of diabetes management, decrease in substance use, increase in exercise programs, self-management of multiple health conditions including diabetes and providing housing assistance for individuals who have been homeless.

At a recent health fair the peer specialists participated in sharing their unique roles at the FQHC and received

a large amount of interest from the broader medical community. The health fair provided an opportunity for networking and expanding knowledge of peer to peer resources that are available in the Muskegon area. In addition to developing partnerships in the medical community, both peer specialists have connections and linkages to the local community mental health program.

Houghton Lake has hired a Certified Peer Support Specialist that is currently or a past recipient of the FQHC following the model as outlined in the grant. The individual will be focused initially on leading health and wellness classes to provide opportunities and support for self-management goals while at the same time integrating systems navigation duties in partnership with other healthcare providers.

Data collection and measurement is in the beginning stages of development. Peer specialists and clinic staff have been examining data that is currently being collected with additional information added to determine the services, supports and effectiveness performed by the peer support specialists providing integrated holistic health care services. Some areas currently being developed as part of evaluation include tobacco use, diabetes, scheduled follow up appointments, involvement in ongoing support groups, accessing community resources and satisfaction interviews/surveys.

The Michigan Primary Care Association continues to provide strong leadership and guidance in the development, planning and outcomes of the Transformation Transfer Initiative grant. Discussions on capturing peer services at the FQHCs with the existing encounter codes used for peer services as described in the Medicaid Provider Manual for behavioral health continue to be an ongoing topic of discussion. The rural location has developed a planning process for sustaining funding using existing resources. Requirement of peer services for health homes from the Center for Medicare and Medicaid Services will provide additional support to embed practices into other models and integrated efforts.

The TTI grant activities will continue at both FQHCs with the possible expansion of an additional pilot site due to the interest and request for additional information from both FQHCs and Community Mental Health Services Programs statewide. Project updates will be provided to NASMHPD for collaboration with other states and to share outcomes measurements in the area of Certified Peer Support Specialists roles and responsibilities as health and wellness coaches and system navigators for the integration of behavioral health and primary care.

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Minnesota



FY2008 TTI PROJECT:

Develop a mechanism for multiple reviewers to simultaneously conduct the Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT) evidence-based practice rating scale reviews while maintaining the integrity of the individual scale.

KEY OUTCOMES:

- The State of Minnesota contracted with Case Western Reserve University Co-occurring Center for Excellence to develop a mechanism for conducting the IMR and IDDT rating scales at the same time while maintaining the integrity of the individual scales.
- The format and process was piloted with Assertive Community Treatment teams in August 2008. These and additional scheduled reviews will provide information to inform Case Western, the State and treatment providers on any changes helpful to the review process. Other states and treatment providers will be able to use the format to conduct IMR and IDDT quality improvement reviews in a more efficient manner than is currently done when conducting rating reviews singly.
- Many states and mental health treatment providers are currently conducting quality improvement reviews using the single rating tool for IDDT and the tool for IMR. Respected researchers in the field have successfully combined the review process to enable reviewers to conduct both IDDT and IMR within a single review. The integrity of the scales are not comprised because the results of both IDDT and IMR ratings remain intact. The combined rating review accomplishes this by eliminating duplicate questions found in both IMR and IDDT, by combining the initial request for information from the provider into one comprehensive request for information, and utilizes a revised ordering of the questions to support efficient collection of information.
- The format and process allows states and treatment providers to measure existing service capacity and to develop a quality improvement plan based on the results of the review. Each IMR and IDDT fidelity scale review has historically taken one full day per review (each includes staff and client interviews, evaluating treatment records, and observing treatment services). With the combined IMR and IDDT fidelity scale process, reviewers can now conduct two reviews simultaneously in the time it has previously taken to conduct one – meaning that staff time for the reviews is cut in half.

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Minnesota



FY2011 TTI PROJECT:

Embedding Primary Care into Act Teams

KEY OUTCOMES:

The discovery that people with serious mental illnesses are dying 25 years earlier than the general population – often from disorders that are inherently preventable or treatable – has pushed the integration of mental health and primary medical care into the top tier of issues nationwide. In response to this public health problem of catastrophic proportions, the *Minnesota 10x10 ACT Initiative* has three objectives:

1. Jump-start a statewide public-private campaign known as the Minnesota 10x10 Initiative by focusing initially on assertive community treatment (ACT).
2. Strengthen the work of Minnesota's 26 ACT teams in the goal area of physical health and wellness.
3. Extend the lessons learned in ACT to our entire state system.

The funding was helpful, but TTI provided the focus that put us in a position to do a good job without micromanaging.

The ultimate goal is to increase the life expectancy of Minnesotans with serious mental illnesses by 10 years in 10 years – identical to the goal of SAMHSA's 10x10 Wellness Campaign.

Why Start With ACT?

Certain features of the ACT approach make it a useful “laboratory” for designing and field-testing strategies to improve the primary care received by adults with serious mental illnesses. These ACT features include:

- a focus on participants who have significant functioning difficulties and who are also, as a result, at a disproportionately high risk for co-occurring medical and substance use issues;
- a multidisciplinary staff team that already includes the all health disciplines;
- generally excellent working relationships with local primary care providers; and
- strong support among ACT psychiatrists and nurses for organized efforts to improve the physical health and wellness of the people they serve.

Components of the TTI Project

Kick-Off Symposium. We launched the *Minnesota 10x10 ACT Initiative* with an all-day symposium attended by about 200 invited stakeholders in Maple Grove, a suburban community northwest of Minneapolis, on June 24, 2011. Invited participants from all parts of the state included ACT psychiatrists, nurses, and team leaders; consumer and family advocates; health plan and primary care representatives; managers of local mental health authorities; and other interested stakeholders. The program featured major

national and Minnesotan speakers, and audience evaluations were overwhelmingly positive.

Stakeholder Advisory Group. Minnesota convened an Advisory Group of key stakeholders, who met on a quarterly basis to provide ideas and advice to AMHD staff and contractors.

Baseline Survey of ACT Teams. The Project Manager conducted a telephone survey of Minnesota's ACT teams to determine the baseline status of their practice in the area of physical health and wellness. Interviews were conducted with all 26 teams during April and May of 2011. The survey included 23 questions probing consumer characteristics, staff composition, staff roles in the team's health efforts, current wellness approaches found to be most effective, and remaining challenges.

Process Improvement Coaching With Seven Pilot Teams. Minnesota selected seven ACT teams to be pilot sites for process improvement coaching by expert staff from the Institute for Clinical Systems Improvement (ICSI), a nationally respected quality improvement organization whose members include most major health plans, hospital groups, and physician groups.

The seven ACT teams were strategically chosen to provide a diverse sample of urban, suburban, and rural settings. In addition, one team was intentionally selected because of its focus on individuals who have been homeless on a long-term basis; another was selected because of its formal relationship with a managed care organization. The sample included teams operated by counties and groups of counties, mental health centers, and both nonprofit and for-profit provider agencies. Although some of the pilot teams had already demonstrated exemplary work in this area of practice, service quality *per se* was not a selection criterion.

ICSI started its work with a one-day collaborative meeting of all seven pilot teams on July 28, 2011. This meeting was followed by monthly conference calls in which ICSI staff helped the teams to develop their own uniquely defined process improvements, based on their particular situations and local realities.

Despite the variety of process improvements developed by the pilot teams, the overall effort was clearly focused on three basic, face-valid goals:

1. Every ACT participant will have an annual physical.
2. This physical will include the key 10x10 health and wellness indicators (body mass index, tobacco and alcohol use, blood pressure, LDL cholesterol, and blood sugar).
3. Any indicator falling outside the "normal/desirable" range will be followed up by the team.

Thus far ICSI and/or ACT team members have noticed that:

- Consumers are experiencing a larger number of primary care visits, resulting in a time shift in how ACT team members spend time with them.
- Some mental health psychiatrists, or other professionals, are increasingly obtaining physical vitals.
- Obtaining BMI scores and assessing monthly tobacco use is increasingly routine.
- At least one ACT team is having a "lab day" at the clinic, and are adding incentives like breakfast for clients to encourage fasting for blood-work.

Getting Every ACT Team Involved

Minnesota recognized that every ACT – not just the seven pilot teams – needs to pay closer attention to annual physicals, 10x10 indicators, and systematic follow-up. Thus far, efforts to include all 26 teams in the 10x10 campaign have included these activities and system-level interventions:

- All teams were included in a two-hour interactive videoconference to introduce the 10x10 issue to ACT team leaders, program directors, psychiatrists, and nurses on March 14, 2011.
- All ACT teams were included in the April and May, 2011, two-hour baseline telephone survey.

- All ACT teams were included in Assistant Commissioner Maureen O’Connell’s formal invitation to the June 24, 2011, kick-off symposium, and most teams sent at least one representative.
- A financial incentive equal to 5% of each ACT team’s annual budget will be paid starting in calendar year 2012 if the team (a) submits to AMHD a plan to implement the three 10x10 goals itemized in the previous section and (b) begins to implement the first goal – annual physicals for all participants – immediately.

Updating AMHD’s Statewide Data Collection System

One or more national experts will consult with AMHD on the opportunities and challenges associated with integrating the basic 10x10 health and wellness indicators with other data sets – including program outcomes and claims data – in system-level analyses. Our goal is to begin monitoring Minnesota’s statewide progress in the 10x10 effort as soon as possible.

Planning for the Future Beyond TTI

The final phase of this project will include a planning process to determine the next steps for Minnesota’s 10x10 Initiative. AMHD staff, contractors, and interested stakeholders will address the ways in which lessons learned in the *Minnesota 10x10 ACT Initiative* can be extended most rapidly and effectively beyond ACT to all parts of our statewide system.

Wrap-Up Symposium for Stakeholders

A two-day wrap-up symposium was held in the Spring of 2012 that allowed us to share:

- What Minnesota has learned through the TTI project.
- What Minnesota intends to do next in this critically important area of practice and system design, and
- How all ACT teams can benefit from participating.
- There has been a noticeable, and surprisingly early, increase in annual physicals, BMI documentation and assessment of tobacco-use.

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Minnesota



FY2013 TTI PROJECT:

Peer support for veterans.

KEY OUTCOMES:

Background- Where We Were

Minnesota has gained national recognition for the Minnesota National Guard's *Beyond the Yellow Ribbon* campaign but services for veterans are often siloed and hard to access in Minnesota. Veterans are often reluctant to engage with the Veterans Administration when they return and experience difficulties adjusting to civilian life. Despite a number of attempts to connect with our VA and connect veterans to community resources, we had been unable to create a lasting collaboration. In September of 2012, Minnesota Department of Human Services (DHS) staff from the Adult Mental Health Division (AMHD), Alcohol and Drug Abuse Division (ADAD), and Children's Mental Health Division (CMHD) attended the *State Plan Boot Camp: SAMHSA's Service Members, Veterans and Their Families (SMVF) Policy Academy* in Alexandria, VA. This was the first attempt to bring together many of the key Minnesota partners, identify currently available services and resources, and recognize remaining gaps in our state system. When the opportunity to apply for the TTI grant presented itself, we seized the opportunity to fund a number of the priorities that were identified at the Boot Camp.

Minnesota's Work with Veterans in MN with TTI funds

There were four identified priorities:

1. Increase the number of Minnesota veterans who are trained as certified peer specialists;
2. Increase the number of vet-specific WRAP (Wellness Recovery Action Plan) classes taught by veterans and the number of support groups led by veterans;
3. Develop a drop-in center for veterans and current service members in the Twin Cities metro area, where they can connect with resources and attend WRAP classes and Vet to Vet meetings; and
4. Create a link on the DHS website for SMVFs to use for connecting with needed resources.

It was evident in order to accomplish our goals, DHS needed to partner with a veteran and/or an organization that is knowledgeable about military culture – in this case the Mental Health Consumer/Survivor Network of Minnesota (CSN) to help us accomplish these goals. Two key staff, Christine Dawson, a veteran with 30 years of service and a mental health professional, and Patti Bitney Starke, formerly employed by the MN National Guard and a wife of a veteran are instrumental in our outreach and training efforts.

Some of CSN's outreach efforts include participation in veteran conferences including the Minnesota County Veterans Service Officers and Standown's throughout the state. A number of ongoing partnerships have been developed. The HUD Veteran's Housing Assistance project, Bridges, is providing an onsite office for CSN to provide resources. This office will be staffed with trained veteran volunteers in the coming months. The St. Cloud VA Medical Center is offering WRAP to veterans and has reserved CSN office space to house resources and possibly a volunteer peer trained veteran. CSN is providing the Minneapolis VA Medical Center WRAP to their mental health practitioners and professionals.

In addition to CSN's outreach efforts, DHS staff continues to search out and attend events that have veteran's participation and opportunities to connect with veterans organizations. The Minneapolis and St. Cloud VA medical centers have begun to work with DHS to recruit veterans for peer training. This has been accomplished primarily with numerous face to face contacts at the VA. DHS staff attended the VA Medical Center's Mental Health Summit in Minneapolis and CSN staff attended the event in St. Cloud.

The DHS Adult Mental Health Division staff are becoming sensitized to the needs of veterans in Minnesota. There have been a number of public awareness events and meetings that have focused on SMVF sponsored by the Chemical and Mental Health Administration. September is National Recovery Month and Minnesota's focus this year was on military members and their families with substance abuse and mental health issues. On September 10th, National Suicide Prevention Day was marked with a lobby display with veteran and family resources and DHS staff answering questions about services and resources available.

As a division, we are working to coach the local mental health authorities to ask the question "Have you served in the military?" when working with an individual who is be looking for services, and to consider the needs of veterans when planning or implementing new services.

Challenges and Future Plans

The challenge of working with the many government agencies that serve SMVF has confounded the Adult Mental Health Division for a number of years. Many of our attempts in the past had not worked very well. There are many resources and agencies, both public and private that are working on behalf of the veteran but accessing them can be a challenge in itself. What should be a simple task in this technological age- linking resources and creating a central point of information is its own giant task. The TTI grant and the work of the State Boot Camp Policy Academy has given us a solid start.

There is ongoing work on data collection around veterans and their use and need for services. A number of the applications/evaluations that are used by the Division or their grantees will include the question of military service on their forms and will be tabulated and reported.

Veteran Courts are expanding in Minnesota and vet mentors are part of that system. A systemic effort to offer additional training is under consideration. One of the vet specific veteran trainings will offer seats in that class for a number of the vet mentors that are currently working in that system.

The DHS project manager for the TTI grant has been assigned to veteran issues for the division and will follow the activities of the Council and the unfinished work of this grant. A statewide effort is underway to recruit veterans to Local Advisory Councils, especially in parts of the state where there have been large numbers of deployed soldiers. Veterans will continue to be recruited for the second vet specific training that will be held in the winter of 2014. The feasibility and the location of the vet drop - in center will be discussed and the decision informed by the Veterans Initiative Advisory Council.

Outcomes
September 15, 2013

1. Identified veterans to be trained as certified peer specialists in collaboration with the VA and the Health Care Systems in Minneapolis and St. Cloud, Minnesota. Contract with Recovery Opportunity Center of Arizona to provide three trainings for veteran-specific certified peer specialists. 30 have graduated thus far, with roughly 20 more to be trained in July 2014. Peers trained have overwhelmingly been veterans. Previously there were 3 such peers in the state.
2. Work with the VA Health Care Systems to employ the newly trained CPSs in their mental health programs. As a result veteran peers are now employed in a multitude of locations, including VA medical centers, drop-in centers, homeless shelters and soon within ACT teams.
3. As of this date, 45 veterans have taken full WRAP classes, with 350+ trained in the one day overview.
4. Two veteran CPSs have been trained to as WRAP 2 Advanced Facilitator trainers and are offering WRAP classes through the state to veterans and non-veterans under field supervision.
5. One veteran has been trained in the Vet to Vet model and will be offering the facilitator training in a number of locations in late 2013 in the metro area and in greater Minnesota in 2014.
6. While the goal of developing and opening a drop-in center for service members and veterans in the Twin Cities metro area was a very good idea, the inability to find sustainable funding or a long term caretaker has thus far proven to be insurmountable. The idea has been pushed further, however, and hope remains that it can be revived. This endeavor has led to dramatically improved relations and dialogue with the VA, including the VA having a much better appreciation of veteran peers.
7. Conduct an inventory of resources for SMVFs and create a link on the DHS website. Resources have been inventoried and a web site developer has been contacted to explore the advantages of a separate site versus a link on the DHS public website.

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Mississippi



FY2010 TTI PROJECTS:

- 1) Transportation needs assessment, 2) statewide training for co-occurring disorders, and 3) housing needs assessment and planning.*

KEY OUTCOMES:

Transportation Needs Assessment

TTI built on work by the Mississippi Transportation Coalition - a group of 35+ transportation stakeholders (from consumers to state agencies) – including the first "real life" study on how the Coalition's transportation plan can help persons with mental illness. Through the project:

1. Trained 17 staff of the Life Help CMHC on the Coalition's transportation needs assessment.
2. The trained Life Help staff administered the needs assessment to 130 Life Help customers to determine their transportation needs and then worked with them to prioritize these needs.
3. Potential transportation service providers were identified. In addition to transporting individuals and providing call center services, providers were required to have the necessary software to a) analyze data from transportation needs assessments, b) schedule and route transports, c) bill and collect payments, d) cost allocate transportation services, e) maintain eligibility rules, and f) produce standard and customized reports. Providers were asked to analyze data from the needs assessments and to offer a plan, including the schedule for and cost of the transports, to meet the transportation needs of these individuals.

As a result of the training, the administration of the transportation needs assessment, and the data analysis accomplished through the TTI project, consumer-based transportation services for Life Help's customers with mental illness have been designed and can be provided when funding for the transports becomes available. Funding for the transports will provide the opportunity to examine these guidelines in a "real life" environment and ensure that the Coalition's plan for the provision of transportation services addresses the requirements of all Mississippians, including those with mental illness.

Statewide Training for Co-occurring Disorders

The TTI grant allowed DMH to provide formalized training on integrated treatment for co-occurring mental illness and substance abuse disorders (COD). Trainers from throughout the state developed the COD curriculum, provided training and technical assistance, and evaluated outcomes of the training in different regions of the state. The trainers attended a three-day workshop on cognitive behavior therapy. The training curriculum implemented included the following components: treatment plan training, coaching employees toward excellence, supervision theory, and motivational interviewing.

Prior to the training, the trainers met with directors and staff at participating CMHCs to tailor the training content. Adult outpatient clinicians and alcohol and drug abuse specialists in the 15 CMHCs and state hospitals were required to attend the 1-2 day training, which was open to all staff. Over 230 staff from 13 CMHCs received the training on integrated treatment for co-occurring disorders. CMHCs in 3 regions requested and received

additional training on motivational interviewing and developing treatment plans. Over 112 staff at North Mississippi State Hospital, South Mississippi State Hospital, Mississippi State Hospital, and East Mississippi State Hospital received training on COD. To facilitate sustainability two trainers were identified in each region and at each state hospital. All COD staff is required to be trained.

As part of the evaluation process, over 300 charts were reviewed after the training. Treatment plans, alcohol and drug abuse assessments, progress notes, and required COD paperwork were included in chart reviews, which reflected that services were more integrated following the training. Therapists in each region who attended the COD training were interviewed regarding whether the training was beneficial and how they had implemented the training. The therapists reported that the training was very beneficial and effective. There were several requests for additional training. Evaluations by consumers reflected positive feedback regarding the quality of services they received following the COD training.

Housing Needs Assessment and Planning

TTI enabled DMH and the Housing Task Force to receive technical assistance in development of the statewide strategic plan - the goal of which is to increase the statewide availability of safe, affordable and flexible housing options and services that support recovery in the community. Consultation activities centered on: (1) needs assessment to research and map current housing stock, needs and demographics; (2) gap analysis to identify priority system issues, to refine strategies for development of housing and supports, and to address consumer and family input on needs and preferences; (3) building housing partnerships at the state and local levels, including work to identify and work around barriers; (4) assessment and planning of service system models, reimbursement mechanisms and capacity to contribute to housing and service system re-design models; and, (5) development of additional funding mechanisms (including Medicaid), maximizing mainstream housing affordability opportunities, and on designing a bridge subsidy program and readiness for use of new federal housing resources.

One important outcome is the commitment by the HUD Hub (state) Office of Public Housing to work with the DMH to develop a Memorandum of Understanding to identify integration strategies, public housing authority (PHA) partnership opportunities, and to increase awareness of services for housing and support service entities. The specific strategy will address: education of PHAs on state services and education of service providers on housing programs, availability, and processes; identification of barriers; collaboration through the statewide planning process; promotion of disability preferences with housing authorities; and, targeting of new development of housing stock targeted for people with disabilities.

In February, 2011, DMH Planning staff presented the housing planning goals and objectives at the *2011 Annual Housing Affordability Conference*, held by the Mississippi Home Corporation and attended by developers, public housing authority staff, property managers and others. A memorandum of understanding between the DMH and the MS State Department of Health was developed to improve communication and coordination of care for individuals living in homes that fall under the regulatory purview of the agencies, and to facilitate improved oversight of these homes.

As a result of the TTI project, the housing consultants identified key policy and operational issues, and made recommendations to DMH leadership for design and implementation of the DMH Strategic Housing Plan. These recommendations also addressed infrastructure and related budget development to support next steps after the TTI project period. The projected date for finalizing the housing plan document for the Mississippi State Board of Mental Health is summer, 2011.

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Montana



FY2010 TTI PROJECT:

Behavioral health and corrections collaboration, including training for law enforcement, criminal defense attorneys, and 911 data collection.

KEY OUTCOMES:

- Training on mental illness and crisis intervention has been provided to 200+ law enforcement officers & criminal justice professionals. Local providers, advocates, consumers and health care professionals have participated in the training. This Mental Illness Intervention curriculum has also been incorporated into Montana Law Enforcement Basic Training.
 - This initiative will continue into the coming years through funding from the Flex Rural Veterans Health Access Program grant awarded to Montana as one of only three states in the nation to be funded.
 - Legislation passed in 2009, and implemented during the TTI grant period, created three new programs for jail diversion and crisis intervention; including training for law enforcement and first responders. The programs include a matching grant program between the state and local county government to reduce emergency and court ordered detentions to the Montana State psychiatric hospital; a program to provide funding for community based, short term crisis stabilization beds; and provides permissive authority for an individual, in process for civil involuntary commitment, to suspend those proceedings and engage in voluntary inpatient psychiatric treatment. All three programs have been utilized over the past year with early outcomes showing measurable success.
- Each cross-training event was eligible for continuing education credit for law enforcement, social workers, professional counselors and addiction counselors. This cross-marketing ensured mixed audiences for each event and further enabled local coalition development.
 - Montana's existing Local Advisory Council and Service Area Authority structure for consumer involvement and grass roots innovation and problem solving will ensure that these relationships are fostered and continue to flourish. The LACs and SAAs will also serve as "think-tanks" for future training topics or needs.
- More than 60 county attorneys and public defenders from across Montana participated in training events developed under this project. The curricula covered topics including civil and forensic commitment, evaluations, effective communication with clients, moral and ethical responsibilities of representation and the NAMI Voices program. Both forensic and civil commitment training events emphasized cross system collaboration and placement in the least restrictive environment possible. Consumer panels shared personal experiences with the commitment process and provided valuable

insight to the attorneys throughout these training events. Presenters included a supreme court justice, deputy attorney general, parole officer, forensic psychiatrist, state prison warden, registered psych nurse, law enforcement, advocates, providers and educators.

- Response to these legal training programs has been tremendous. The Montana Office of Public Defender and Department of Justice are committed to partnering with DPHHS for future training events. In addition, the presentations developed are now available for ongoing training efforts.
- A data collection protocol and integrated technology was created to track the aggregate number of calls to 911 with a mental health element. Information generated from this new technology furthers the state's efforts to provide quantifiable data on the needs for community based mental health crisis intervention programs, rather than relying on anecdotal information.
 - Montana's 56 counties are served by numerous vendors providing software programs to dispatch centers. Under this TTI project, the technology upgrades have been coordinated for multiple vendors serving the majority of counties, including the largest jurisdictions. With this technology in place, data collection becomes routine with all other data reporting for dispatch centers.
- A joint Crisis Intervention Team (CIT) workgroup has been formed from the three largest training areas. In partnership with the Montana Law Enforcement Academy and the University of Montana, DPHHS is working to review curricula for consistent learning objectives, evaluation measures and to determine if need exists for competency assessments. The group has plans to post a statewide training calendar, share information on funding options, collect aggregate data on officers trained and discuss a statewide program coordinator position to further enhance our efforts across the state.
 - The Montana Law Enforcement Academy, as the preeminent training entity for all sworn peace officers, has become an integral partner in this project. The academy is committed to assisting with coordination efforts to ensure that all officers, including law enforcement, corrections & detention staff, probation, parole and all other sworn officers receive consistent and outcome oriented education on mental health and crisis intervention.
- Technical assistance was provided to a number of neighboring and distant states. Montana presented on cross-agency collaboration at the 2010 GAINS conference, has provided training materials and resources on criminal justice list serves, and has been invited to submit a presentation to the International CIT conference this year.
 - This project was fostered from a strong commitment to collaboration between the Directors of the Montana Department of Public Health and Human Services and the Department of Corrections and the Montana Attorney General and Department of Justice. This relationship continues into the future and may serve as an innovative model to other states.

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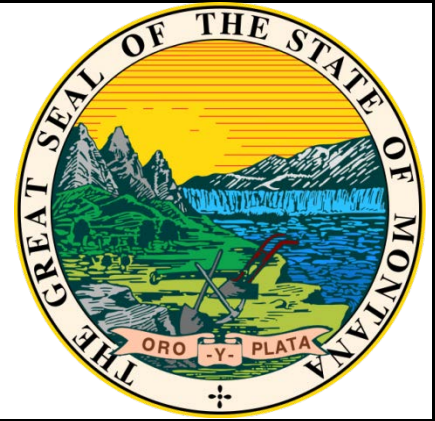
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Montana



FY2012 TTI PROJECT:

Criminal Justice, Corrections and Courts Collaboration

KEY OUTCOMES:

The Montana TTI Project has been tremendously successful in building, expanding and enhancing system transformation in mental health and criminal justice. Strong partnerships have been developed across all levels of the criminal justice and behavioral health continuum of services and programs. These partnerships ensure that initiatives begun under this TTI project will continue beyond the grant.

The sequential intercept model has been used in Montana since 2006 to frame and guide Montana's transformation efforts.

A careful analysis of needs, resources and opportunities at each intercept has enabled Montana to plan and implement programs that meet specific needs, are sustainable and have a positive impact on a target audience of offenders with mental disorders and people who become justice involved as a result of behaviors associated with their mental disorders. The model, inserted here, has been used in strategic planning, education events, advocacy, and evaluation of outcomes.

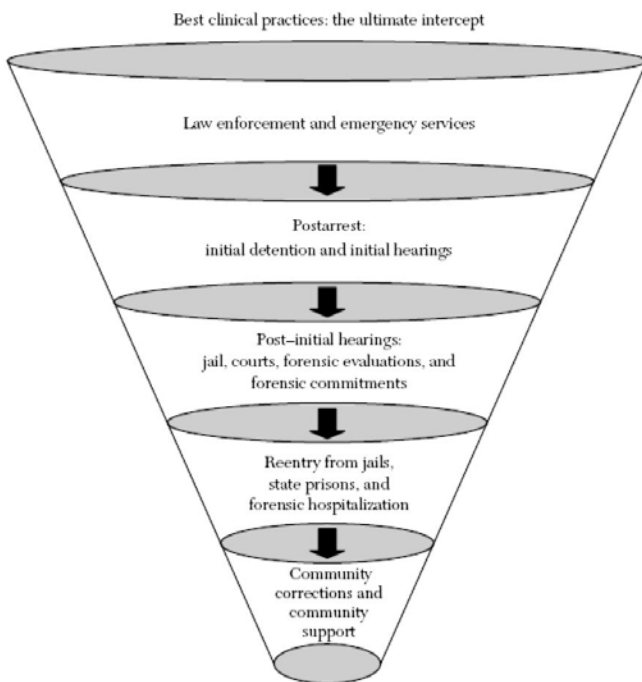
The 2012 TTI Project created new initiatives at Intercepts 2 & 3, with reinforcement of existing programs at Intercept 1:

Pretrial Services Program:

Pretrial services programs for diversion from detention are recognized as best practices by the National Association of Counties. Using the model as a framework, this TTI project partnered with Gallatin County to develop a replicable tool kit for expansion of this effective program. Specific activities include creation of a sample budget, job

descriptions for key personnel, training for program staff including court personnel, supervision officers, mental health providers, detention officers and administrative support. This model has been created to work together with the 24/7 sobriety program; created and enacted by the 2011 legislature to provide for diversion from jail detention for offenders charged with driving under the influence (DUI). Mentoring activities in Ravalli and Lewis & Clark counties have resulted in the preliminary development of best practice models in these new communities. Partnerships continue and we are optimistic that a pretrial program will emerge in both areas, resulting in additional jail diversion

The Sequential Intercept Model viewed as a series of filters



options for persons with mental disorders who interact with the justice system.

Court Training

A three-hour training course has been developed for district court judges that include information on major mental disorders, sentencing options, programs and services for forensic patients and offenders. In addition to a presentation at the annual judges' conference, this presentation will be made available via webinar for ongoing training within the state. Thus far, about 30 judges and approximately 150-175 court personnel have been trained.

Attorney Education

A training tool has been created to educate public defenders on the challenges with effective representation for clients with mental disorders. This video training tool illustrates an initial client/attorney interview in three separate presentations: 1) interviewer is rushed, uses complex legal terms, and does not engage with the client or address her/his concerns and anxiety; 2) Interviewer demonstrates strong communication skills, engages with the client and establishes trust, and explains legal proceedings in laymen terms; and 3) replays second interview with strong communication skills, but overlays with audio and visual effects to simulate hallucinations to demonstrate that even under the best communication scenario, the client may still struggle to comprehend the information presented. The training video is shown as part of a facilitated discussion, a lecture presentation on major mental disorders and a review of the adopted mental health protocol utilized by state public defenders. Total training time is 3 – 4 hours. Thus far, 150-175 attorneys have completed the training. CLE's are awarded.

Crisis Intervention Team Training

Three established CIT teams are providing the 40-hour CIT program. Each team hosts 1–2 academy events per year, with approximately 30 – 40 people in attendance at each course. Annually, approximately 100 officers complete training in addition to mental health providers, advocates and community health providers who attend the courses. Outreach has been conducted in 4 new communities to expand the CIT program to other larger communities. This has included stakeholder meetings and training. CIT Academies (40hr programs) have been conducted in Gallatin (February); Ravalli & Yellowstone (March) counties. Additional programs are scheduled in May/June in Lewis & Clark County; and October in Ravalli County. An orientation to CIT stakeholder meeting occurred April 16th in Missoula County. It included presentations from the Ravalli & Gallatin counties. Overall, these CIT trainings have reached over 700 people, two-thirds from law enforcement and one-third from first responders (crisis nurses, social workers, etc...).

Mental Illness Intervention

This 2 day course provides an overview of major mental disorders, suicide prevention and intervention, and veteran's health issues. The course is approved for both law enforcement as well as a variety of behavioral health providers including licensed professional counselors, social workers, addiction counselors and psychologists. **More than 2500 people trained thus far, with roughly 50% of that total as law enforcement.**

CIT Workgroup

The CIT workgroup was formed in 2010 under the previous TTI grant project with representation from the three established law enforcement jurisdictions, mental health providers, NAMI Montana, the MT Law Enforcement Academy and DPHHS. Since then, it has reviewed all curricula and determined statewide learning objectives, meets 4+ times per year, has begun planning for a CIT for Youth training event, and discussed an annual conference, newsletter and website. The CIT workgroup was incorporated as a nonprofit membership organization in January 2013. The primary mission will be expansion of CIT statewide. A board of directors has been nominated and an advanced CIT training is scheduled for August 2013 - taught by the original CIT founder, Maj. Sam Cochran and his team from Memphis, TN. Teams from each CIT community are scheduled to participate.

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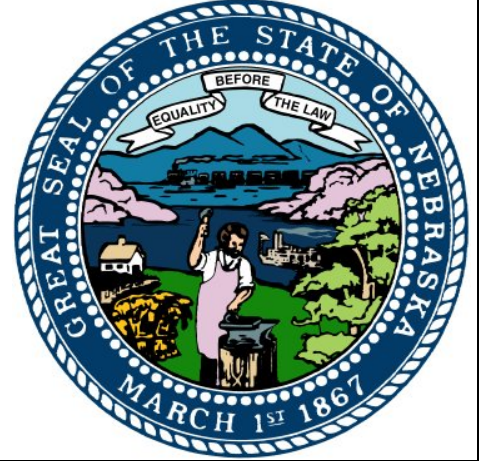
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Nebraska



FY2009 TTI PROJECT:

Statewide Peer Support Training.

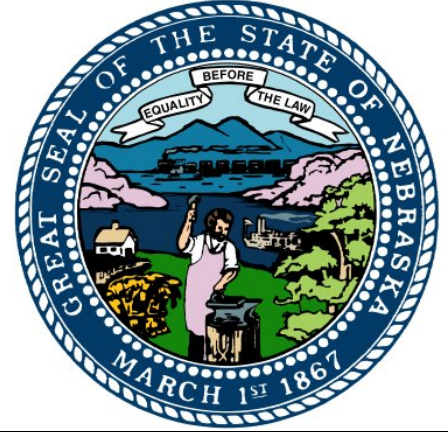
Key Outcomes:

- The Division of Behavioral Health created and hired an Administrator of Consumer Affairs within the department. The new administrator is a trainer in the implementation of peer support.
- As a pioneering state Nebraska is largely rural and peers face great challenges in bridging the great distance to Network. While there is an active Peer Support workforce in Nebraska there is a need for greater statewide coordination and standards.
- University of Nebraska Public Policy Center held three steering committee meetings of consumers of mental health services for input and direction of this project. The consumer steering committee selected Focus on Recovery- United, Inc. (FOR-U) in partnership with Sherry Mead Consulting and Yale University as contractors to provide a Nebraska specific peer support training curriculum. The group will provide an evaluation of the training as well as a curriculum to the State of Nebraska.
- Seven Town Hall Meetings were held across the state. There were meetings in Lincoln, Omaha, at the Omaha's Ponce Tribe facility, Norfolk, Hastings, Scottsbluff, and North Platte, with combined attendance of over 300 people. As a result, a report was created, one person was inspired to open their own business as a clubhouse, and new connections to the Native American community were fostered.
- A Statewide Peer Support Training is on schedule for January 2010 and a train the trainer will follow with a mock training opportunity.
- The State's final report will be available in March and will be presented at a statewide conference of Success Stories.

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Nebraska



FY2013 TTI PROJECT:

Multiple concepts related to trauma informed care

Key Outcomes:

For the FY 2013-14 Transformation Transfer Initiative (TTI) project, Nebraska proposed to work towards several goals under the general premise of *Trauma Informed Peer Support within Family Systems*. The focus of this initiative was how trauma impacts consumers of mental health services across the lifespan and how to promote healing that is developmentally specific. Key outcomes for the project included:

- A Statewide Conference on *Trauma Across the Lifespan* was held in Lincoln, NE. Speakers included Dr. Sharon Wise, Dr. Bruce Perry, Nathan Ross, and a Trauma Survivor Panel. Over 900 people attended from around that state. The Department of Education gifted two books to all participants: *The Compassion Fatigue Workbook* by Francoise Mathieu and *The Boy Who Was Raised As A Dog* by Dr. Bruce Perry. Additional literature included the Babies Can't Wait Program brochure, Answers 4 Families, the Nebraska Family Helpline, and a bookmark on a computer application of developmental milestones. Attendance included Adult and Family Peer Support Specialists, Behavioral Health Providers, Department of Family and Children Services, Teachers, Advocates, and Foster Care Representatives.
- A Train-the-Trainer in the current trauma-informed peer support training from Chyrell Bellamy of Yale University and Chris Hansen of Intentional Peer Support was held in Omaha, Nebraska, and there was one family member representative and four veterans in the class of ten Facilitators.
- A Family and Adult Peer Support Training on Compassion Fatigue and tools to address Compassion Fatigue entitled *Walk the Walk* was held in Lincoln, NE by Kay Glidden and Beth Reynolds for 22 participants.
- The impact of trauma on the workforce utilizing two validated screening tools was studied.
- Family Peer Support providers gathered to give their insights into the development of competencies that encompass the work of family peer support. After reviewing trauma informed materials for adult peer support, a one day overview of this training was determined to be needed. An overview of the materials was created and is currently being refined for families.
- Survey and focus groups were designed to examine the experiences of adults and families related to trauma and the positive and negative effects produced by the trauma. Two standardized instruments were used in the survey: the Post Traumatic Growth Inventory and the Post Traumatic Stress Disorder

(PTSD) Checklist. There were 103 survey participants and 147 individuals who participated in focus groups.

- Table 1 shows the incidence of trauma for the four respondent groups. All adult and family peer support specialists reported having experienced trauma; over 90% of each group had experienced personal trauma, and over 75% of each group had experienced vicarious trauma and/or compassion fatigue. Approximately 85% of adult and family consumers who completed this section of the survey had experienced trauma; adult consumers were more likely to experience personal trauma than family consumers.

Table 1: Trauma Experienced (Percentage & (Number) by Respondent Group and Type of Trauma

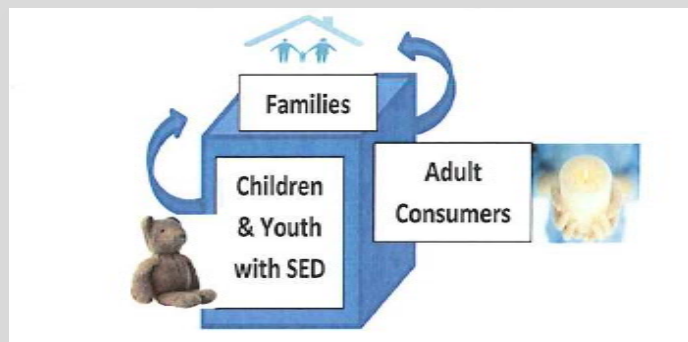
	Adult Consumer	Family Consumer	Adult Peer Specialist	Family Peer Specialist
Trauma	81.1% (30)	70.6% (24)	93.8% (15)	96.2% (25)
Vicarious Trauma	45.7% (16)	47.1% (16)	87.5% (14)	76.0% (19)
Compassion Fatigue	54.1% (20)	57.6% (19)	75.0% (12)	80.8% (21)
Any Trauma	84.2% (32)	85.3% (29)	100% (16)	100% (26)

- Table 2 shows responses by participant group for the Post Traumatic Growth Inventory (PTGI) and the PTSD Checklist. Adult and family peer support specialists were expected to show greater adaptation to trauma compared to adult and family service recipients, and the survey results support this hypothesis; total scores for adult and family peer support specialists were about 10 points higher than scores for adult and family consumers. Adult and family peer support specialists were expected to show fewer problems related trauma, and the survey results support this hypothesis; total scores for adult and family peer support specialists were lower than scores for adult and family consumers.

Table 2: Average Scores (standard deviations) by Participant Group for PTGI and the PTSD Checklist

Scale	Adult Consumer (N=32)	Family Consumer (N=29)	Adult Specialist (N=16)	Family Specialist (N=26)	All Groups Combined
PTGI	66.97 (22.90)	68.39 (25.12)	79.07 (21.26)	77.16 (14.97)	71.83 (21.89)
PTSD Checklist	58.04 (15.74)	45.77 (19.01)	38.23 (10.41)	35.38 (14.64)	45.23 (18.05)

- The figure below explains the influence that trauma has across families and the opportunity for healing:



- Several webpages were designed to highlight basic concepts of trauma and peer support. Short videos highlighting the *Silver Lining* or the ways in which people have overcome trauma have been developed. These work products will become live on the Division of Behavioral Health Website after careful review of trauma survivors. These videos and a library of trauma related topics can be found at www.dhhs.ne.gov/trauma.
- An unexpected outcome of this grant was a new relationship with Veterans in Nebraska. Organizations that represent Veterans are not only inviting the community into Veterans Administration (VA) peer support training, but more and more Veterans are being referred to all peer support trainings hosted in Nebraska.

Lessons Learned

Addressing self-care before entering a trauma-informed peer support training is very important. The Office of Community Affairs (OCA) always asks people to complete a WRAP (wellness recovery action plan) that relates to their individual recovery experience before engaging a training. We learned that not all the OCA Facilitator Circle Members are engaging this important practice that encourages self-care. Vicarious trauma is often not recognized by the peer workforce as something that impacts them. Greater identification of the Impact of Trauma on the Self is needed and the work products of this TTI award will provide this.

The Trauma Across the Lifespan conference brought many lessons from the speakers, including an excellent recommendation from Dr. Bruce Perry on how to end seclusion and restraint of children in schools by tapping into children’s brain systems with movement and relationships.

As previously mentioned, an unexpected outcome of this award was a new relationship with Veterans in Nebraska. Organizations that represent Veterans are not only inviting the community into VA peer support training, but more and more Veterans are being referred to all peer support trainings hosted in Nebraska. The Omaha VA has been empowered to begin their own trauma informed peer support training.

What We Did that We Couldn’t Have Without the Funding

With this small amount of funding, the Office of Consumer Affairs in the Division of Behavioral Health was energized to be creative and grow our state in ways that we would not typically be able to. This opportunity took Nebraska’s Trauma Informed Focus to a new level. The Division was able to inform the adult and family peer support community about the impact of trauma across the lifetime within family systems with multiple educational opportunities. Typically in our state there is not extra funding for this type of education and research. The TTI flexibility allowed our state to redesign the plane while we were flying, resulting in a higher quality product. Typically, with fixed funding opportunities the Division designs the project and must continue building even if the needs for the design have changed. This results in having out of date work products. The flexibility allowed the Division to have increased quality products.

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New Hampshire



2011 TTI PROJECT:

Statewide implementation of client level outcome measures for adults and children/adolescents

KEY OUTCOMES:

The New Hampshire Department of Health and Human Services (DHHS), Bureau of Behavioral Health (BBH) was awarded a Transformation Transfer Initiative (TTI) grant for statewide implementation of client level outcome measures for adults with a severe mental illness (SMI), and children/adolescents with serious emotional disturbance (SED). These outcome measures are used statewide for all individuals receiving or requesting services from the designated community mental health programs. Two public domain tools are utilized to collect and report on this data: the Child and Adolescent Needs and Strengths (CANS) and the Adults Needs and Strengths Assessment (ANSA). These tools have been demonstrated to be highly effective in supporting a person centered treatment planning process, improving communication and collaboration with an individual's supports and services in the community, empowering individuals and families in the service planning process, and promoting a more effective management of service resources and supports over time.

TTI significantly increased collaboration between the state mental health authorities and the community mental health centers

The CANS and the ANSA are both available as a web based application, which not only has the capacity to provide online training and certification to clinicians administering the tool, but also track client progress over time and generate client level, regional and statewide outcomes reports. These reports are reviewed with stakeholder groups, including the NH State Planning Council, the NH Consumer Council, and the Community Mental Health Center (CMHC) providers to promote the continued improvement of services, identify regions which will be identified as centers of excellence, and also identify areas where additional resources may be needed to improve the effectiveness of services.

Accomplishments and the hurdles encountered to date:

- ❖ In December 2010, BBH developed a supplemental job description for a Planning Analyst/Program Coordinator whose scope of work is centered around managing and supervising the collection, analysis, reporting, and interpretation of community mental health center contract performance measures and individual client outcomes data for use in the planning and management of the community mental health service delivery system. To provide technical assistance and training to community mental health programs in the implementation and development of sustainability plans for client level outcomes measures. The Planning Analyst/Program Coordinator was hired in May 2011.
- ❖ Contacted Dr. Lyons, a national trainer and developer of CANS and ANSA, regarding consultation and training. Training started in April. In the focus groups, Dr. Lyons and BBH designed the first draft of the NH version of CANS and ANSA. It was felt that the NH CANS/ANSA was very inclusive of assessing the individual's needs and treatment options that some required documentation could be eliminated or combined. Concluded that

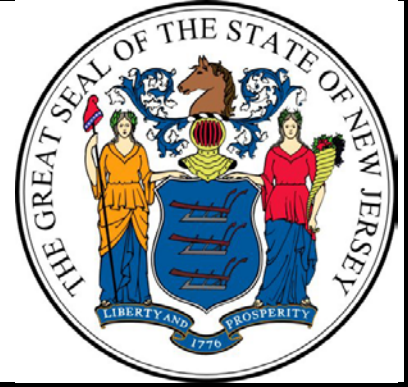
eligibility criteria for services, and quarterly reviews of the treatment plan could be folded into the CANS/ANSA assessment.

- ❖ The CANS/ANSA training and certification will be web based. Reviewed vendors, chose one and drafted an RFP. Since the program was a Commercial Off-The-Shelf Software program, an RFP was required. Over four months, what was originally a 6 page RFP developed into an 89 page RFP. The RFP was posted on the website on August 22, 2011. The process was quite helpful to BBH staff in understanding how the program would interface with the data collection that was needed.
- ❖ As of July 1, 2012 all 10 CMHC's have Electronic Medical Records (EMR) established. Five out of the 10 centers will have the same type of EMR. Staff began working with the representative of the company they are using to input the CANS/ANSA into their EMR. At the time the original RFP was written, it was stated that the centers would import data into the vendor and they could export the data to their centers. Because of this development where all centers would have EMR's by the end of the year, the RFP was re-written to state that the 10 CMHC centers could export and import data into the system.
- ❖ BBH met with Children's Directors, Community Support Program Directors, Older Adult Directors, and Quality Improvement Directors to solicit feedback on the NH version of the CANS/ANSA. Two staff from BBH attended the CANS/ANSA conference in Virginia, for a Train the Trainer, to become certified in the assessment tools. New Hampshire consulted with other states (such as Pennsylvania and Indiana), which have used these tools, to discuss how they rolled out these tools in their states.
- ❖ Each CMHC was offered 5 seats in the Train the Trainer training of CMHC managers. Training of all clinical staff statewide will begin to take place. Staff will have several options to become trained and certified:
 - Individuals can utilize the web based training when it becomes available.
 - Individuals can utilize their centers' staff that were trained as trainers.
 - Individuals can utilize BBH staff that were trained as trainers.
- ❖ Final accomplishments:
 - A draft has been finished of the NH CANS and ANSA.
 - Negotiations are ongoing to add CANS/ANSA to the managed care contract.
 - Providers and centers continue to train. Two have finished; the remaining 8 will train post-RFP.
 - BBH will begin organizing a Super User Group of the CANS/ANSA with those individual staff who were initially trained.
 - In October 2011, BBH will modify NH He-M rules to reflect the changes in eligibility and utilizing the CANS/ANSA.
 - One year after using the CANS/ANSA, the focus groups will reconvene to make any necessary changes that may be required.

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New Jersey



FY2009 TTI PROJECT:

Creation of and training of Peer Specialist Wellness Coaches and a State Medicaid Plan Amendment to allow for reimbursement of peer specialist services.

KEY OUTCOMES:

- Five regional peer focus groups were held throughout January and February confirming both the need and demand for Peer Support Wellness Coaches throughout New Jersey.
- Partnered with the University of Medicine and Dentistry, New Jersey (UMDNJ) for curriculum integration and development. Four academic departments of SHRP (psychiatric rehabilitation, nutritional sciences, physical therapy, dental hygiene, complementary and alternative medicine) and CSP-NJ Institute for Wellness and Recovery were involved in the curriculum development.
- A statewide wellness and recovery conference was attended by over 400 participants in March 2009.
- Two regional meetings with Providers in April 2009 were very successful.
- Twenty-two peers specialist have completed six full days of training in the curriculum (42 hours). Topics included: overview of health/wellness needs of persons with severe mental illness, explanatory models of health and wellness, developing health habits/stopping unhealthy habits, basics of communication including responding, paraphrasing, and facilitative questions, as well as two full days on life coaching skills.
- Beginning on June 10, 2009, twenty peer specialists began training as Peer Wellness Coaches. Classes ran two consecutive days over the course of eight weeks. They participated in 96 hours or 16 full days of intensive learning. Six semester credits of academic programming successfully delivered to seventeen students who successfully completed course in terms of mid-terms, final exams and projects.
- Recruitment for new class commenced this November and additional funds to supplement TTI funding to provide additional students with scholarships to attend classes this fall were negotiated. Eight peer specialists will be supported with TTI funds, and eight additional will be supported with NJ DMHS funds.
- In order for the Peer Wellness Coaches to effectively apply what they had learned and to provide an opportunity for further skill refinement, the project established formalized **“Coaching Tele-classes”** for peer specialists to get continued support, encouragement, and to have a forum for problem-solving.
- New Jersey has begun data collection for the program evaluation process.
- New Jersey has submitted a draft State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for Community Support Services (CSS) in the spring of 2009 under the Medicaid Rehabilitative Option and has had several collaborative conversations with CMS staff in an effort to finalize a formal submission that would receive favorable consideration.
- Working closely with the TTI Whole Health Peer Support Projects in New Jersey and Michigan.

For more information contact:

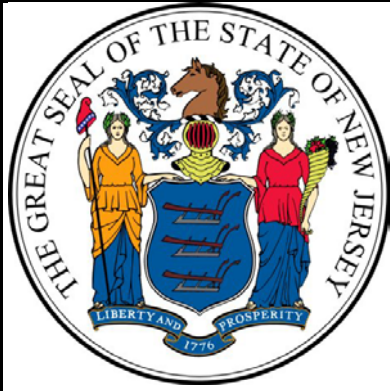
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New Jersey and Pennsylvania



FY2012 TTI PROJECTS:

Peer Wellness Coaches

KEY OUTCOMES

People living with serious mental illness are encountering co-morbid medical conditions and co-occurring substance use which significantly impacts their quality of life and decreases their longevity. Cognitive, emotional and social issues related to aging further impact quality of life and health outcomes. Pennsylvania's and New Jersey's current TTI grants built upon the successes of previous TTI funds by collaborating to prepare a peer workforce to meet the health and wellness needs of older adults with mental health and substance use disorders. This joint effort strengthened the capacity of the workforce of both states to meet the health and wellness needs of people with serious mental illness who are aging, but whose health needs are often neglected.

Peer wellness coaches offer an important service to persons with high-risk co-morbid serious mental illness and other medical conditions. The peers use peer support methods to diminish the likelihood that these especially vulnerable individuals experience further debilitating disease and premature death. Peer Wellness coaching is becoming an important tool in fighting the epidemic of premature death among persons with SMI. The wellness coach can be an effective source of support to educate and assist people in managing chronic health conditions to set and achieve healthy lifestyle behaviors. Adoption of peer wellness coaching is leading to better health outcomes for people with chronic conditions and can lead to an enhanced quality of life. In NJ, over 60 peers have been trained in this approach developed with TTI funding. It is also being adapted for delivery by non-peer providers, including job coaches and wellness management and recovery facilitators to integrate this approach in other services. In New Jersey, outcomes among coaching recipients (coachees) have included: weight loss, cessation of smoking or decreased smoking and a return to regular medical and dental care.

Simultaneous to these developments in New Jersey, Pennsylvania developed a curriculum for peer specialists to address older adult behavioral and health issues. Whole health, including both mental and physical health issues, is of paramount concern among older adults with serious mental illness, as in the general population. Whole health concerns are of greater urgency among persons with serious mental illness, as they often acquire serious co-occurring medical conditions earlier in their lives than persons in the general population. This whole health model, integrating an understanding of successful aging, wellness management, and peer coaching provides a multi-dimensional model to address multiple life issues. Even though persons aged 65 years and older represent the fastest growing age group in the United States, older adults are highly unlikely to seek treatment from mental health professionals due to stigma. These older adults with untreated behavioral health disorders are at increased risk of hospitalization reduced physical functioning, and earlier death. In addition to the general population of older adults who have never received services, many current recipients of mental health services are aging and in need of more specialized services for older adults.

This cross system training program has trained peer specialists to work more effectively with older adults. Current TTI funding has also given peer specialists opportunities to put their training into practice through supervised

internships. PA has valued the opportunity to have a class of 20 Certified Older Adult Peer Specialists (COAPS) trained in the Wellness Curriculum, a highly regarded training that New Jersey in partnership with the University of Medicine and Dentistry of New Jersey (UMDNJ) developed. Prevention and Wellness is in keeping with Pennsylvania's goal to implement a prevention and wellness initiative and aligns with the National Prevention Strategy. Current TTI funding has allowed PA the opportunity to train 23 CPS/Wellness Coaches in the Certified Older Adult Peer Specialist (COAPS) Curriculum developed by Dr. Cynthia Zubritsky, PhD, University of Pennsylvania. The following four major goals were accomplished in this collaboration.

Goal 1: Educate one class of NJ peer specialists (20) in Older Adult Mental Health

A 3-day, 18-hour Older Adult Peer Specialist training was conducted in Scotch Plains, New Jersey August 15-17, 2012. The training took place at the University of Medicine and Dentistry of New Jersey Scotch Plains campus. The training was facilitated by faculty and staff from the University of Pennsylvania, OMHSAS, Mental Health Association of Southeast PA, NJ Division of Mental Health and Addiction Services, New Jersey Department of Aging and graduates of the Older Adult Peer Specialist Train the Trainer program. Nineteen NJ peer specialists (upon completion they are called wellness coaches) successfully completed the training, which was comprised of a total of 50 hours of classroom teaching.

Goal 2: Twenty peer specialists (students) complete a 3 day training focused on the Principles of Wellness Coaching

A 3-day, 18-hour Principles of Wellness Coaching training was held in King of Prussia, Pennsylvania in May, 2012. Training selection occurred through an application process that was conducted by an OMHSAS organized review and selection committee. 25 CPS were accepted and 20 CPS successfully completed the training. The training was facilitated by faculty and staff of the University of Medicine and Dentistry of New Jersey.

Goal 3: Collaborate with OMHSAS, University of Pennsylvania and Community Health Providers to develop internships for the trained peer specialists

OMHSAS, the University of Pennsylvania and Community Health Providers have collaborated to build relationships and rapport regarding the specialized pool of CPS in southeastern PA. Grantee staff met with area CMHCs, FQHCs and Senior Centers to gauge interest in, and feasibility of, CPS wellness/older adult internships. Internship supervision and management materials have been developed and include: CPS internship job description, CPS internship agreement, CPS supervision, CPS satisfaction and CPS internship weekly report form. These materials may vary slightly based on the host-agency's policies and procedures.

Goal 4: Develop a coaching/mentoring system to provide support and technical assistance to peers serving internships and the provision of coaching/mentoring

The multidisciplinary collaborative including OMHSAS, University of Pennsylvania and Community Health Providers allow for a comprehensive support system for the CPS interns. Two teleconferences have been held with COAPS and training staff. The COAPS shared challenges and successes with staff and requested some follow-up for individual issues.

Pennsylvania Internships. The first Wellness Coach/COAPS internship began in October 2012 and ended in January 2013. Project Health, a collaboration between Horizon House and a Philadelphia FQHC, hosted the grant-funded Wellness Coach/COAPS internship. Grantee staff developed a job description and agreement in collaboration with Project Health staff. Internship responsibilities included: provision on one-on-one WRAP services; development and implementation of an on-going education group "Issues in Aging for Older Adults." This well attended group allowed older adults and their care givers an opportunity to learn about and discuss topics of concern to older adults, including: preparing for a doctor's visit; mental health in older adults; substance use; medication management and much more.

The second Wellness Coach/COAPS internship began on Monday, May 6, 2013 at two Reading Housing Authority senior apartment buildings in Berks county. Grantee staff have worked closely with Berks County to design the

internship which is a collaboration with the Reading Housing Authority, Threshold, Inc., a community mental health provider, OMHSAS, University of Pennsylvania and Berks County AAA. Planned activities include the delivery of wellness groups at multiple senior housing residences and the delivery of individualized in-home mental health and wellness activities for senior residents in the community. The Wellness Coach/COAPS intern has completed a one month orientation with the Reading Housing Authority, observing existing wellness groups and conducting outreach with senior residents.

New Jersey Internships. New Jersey opted for a different approach to its interns, placing 12 interns in a variety of settings – including supported housing, congregate living, residential health care facilities, partial care facilities, outpatient clinics, and self-help centers (many settings were resistant to intern placement, and these 12 locations were whittled down from the original 18 sought). Hurricane Sandy, unfortunately, severely disrupted many of the internships. New Jersey’s 12 original interns have since trained/coached 37 additional intern candidates, and their internships are now underway. New Jersey has also committed to have two classes a year for supported housing representatives, and guidelines are currently being re-written to make these services billable. New Jersey also held a Wellness Coaching Symposium on May 31, 2013.

Through cross training and internship development, the PA/NJ TTI initiative has bridged the gap between physical health and behavioral health, while increasing employment opportunities for Certified Peer Specialists. Grantee staff will continue to share project activities and build partnerships. The Pennsylvania Transformation Transfer Initiative was presented at the American Public Health Association conference in San Francisco, CA in October 2012 and at the Wellness Symposium hosted by the University of Medicine and Dentistry of New Jersey in May 2013.

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New York



FY2009 TTI PROJECT:

Using "Recovery Centers" focused on consumer/family education, peer support and assistance with treatment planning to restructure care in New York State.

KEY OUTCOMES:

- Partnered with Dartmouth University to conduct research on the development of recovery centers and enhance the use of supported employment.
- One hundred peer organizations and individuals were identified to conduct the search, interviews and summary of promising practices that informed the peer forums and focus groups and ultimately will inform the Recovery Center model.
- Conducted interviews of thirty-five peer organizations and individuals which were identified as representative of innovative or promising practices.
- New York conducted six regional peer forums that served as the avenue for soliciting peer input related to Dartmouth's research:
 - August 27 - St. Francis College, Callahan Center, Brooklyn, NY
 - August 28 - Islandia Marriott, Long Island
 - October 8 - Newburgh, NY
 - October 9 - Saratoga Springs, NY
 - October 14- Syracuse, NY
 - October 15 Batavia, NY
- Dartmouth data and peer feedback regarding the development of recovery centers has been strong enough for the New York State Office of Mental Health to dedicate \$1.5 million for fiscal year 2009-10 (annualized) and \$3 million for FY 2010-11, to begin two Recovery center pilot sites in New York City and Rochester.

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North Carolina



FY2008 TTI PROJECTS:

- 1. Training and support to the Local Management Entities (LMEs) to learn from each other and foster evidence-based practices; and*
- 2. Improve LME responsiveness to consumers and improve the delivery and management of mental health services by training licensed clinical social workers, masters level psychiatric nurses and certified clinical addictions specialists to conduct the initial (first-level) examinations of individuals to determine if they meet criteria for involuntary commitment under North Carolina law.*

KEY OUTCOMES:

LME Training

- North Carolina's community mental health centers, or Local Management Entities, are no longer providers and have assumed a new role as intermediaries to manage and oversee providers. The Local Management Entity manual revised for this project is supporting their adjustment to this new role by utilizing Evidence-Based Practices. The web-based manual links to forty documents and training presentations created and in use by the original Local Management Entities. It also links to over seventy websites considered to have relevant information and strategies for developing evidence-based practices.
- The manual will assist greater understanding of the local centers' new role and the development of an infrastructure for supporting and sustaining the implementation of EBPs.

Improving LME Responsiveness

- Development of a stakeholder advisory committee to assist the implementation of this project.
- Development of a training curriculum.
- Nine LMEs participated in this project.
- Three-day statewide training for twenty LME representatives.

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North Dakota



FY2008 TTI PROJECT:

Peer Support Training and collaboration with State Medicaid Office in a statewide peer support initiative.

KEY OUTCOMES:

- Creation of a 35-member statewide stakeholder Peer Support Work Group, with five subcommittees:
 - Certification & Training Curriculum
 - 1915(i)/rehab plan
 - Research & Outcomes
 - CMS/3rd party reimbursement
 - Information technology support;
- More than eighty individuals attended each of the workgroup's three meetings.
- Developed a Management and Implementation Plan.
- Developed Peer Support Certification Curriculum.
- Held Stakeholder Training in eight regions to ready providers and systems for these new services.
- Worked with the state Medicaid Office to submit Medicaid Requirements for statewide Medicaid funded Peer Support service in the form of a Medicaid State Plan Amendment and a Medicaid Waiver.

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North Dakota



FY2010 TTI PROJECT:

Development of the Transition Aged Youth Pilot Project.

KEY OUTCOMES:

The North Dakota Division of Mental Health and Substance Abuse Services provided a pilot project to address the needs of transition-aged youth at risk. The pilot site was North Central Human Service Center in Minot, North Dakota with service coverage of seven counties representing 82,159 North Dakota Citizens. In early 2009, the Sixty-First Legislative Assembly of North Dakota passed House Bill 1044 to enact programming for services to transition-aged youth at risk. The legislation calls for the Department of Human Services to develop a service program for transition-aged youth at risk by using a wraparound planning process.

The Transformation Transfer Initiative Project at North Central Human Service Center targeted transition-aged youth ages 14 -24 and built upon current transformation services as well as Bill 1044. This project collaborated and worked intensively with multiple community resources to provide the necessary supports to youth in transition.

The Transition Team at North Central Human Service Center reviewed requests for assistance by youth or their case managers and made recommendations to the Children's Mental Health Program Administrator for approval. Outcome of each youth receiving flex funds and wraparound case management services were tracked through the electronic health record systems of ROAP & FRAME.

As of March 31, 2011 the Transition to Independence Pilot Project has a case load of 18 transition aged youth/young adults. There were five males (ranging from ages 18-23) and 13 females (ranging from ages 18-24).

There have been 63 grant fund requests to assist youth/ young adult in their transition to adulthood. Grant requests included assistance in the following areas:

- Eye Appointment & glasses
- Birth Certificate
- GED - General Education Degree
- Transportation (bicycle, taxi, bus)
- Rent Deposit
- Rent Assistance
- Food

- Clothing
- Miscellaneous (household items, baby items)
- College expenses (books, equipment)
- Honorariums

The Transition Facilitator average 7-10 consultation cases each month between Partnerships, Extended Care and other systems partners throughout most of the TTI grant term.

The TTI grant also assisted with several activities which will continue post-TTI, including many of the above described activities, the development of a regional transition advisory committee, a state wide advisory council and several partnerships.

- A state wide Transition Interagency Advisory Council was formed and held its first meeting on December 14, 2010. The Council will specifically advise the Department of policy issues, delivery of services, and methods for reaching potential consumers. The Department will provide oversight of the transition program along with development and facilitation of the advisory council meetings. The Council will meet on a regular basis. A statewide survey was completed in January 2011 to determine the top transition needs across the state. The survey had a 65% response rate with five over all themes being pulled out of the responses: 1. Housing and Transportation; 2. Jobs and Employability; 3. Support Systems; 4. Health (Mental & Physical); 5. Management Systems. These areas will be used to develop a strategic plan for the State Advisory Council at subsequent meetings. This Council is advised by subcommittees formed in each of the eight North Dakota human service center regions, which have a regional representative at the Council.
- An MOA has been established with the National Network on Youth Transition (NNTY) for consultation services, training and technical assistance for implementation and sustainability of the Transition to Independence Process (TIP) Model for Transition Facilitators in ND. Discussions with the National Network on Youth Transition continue on how the TIP model would best work in ND. Collaborative discussions are occurring with states who have implemented the TIP program to determine the best route for implementation in ND. It was decided that ND will train all Transition Facilitators in the TIP model of practice for case management services for transition aged youth and this program. The TIP training was held on May 17-20, 2011 in Bismarck ND.
- The Transition Facilitator (formerly the Transition Coordinator under the TTI grant) continues to provide consultation services to case managers with transition aged youth being service through Partnerships & SMI/Extended Care case management along with case management services for those youth who do not receive services through either of these programs. The Transition Facilitator continues to provide case management services for 12 young adults with 11 infants/toddlers. Finding affordable, appropriate and safe housing continues to be the biggest struggle.

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Pennsylvania



FY2008 TTI PROJECT:

Older Adult Peer Support Services Initiative.

KEY OUTCOMES:

- Developed an Older Adult Peer Support Competent one-day curriculum.
- Developed an Older Adult Peer Support Enhanced three-day curriculum.
- Recruited twenty Certified Peer Specialists age 50 and over to specialize in working with older adults;
- Piloted the three-day Older Adult Peer Support Enhanced curriculum in Harrisburg, PA, with twenty older adult Certified Peer Specialists.
- Piloted regional one-day Older Adult Peer Support Competent trainings, recruiting twenty Certified Peer Specialists in each of three regions of the state (a total of sixty trainees).
- Seventy-eight Certified Peer Specialists' completed the trainings. Sixty-eight percent (68%) were female and thirty-two percent (32%) were male. Ages ranged from 28 to 67, with an average age of 51.
- Created specialized work opportunities for Certified Peer Specialists who completed the enhanced older adult curriculum.
- Collaboration among state agencies (OMHSAS and PA Department of Aging and Long Term Living) and university staff (Center for Mental Health Policy and Services Research, University of Pennsylvania).
- Leveraging of this TTI grant to secure another grant from the University of Pennsylvania to build and continue these services after the end of the TTI project.

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Pennsylvania



FY2011 TTI PROJECT:

Older Adult Peer support training and training infrastructure

KEY OUTCOMES:

Introduction. In efforts to reduce barriers to treatment the Office of Mental Health and Substance Abuse Services (OMHSAS) has been developing a cadre of older adult peer specialists to provide recovery services to older adults. At the time of the 2008 TTI grant, 854 Pennsylvanians were trained as Certified Peer Specialists (CPS). This core group includes many older adults, who were identified in 2008 for a special training initiative, Older Adult Peer Specialist Training. In 2008, sixty peer specialists were trained to work with older adults in recovery; twenty were certified as Older Adult Peer Specialists.

Goal 1: Train the Trainer Curriculum Development.

A modification of the Pennsylvania Certified Older Adult Peer Specialist(COAPS) train the trainer curricula was developed and implemented with existing older adult peer specialists and targeted professional trainers. The curriculum included learning objectives, content training information, experiential techniques, and performance measures in methods for working with adult learners and the prescribed behavioral health modules that are currently used for the COAPS Training. The curriculum format was designed for use in the field by COAPS.

Goal 2: Recruitment.

OMHSAS developed and implemented a training application process beginning in December 2010 to identify and select up to 2 out of state trainer candidates and two training vendors. Each vendor contracted with two professional trainers and two COAPS trainers. Recruitment and selection was operationalized through an application and selection process that was conducted by an OMHSAS organized review and selection committee, using the recruitment and selection process devised under the original TTI grant for recruiting up to ten older adults (age 50 +) to provide peers services to older adults. The recruitment strategy included distributing a statewide training announcement and utilizing the Pennsylvania Peer Support Coalition to publicize the training opportunity.

Goal 3: Pilot the Train the Trainer approach.

The train the trainer approach was piloted with 10 trainer candidates and 10 certified peer specialists. Counties and providers were notified of the availability and location of the training session; grant funds were used to pay for the hotel costs and the trainee costs. Evaluations of the training were completed by all participants and feedback from these pilot trainings session will be used to develop the final curriculum package. All training was delivered through training dyads comprising one professional trainer in partnership

with a certified older adult peer specialist trainer.

Goal 4: Follow-up evaluation.

Both trainers and students will be surveyed at the end of September, then again in December and March. This evaluation process will be used to inform the continuing development of both the trainer curriculum and the peer specialist curriculum. The curriculum and the training processes will be modified to reflect the participant input in the final edition.

Goal 5: On-going COAPS training.

The two professional training vendors are contracted with OMHSAS to deliver the COAPS curriculum in PA through 2014. Each entity had their first COAPS training in November 2011, in two different regions of Pennsylvania. PA also reviewed the entire training curriculum with both vendors looking for possible changes and improvements – one change was the addition of gambling sections. Each vendor will conduct two trainings annually through 2014. OMHSAS has presented on COAPS at the annual Area Agency on Aging Directors meeting as well as 5 regional Behavioral Health and Aging “Share the Care” trainings.

Goal 6: Follow up data collection and consultation.

Two conference calls will be scheduled for all Trainers at 3 and 6 months following their completion of the course. These calls will be instituted on a quarterly basis thereafter for two years to develop a national COAPS learning community, starting with PA and other selected states. The calls will be used to collect data about the trainers and their training programs, provide cross-fertilization for the trainers and provide technical assistance to the trainers.

TRAINING

Certified Older Adult Peer Specialist training was held in two parts: August 1, 2011 10 individuals participated in train-the-trainer activities. This one day training followed four teleconference TA calls. The training day addressed issues of adult learning theory and public speaking techniques. Participants became familiar with the curriculum and had the opportunity to practice the modules.

Older Adult Peer Specialist Training was held August 2-4, 2011 for 10 participants (total of 20 trainees). Potential trainers participated in the training both as trainees and as trainers.

The 8 Pennsylvania trainers began training Pennsylvania peers, and each vendor has held 1 training with 20 people per class. Each vendor is scheduled to have two trainings this year and each of the following two years as well (6 per vendor).

With the work accomplished in this TTI project, PA now has over 2,000 certified peer specialists, some of which are specialized in areas of Older Adult, Wellness and Forensics.

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Puerto Rico



FY2008 TTI PROJECT:

Integration of behavioral health into rural primary care settings.

KEY OUTCOMES:

- Increased knowledge in the physical health professionals of signs and symptoms of emotional illness and procedures for referral (Pre/post SSEI scale).
- Increased access to integrated physical and mental health services for patients of the Northwestern Region, and particularly of the Isabela municipality (service log attached to each medical record).
- Early detection, evaluation and intervention for patients presenting symptoms of mental illness within the Isabela primary care clinic (Evaluation and intervention checklist attached to each medical record).
- High satisfaction (staff survey) of the integrated health team members with the IPC model.
- High satisfaction (on client survey) with the IPC model with the integrated physical and mental health services received.
- Reduced ER visits of patients with co-morbid disorders attended through the project (Pre-post ER and outpatient data).
- Positive outcomes in the Isabela pilot have fueled other Mayors to reach out to the Department to collaborate to fund similar projects in other rural areas across the commonwealth.

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Rhode Island



FY2011 TTI PROJECT:

- 1. Creating/Deepening a Recovery Culture in RI Community Mental Health Centers*
- 2. Cultivating a Skilled Peer Specialist Workforce through Competency-Based Training in Peer Support*

KEY OUTCOMES:

The TTI project in Rhode Island has gained tremendous momentum by engaging with stakeholders and through the formation of a Transformation Advisory Group. This group recently met with members of Yale University's Program for Recovery and Community Health (PRCH), and has contracted with The Rhode Island Council of Community Mental Health Organizations (RICCMHO), who in conjunction with the Yale University group will be providing all training components of the TTI. BHDDH also contracted with NAMI of Rhode Island to support the internship phase and supervision of trained peer specialists.

On September 29, 2011, BHDDH hosted a recovery training kick-off facilitated by the PRCH group at Yale with participating Community Mental Health Organization CEOs and other members of their leadership teams. This event provided clarification on the direction of the TTI program, the trainings that were provided, the role of peer specialists and the supports that were provided for all participants.

Flexible funds and timing led to great, responsive, innovative results.

Following this initial kick-off, the Yale PRCH team scheduled individual recovery trainings for each CMHO. Prior to the actual trainings, BHDDH and RICCMHO provided Yale with agency policies, documentation examples, and Recovery Readiness Survey results to aid in their assessment of each agency's recovery orientation.

Component 1: Creating/Deepening a Recovery Culture in Rhode Island CMHCs.

This was a one-day comprehensive learning event (e.g., *Recovery: From Theory to Practice*) for each of the nine involved CMHCs. Training included a mix of didactic material with rich interactive/experiential exercises to reinforce learning.

- There was an emphasis placed on how "concepts" of recovery translate into concrete practice-based strategies which are reflective of recovery-oriented systems, i.e., the training focused not only on key recovery values and philosophy but also on the "nuts and bolts" of practical implementation at the level of the individual service practitioner. It discussed the roles of clinical and rehabilitation staff, as well as

- the potentially powerful role of Peer Specialists, in implementing person-centered planning.
- There was an emphasis upon the unique value and contributions of Peer Specialists within a recovery-oriented menu of services as well as ample time for discussion around frequently asked questions which arise as systems strive toward the integration of Peer Specialists within Community Mental Health Recovery Support Teams.
 - After each CMHC training, there was specific tailored technical assistance and follow-up to each regarding their implementation of recovery-oriented services and best-practice peer support. This largely occurred via web and teleconferencing forums without decreasing the impact of the interventions.

Component #2: Cultivating a Skilled Peer Specialist Workforce through Competency-Based Training in Peer Support

After an initial set of requests for participants, Rhode Island ended up with 50 responses for peer training. 28 individuals were trained in the 8 week Yale PRCH curriculum. All took the qualification exam for statewide certification purposes. 25 will be placed in Health Homes, and as part of that assignment each will take the Wellness Coaching training provided by Peggy Swarbrick's group from the UMDNJ-SHRP Department of Psychiatric Rehabilitation and Counseling Professions. That training will occur Jul 16-18, 2012, followed by an exam held on July 20th which will confer an advanced certificate in health and wellness. The remaining three individuals received additional training as employment specialists and will be placed in vocational programs, receiving supervision from an IPS certified vocational rehab counselor as they offer assistance to people looking to find and maintain employment. Rhode Island is hopeful that these processes will ultimately lead to a streamlining of the certification process and result in declining costs for certification and training. Rhode Island has also obtained the rights to use these training materials in the future, so this will be a self-sufficient program that will not need additional outside consulting visits.

Following certification, the certified peers started internships in community settings. These internships are occurring at the intended places of eventual employment. Some CMHCs are opting to immediately begin the employment phase of the peers. ***Certified peers are required on Rhode Island health home teams, and are part of the health home bundled rates.***

The training was highly experiential based on prior experiences designing similar training models/curriculums with other systems of care, including the following:

- SAMHSA Ten Fundamental Components of Recovery and implications of this for a wide range of Peer Specialist interventions;
- Core values and key practices within the Intentional Peer Support (IPS) model developed by Shery Mead;
- Core values and key practices within the delivery of Wellness Recovery Action Planning (developed by Mary Ellen Copeland) and the Pathways to Recovery Program (developed by Priscilla Ridgway); and
- Role of Peer Specialists as mentors/educators in training and supporting people in recovery in person-centered planning models and maximizing the participation of all persons in decisions regarding their care and life.

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South Carolina



2011 TTI PROJECT:

Models of Integration for Community Health Centers and Community Mental Health Centers

KEY OUTCOMES:

The South Carolina Department of Mental Health used their TTI funding to initiate a partnership and planning process with the South Carolina Primary Health Care Association: to identify, adapt or develop bidirectional models of integrated care for both Community Health Centers (CHC) and Community Mental Health Centers (CMHC); and provide statewide training forums.

The SC TTI provides a mechanism for expanding collaborative partnerships for integrated primary care and behavioral health services and meeting the statewide goals which are:

1. To expand stakeholder involvement and leadership coordination for joint planning and shared decision-making;
2. To identify promising practices and models of integration;
3. To identify and address cross training needs for integrated workforce development and client coordination strategies;
4. To engage local partnerships for assessment of integration opportunities, gaps in service delivery and provide infrastructure funding support;
5. To conduct regional and statewide training forums; and
6. To identify effective methods and benchmarks for implementing and sustaining integration partnerships and improving access to care.

The flexibility to create a framework allowed South Carolina to plan better. It's not a popular statement, but the limited TTI funding can produce better results because it produces a stronger focus, prevents lackadaisical planning, and forces an immediate focus on sustainability.

During the course of the TTI, eight pilot sites comprised of county CMHC and CHC were developed and are now in various stages of implementation of their collaborative efforts to provide integrated care. Seven of the eight pilot sites were able to implement various infrastructure building components of the integration initiative. However, one of the CMHC pilot sites decided not to execute a contractual agreement for the proposed integration planning initiative due to significant administrative barriers and low patient referral rates within the targeted geographical area. This pilot site represented a very rural area of the state with no prior relationship between the CMHC and CHC. However, the CMHC pilot site has entered into an arrangement with another primary care community health center for which it has a longstanding partnership.

The state has identified key staff responsible for integration policy/program planning and direct clinical treatment staff for participation in the University of Massachusetts Certificate Program in Primary Care Behavioral Health, a six month training program for strengthening its administrative and clinical capacity for an integrated workforce.

An additional part of the TTI planning process involved the establishment of a Leadership Advisory Council to facilitate a joint planning and shared decision-making forum for behavioral health, primary care, consumer advocacy and other key stakeholders in order to develop integrated policies and to create the state's vision of service delivery. In addition, the SC Primary Care Association has formed a Behavioral Health Network among their members.

As part of the evaluation process of the TTI, a short integration baseline survey was conducted to gather background data on pilot project sites. At baseline, nearly three quarters of survey respondents indicated that they were currently collaborating with other organizations to provide integrated care, however, collaboration methods varied and were found to be both formal and informal.

The TTI funding enhanced South Carolina's capacity to develop a blueprint of behavioral health and primary health care integration options to enhance access to care for our citizens.

Highlights of SC's accomplishments include:

- Establishment of the state level partnership between the South Carolina Department of Mental Health (state mental health authority) and South Carolina Primary Health Care Association;
- Establishment of state level Integrated Health Leadership Advisory Council and quarterly forums;
- Establishment of eight (8) integration collaboration partnerships;
- Engagement of supportive partnerships (Medicaid Agency, Consumer Advocacy Organizations) for expansion of policy development and future planning infrastructure;
- Increased awareness of TTI partnerships through presentations at behavioral health and primary care providers and policy forums;
- Preliminary assessment of training needs and resources for future workforce development efforts;
- Collected and compiled baseline integration data collection of each pilot site;
- Ongoing tracking of new patient admissions for integrated treatment tracks; and
- Implementation of Whole Peer Health Training.

South Carolina continues to receive feedback from both state and local level integration partners regarding strategies to overcome barriers and challenges encountered. Keys areas of focus include:

- Orientation to each entities' organizational policies and procedures to ensure a streamlined approach to subcontracting and sustainability of partnerships;
- Best practices for client referral, service delivery and adhering to regulatory requirements;
- Sharing of client information and outcome measurements;
- Implementation of cross-training of staff; and
- Involvement of consumer advocacy organizations regarding patient engagement strategies.

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South Dakota



FY2009 TTI PROJECT:

Strengthening rural MH transformation through the development of family-voice in implementation efforts. South Dakota is also expanding an existing System of Care Pilot Project by implementing Wraparound training in two regions of South Dakota that are actively working toward the creation of an integrated services system for children and their families.

KEY OUTCOMES:

Development of and Utilization of the Family Voice in Development and Implementation of a systems of care frame work.

- Families in both pilot sites met with Amanda Lautenschlager, South Dakota Parent Representative, Barbara Huff, consultant and Phyllis Arends, NAMI South Dakota Director, to discuss family options for support and education as South Dakota moves forward.
- Parent Professional Partnership Trainings were held in both Pierre and Sioux Falls and were the catalyst for development of Family Support Meetings in each community led by a Parent Representative that is also involved in the community-wide efforts to support a system of care framework. This is an important first step to building family/provider partnerships in the future. There is excitement among training participants about changing the way South Dakota does business with children and families.
- South Dakota providers are strongly considering parent positions. One mental health center has employed a parent partner through grant funds and is working on sustainability plans. The Rapid City group is considering a parent position, but this will likely resemble more of a consultant relationship with specific deliverables.
- Dialogue and relationship building has begun with Parent Connection- the states' only Parent Training and Information Center (PTI), Navigator Program (alternative dispute resolution), and Family to Family Health Information Center (F2F HIC) to further support the infrastructure needed to sustain family involvement in all aspects of systems of care development.

Build Capacity for Wraparound Implementation to help children and their families realize their hopes and dreams. The wraparound process also helps make sure children and youth grow up in their homes and communities.

- Wraparound Training was delivered in both Rapid City and Pierre and subsequent technical assistance coaching visits were provided to both sites as follow-up. Both providers and families participated in the trainings and follow-up visits.
- Mary Grealish conducted an individualized training/orientation meeting for Pierre to help them gain commitment and participation from the community stakeholders involved. She then completed additional coaching on Wraparound for Pierre and Rapid City.
- Discussions are underway for cross-agency training on Family Group Decision Making utilized by the Rapid City Child Welfare agency.

Relationship building and coordination of efforts.

- Multiple child-serving agencies working well in tandem at both the state and local levels.
- Local level governing and planning groups are established.
- State agency directors met with financing consultants from Nebraska to discuss options for restructuring their current funding streams to more effectively support a system of care framework.
- Both Pierre and Rapid City's local system of care steering committees have realized that the majority of youth and families have co-occurring substance use issues and are interested in coordinating their efforts with some of the existing infrastructure provided through the South Dakota Co-Occurring State Infrastructure Grant's Change Agent group.
- Utilizing the core principles and values of a system of care, South Dakota has been able to coordinate its efforts towards the State's Co-SIG, suicide prevention, and Data Infrastructure Grants as it relates to TTI outcomes.

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Tennessee



FY2008 TTI PROJECT:

Transforming their juvenile forensic mental health services by providing courts with alternatives through a program of outpatient screening and forensic evaluation.

KEY OUTCOMES:

- Supplied training and technical assistance to community providers for the transformation of the juvenile forensic mental health evaluation service to a community-based service and connecting juveniles to other age-appropriate mental health services.
- Established working relationships with essential departments in Tennessee's Executive, Legislative and Judicial branches, including the Administrative Office of the Courts, the Attorney General's office, the General Assembly's Fiscal Review Committee, and the Governor's Office of Child Care Coordination.
- Collaborated with the Tennessee Council of Juvenile and Family Court Judges and the Administrative Office of the Courts to revise and distribute model court orders for both inpatient and outpatient, including the training for judges and contact information for providers for each court.
- Engaged additional judicial leadership through the Tennessee Council of Juvenile & Family Court Judges to establish an understanding of the needs of judges for mental health evaluations, DMHDD services, and the proper approach to implementation of a wider use of outpatient evaluation, access to services, and competency training.
- Prepared, at the TDMHDD level, to respond to a crucial decision by the Tennessee Court of Appeals directly affecting all courts and all evaluation providers.
- Provided key leadership in the development of legislation to complete the transformation.
- Proposed funding availability for an increase in outpatient evaluations *prior* to seeing any cost reductions from a decrease in inpatient evaluations.
- Identified the primary missing resource resulting in the over-reliance on restrictive, expensive inpatient evaluations.
- Placement alternatives for juvenile justice system youths other than detention or home.
- Began an effort to create a new database to streamline data across state agencies.

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Tennessee



2011 TTI PROJECT:

Early Intervention for Prevention:

Improving Access to Mental Health and Substance Abuse Services for Youth in Juvenile Courts

Transformation Goals: To deploy a public health approach of early intervention to improve access to mental health and substance abuse services for youth in juvenile courts as well as to support follow-through with and participation in available services which contribute to diversion from the juvenile justice system and reduce recidivism.

Background:

This project focused on putting Family Service Providers in place to assist youth (and their families) with charges in juvenile courts in accessing a broad array of services. A Family Service Provider (FSP) is a self-identified parent/caregiver or family member of a child or youth with a SED which has required mental health and/or substance abuse treatment. FSPs have to complete a certification process provided by the Tennessee Department of Mental Health (TDMH) which is similar to a Peer Support Counselor. The specific role of the FSPs was defined to some extent by the needs of each individual juvenile court and each individual case. Family Support Provider typically include:

- Provide support to individual families to assist them in accessing services and in navigating the various child-serving systems in the following ways:
 - Assist families in overcoming barriers to accessing services
 - Provide support and information on community resources
 - Assist caregivers in learning how to build collaborative relationships with service providers involved with their children
 - Assist caregivers in establishing a support network of formal and informal support persons
 - Empower families to advocate effectively for their children
- Participate as a member of the Child and Family Team
- Are responsible for timely and concise case documentation, as well as entry of accurate demographic and other information into the database
- Collaborate with local providers, Juvenile Court staff, and school staff in the best interest of the child and family
- Participate in weekly supervision with Supervisor and for following case direction
- Participate in collaborative meetings/trainings and team building activities with the program staff

Flexibility around timing allowed TN to pick the best battles to fight as opposed to having to use all the money in a certain time period.

Implementation:

Implementation of this TTI project capitalized on the cross-agency collaboration established in Tennessee's first TTI grant in FY 2008 with the Administrative Office of the Courts, the Department of Children's Services, the Vanderbilt University Center of Excellence, the Tennessee Council on Children and Youth, Tennessee Voices for Children and the Governor's Office of Children's Care Coordination. A task force with representatives from each of these agencies established a court screening project in which youth who had cases in ten volunteer juvenile courts were screened by youth service officers with a 33-item Juvenile Justice screening version of the Child and Adolescent Needs and Strengths survey (CANS). This is a service-planning instrument which rates the presence and intensity of needs related to mental health, substance abuse and delinquency. Any identified need resulted in a referral.

This TTI project established FSPs in four of the courts, who followed up to help the youth and family identify the proper services and overcome barriers to access for those services. FSPs provided a wide range of services, from working directly with caregivers on parenting strategies to providing coordination among a number of treatment providers on a single case. Specific examples include:

- ✓ Diversion of female juvenile to residential program (Operation Hope) resulting in dismissal of shoplifting charge;
- ✓ Coordinating services for a child with alleged delinquent behavior and disclosure of being sexually victimized;
- ✓ Arranging a cross-discipline caregiver meeting for a child receiving multiple services;
- ✓ Coordinating aftercare services for youth discharged from inpatient psychiatric treatment post- suicide attempt;
- ✓ Educational advocacy to secure additional testing for a juvenile with Tourette's syndrome who had been referred to Juvenile Court for behavior problems at school (the FSP planned to advocate for a behavior plan to be integrated with the educational plan);
- ✓ Assisting the mother of a child with ADHD referred to court for school behavior problems by coordinating the child's mental health care and the mother's physical care. This child's mother has significant mobility problems due to advanced diabetes and associated foot problems. The FSP was able to assist her in applying for a lift chair for her vehicle, a shower chair, a diabetes bracelet and transportation options that will improve her ability to get her daughter to the mental health center for services; and
- ✓ In a case opened in April on a female with behavior problems at school, the FSP's initial interventions were to assist with a referral to local mental health services for the juvenile and parenting classes for the mother (actually requested by the mother-she knew what she needed but not how to get it). The FSP also helped the mother to request school records so she would be more able to talk to the school about educational needs.

A meeting of staff and project coordinators from all the courts involved was held during the annual Tennessee Juvenile Court Staff Conference, and anecdotal feedback indicated strong support for FSP services, particularly in rural areas where services were distant and difficult to identify. One juvenile court judge said:

"Macon county is one of the counties participating in the CANS Pilot program. We also have a Family Support Specialist working with us in the program. She can verify Macon County's lack of services for our children. Ms. Howell has been a big help for us, but we could benefit from more of her time in Macon County. I am writing to request more of her time in Macon County if possible. Thank you, Ken Witcher, Juvenile Court Judge."

Sustainability:

TennCare has approved FSP services as a cost-effective alternative, reimbursements are ongoing on a case-by-case basis, and formalized reimbursement (leading to potential program expansion and continuation post-TTI) is expected by the end of 2012.

Next Steps:

- ➔ Current TTI funds will allow for the continuation of FSP services through June 30, 2012, including additional hours of service available in those counties currently being served by FSPs;
- ➔ In 2012, data from the participating counties will be analyzed for patterns of need and effects on recidivism, and structured interviews will be completed with court staff to identify strengths and weaknesses of the FSP services;
- ➔ Data analysis and feedback will guide the task force in determining how to identify the best county and court environment for expansion and the best method for implementation;
- ➔ The TTI FSP project will be integrated into TDMH's broader goal of developing local Systems of Care which are comprehensive, culturally and linguistically competent, child-driven and family-focused with an emphasis on keeping children in their homes; and
- ➔ The program is currently largely rural; Tennessee next hopes to expand it into more urban areas.

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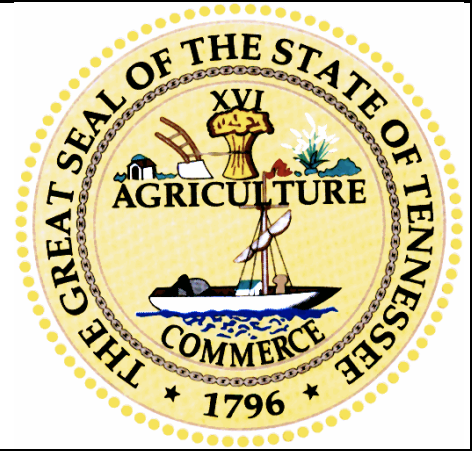
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Tennessee



2013 TTI PROJECT:

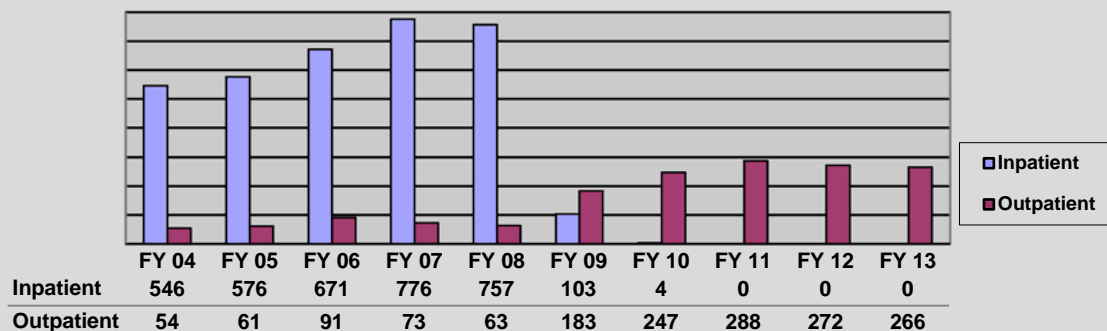
The transformation of juvenile court services by expanding the use of screening for mental health, substance abuse and family service needs of youth referred to juvenile courts as unruly or delinquent, provide family-peer support services to the families of these youth, and increase the use of evidence-based therapeutic practices for the juvenile justice population.

KEY OUTCOMES:

Background

The Transfer Transformation Initiative program has supported the complete transformation of the system for providing mental health and substance abuse evaluations for youth in juvenile courts from an expensive and inappropriately restrictive inpatient service to a range of community-based screening and assessment procedures. Due in large part to past TTI efforts, formal juvenile court-ordered forensic mental health evaluations are now provided exclusively on an outpatient basis. **The budget impact has been reduced from a cost of approximately \$7 million in (state) Fiscal Year 2007 compared to \$240,050 in (state) Fiscal Year 2013.**

Annual Totals of Inpatient and Outpatient Juvenile Evaluations



This transformation was accomplished through a multi-agency Task Force including the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), the Administrative Office of the Courts, the Department of Children's Services, the Vanderbilt University Center of Excellence, the Tennessee Commission on Children and Youth and Tennessee Voices for Children, all working with juvenile court judges and the Tennessee Council of Juvenile and Family Court Judges.

The Current Project

This Task Force has established the Tennessee Integrated Court Screening and Referral Project. Youth service officers (YSOs) in juvenile courts are trained to complete a 33-item Juvenile Justice screening version of the Child and Adolescent Needs and Strengths (JJ-CANS) survey. If any mental health, substance abuse or family service needs are identified, the Department of Children's Services court liaisons help with referral to locally available services. Mobile crisis teams are contacted in emergency cases. In selected courts, a Family Service Provider (FSP) assists the child and family with accessing and coordinating services. FSPs are self-identified caregivers of youth who have been in the mental health/substance abuse services system and have been trained and certified by the TDMHSAS to help other families navigate the service-providing system. The Administrative Office of the Courts developed a web-based, password-protected application for the YSOs to enter the JJ-CANS scoring and any referral information. Outcome data on frequency of screenings, item scoring, referral patterns and a rough estimate of recidivism are generated from this application.

Strategies:

- Provide training and technical assistance to youth service officers, Department of Children's Services court liaisons and court administrators in the use of a 33-item juvenile justice version of the Child and Adolescent Need and Strengths (CANS) survey.
- Provide screening outcomes to Department of Children's Services court liaisons for referral to evidence based therapeutic services.
- Establish Family Support Providers to assist the families of youth in juvenile courts who are identified as having behavioral health needs to negotiate the human services providers network.
- Provide training and technical assistance to juvenile court judges and attorneys in the use of the screening process and Family Support Services.
- Collect and analyze data during expansion of the program, review results, and implement delivery system changes.
- Develop a train-the-trainer protocol to sustain the project beyond this Transformation Transfer Initiative funding.

Results

The eight original pilot courts (Dickson, Madison, Macon, Morgan, Obion, Hawkins, Washington counties and Johnson City Juvenile Court) have been expanded to twelve with the addition of Bradley, Davidson, Knox and Montgomery counties. Davidson (Nashville) and Knox (Knoxville) are the second and third most populous counties in Tennessee with very busy juvenile courts. Knox County will be an ideal location for expanding the Family Service Provider piece of the project (Davidson County already has a Family Service Provider funded by the county and Bradley and Montgomery have other family outreach services). Dyer and Lauderdale counties will be added by June 30, 2014, and we are targeting Sullivan, Putnam and Shelby counties for the next wave of expansion. The goal of this project is to offer to train juvenile court staff and set up the project in every juvenile court in the state, court by court.

The TTI project has allowed us to establish the use of a uniform screening measure of the needs of youth in juvenile courts in all regions of the state. The Three Branches Institute, a collaboration between all three branches of state government on juvenile justice reform are exploring the use of the juvenile court screening program as the vehicle for state-wide juvenile court reform. The JJ-CANS screener is ideal for establishing an evidence-based, standardized intake procedure whether it is at the point of initial referral to the juvenile court, opening a probation case or entering detention.

The Vanderbilt University Center of Excellence for Children has established a monthly conference call for updates on JJ-CANS scoring, trouble-shooting and data requests for all participating court staff to join. Guest discussants are occasionally featured, such as Lourdes Rosado, Associate Director of the Juvenile Law Center, speaking on protections against self-incrimination in screening and assessment of youth in juvenile courts.

The Administrative Office of the Courts continues to provide participating courts with data on the number of screenings and referrals quarterly:

	10/1/2010-3/31/2014
Total Screened	4,177
MH Referrals	419
SA Referrals	275
Family Services	2,326
Total Referrals	3,020

This TTI grant has allowed us to expand and improve a juvenile court screening procedure which integrates referral to services and family supports leading to real change for youth in juvenile courts. The flexible nature of the funding allowed us to shift funding to needed areas, e.g. additional training and technical assistance for courts having difficulty getting regular screenings done, or the addition of FSP services in high-demand courts. We have also leveraged state funds; the TDMHSAS has included \$20,000 of the community re-investment funding for expansion of the project. The “Fixed Price” nature of the TTI grant, allowing for expenditure of residual funds beyond the end of the subcontract will allow us to continue expanding the juvenile court screening project. We have contracted with the Vanderbilt University Center of Excellence for Children and Tennessee Voices for Youth to continue this work into the future.

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Vermont



FY2011 TTI PROJECT:

Vermont Evidence Based Practices Cooperative

KEY OUTCOMES:

The Vermont Department of Mental Health (DMH) is establishing an independent, cooperative organization focused on mental health practice improvement and workforce development. This new organization, referred to as an *Evidence-Based Practices (EBP) Cooperative*, will work with mental health providers, consumers, family members, and other service organizations to support the adoption of promising, evidence-based, and recovery-oriented practices within the state's community mental health system and improve the quality of life outcomes for individuals receiving services from that system. The EBP Cooperative will also focus on establishing and supporting core competency training for Vermont's community mental health providers to ensure that our workforce has the core values, skills and knowledge to meet the needs of the consumers they are working with.

Vermont has previously used other federal grant funds (*New Freedom Initiative – State Coalitions to Promote Community-Based Care*) to support a multi-stakeholder (consumers, family-members, mental health providers) panel to review and make recommendations regarding how evidence-based practices should be implemented in Vermont. The panel has been responsible for 1) evaluating reviews of the scientific and practice literature on specific practices, as well as “lessons learned” from in-state pilots and state-wide implementation of those practices, and 2) creating recommendations about the scope and scale of implementation of those practices in Vermont. The panel has evaluated and produced recommendations for eight EBP's to-date. Based on these recommendations, the panel has also developed recommendations to create an Evidence-based Practices Cooperative as the primary method for implementing their recommendations. The TTI award has taken these recommendations and sought to implement them.

Description of the EBP Cooperative

The Evidence-Based Practices (EBP) Cooperative will serve as an independent practice improvement and workforce development organization focused on the adoption of evidence-based practices, recovery oriented practices, core competency practices, and practices that are supported by efficacious outcomes (i.e. practice-based evidence) within Vermont's community mental health system. Membership of the cooperative will include community and inpatient mental health providers, consumer and family support organizations, higher education, and consumer and family members. Each stakeholder group will share responsibility for supporting the work of the cooperative to identify, implement, and sustain EBP's in Vermont.

Specific functions of the EBP Cooperative will include:

1. Perform systematic review, evaluation, and analysis of new evidence-based and promising practices for possible implementation in Vermont.
2. Operate as a state clearinghouse for resources and information on evidence-based practices (this will include specific information on EBP's for consumers and families to support informed consumer choice).
3. Develop and sustain in-state resources to support the implementation of evidence-based practices (e.g. training of

trainers to establish in-state experts on specific EBP's, web-based training, training materials, and consumer and family panels). Develop opportunities for new learning and continued education.

4. Assist agencies in specific practice reviews and perform outreach, evaluations and fidelity assessments of mental health services to determine availability and quality of evidence-based practices in the state. Support peer review processes for agencies when they are desired.
5. Coordinate training, case consultations, technical assistance, and other workforce and program development activities to support adoption of core mental health competencies and evidence-based practices.
6. Identify state and local implementation opportunities and barriers (e.g. policies, funding) and facilitate efforts to address barriers (i.e. the creation of flexible funding to purchase trainers/consultants).
7. Support the use of data collection, outcomes-monitoring and community-based research to evaluate the effectiveness of practices being provided by the community mental health system.
8. Grant writing acquisition and fundraising to support the EBP Cooperative activities.

To create the Cooperative, Vermont has:

- Utilized stakeholder input to revise the original proposed timeline for the initiative and recognized that a business model should be developed to ensure that the services being envisioned for the EBP Coop should be clearly described and reflect the researched wants of the mental health provider system. In doing so, Vermont reconvened the original Clinical Practices Advisory Panel (CPAP) of the Community Rehabilitation and Treatment (CRT) programs of the 10 designated community mental health agencies in the state of Vermont.
- The members of CPAP affirmed that a business model and a smaller EBP Coop Development Committee should be developed to continue the initiative process. Additional recommendations enabled the Development Committee to add a strong consumer advocate with significant business acumen in the highly competitive computer software market and a family advocate member with long standing ties to service with DMH and specifically the state hospital. CPAP also reaffirmed the mission statement, vision statement, and revised the desired business functions as outlined in the original initiative application. This unique committee structure, which in the past would have been dominated by only provider members, has provided greater confidence that the created final business model will create an entity that has a greater chance of surviving and flourishing in financially uncertain time periods.
- Market survey interviews have been done with a portion of the possible end users have been ongoing. This information has been used to modify functions further and provide for a clearer picture of the core needs of the system providers which could be met by the EBP Coop. Several revisions and re-constructions of the structured market interview survey tools were developed, and the final tool appears to be effective in garnishing the desired information in an efficient format during the brief interview time periods.
- Research by DMH staff members into the various e-learning opportunities has also been a constant activity which has revealed some deficits in the current e-learning provider system, but has also lead to the discovery of some promising curriculums.

As a result of these activities, Vermont has issued an RFP for the creation of the Cooperative. Next steps will occur in the Summer of 2012.

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Virginia



2011 TTI PROJECT:

State CIT conference and CIT expansion

The Department of Behavioral Health and Developmental Services (DBHDS), in collaboration with NAMI Virginia, the Virginia Organization of Consumers Asserting Leadership (VOCAL), the Virginia Beach Department of Human Services (VBDHS), the Virginia Crisis Intervention Team Coalition (VACIT) and the Virginia Beach/Commonwealth of Virginia Steering Committee overseeing the Crisis Intervention Team International (CIT I) International Conference sought to advance Virginia's comprehensive and ongoing systems transformation by addressing the area of behavioral health and criminal justice transformation. Virginia utilized this funding to focus on: 1) improving its statewide Crisis Intervention Team Initiative through greater involvement of consumers and families in local programs and 2) with the VACIT, identification of key barriers and solutions for effective implementation of the CIT model and increasing awareness of Virginia's activities, challenges and opportunities to address comprehensive systems change throughout the criminal justice and behavioral health interface utilizing the Sequential Intercept logic model as a foundation.

The core activity of the TTI initiative was to entrench CIT within Virginia Communities and empower peers and families by overlapping and supporting NAMI Virginia's annual statewide conference with the CIT International and Statewide Conferences September 12-14, 2011. Bringing Virginia's consumers, family members, law enforcement personnel and mental health stakeholders together provided a unique opportunity to focus on Virginia's behavioral health and criminal justice transformation challenges and opportunities. Concurrently, it also exposed Virginia's stakeholders to the breadth of information, innovation and insights available from participation in the CIT International conference.

This is the kind of grant that lets you do the kinds of things that you are never able to do.

TTI funds were utilized to:

1. Support overlap of the NAMI Virginia Annual Statewide Conference with the Virginia Statewide CIT and the CIT International Conferences in September 2011;
2. Develop a series of workshops targeting Virginia stakeholders to be presented at the Conferences which enhanced consumer-family member participation in Virginia's CIT initiatives and strengthened local and statewide stakeholder relationships, b) provide joint conference programming that addressed Virginia's particular challenges in creating successful CIT programs, including limited access to services, models for developing therapeutic alternatives to incarceration, the significance of data development and need for improved consumer-family member integration;
3. Provide a Virginia-only program track as part of the joint conference which exposed participants to the full spectrum of Virginia's criminal justice and behavioral health transformation initiatives, with presentations based on a) the Sequential Intercept Model, b) Virginia's Cross Systems Mapping project, c) Virginia's 10 site cohort, representing a variety of jail diversion and jail treatment approaches, and d) significant consumer training and

support programs and initiatives;

4. Provide 168 scholarships for consumers, law enforcement and mental health stakeholders to attend the overlapping Conferences; and
5. Hire a part time VA CIT coordinator to work with stakeholders and improve CIT program outcomes by a) serving as a liaison with Virginia's CIT programs and communities for the VACIT Coalition to improve information sharing, coordination and program strengths, b) providing guidance and technical assistance to Virginia's 24 CIT programs to help implement all three elements of CIT in Virginia's programs, d) assisting the VACIT in developing statewide policy and minimum expectations which set out these elements for CIT programs and e) providing coordination among stakeholders to assure that Virginia participants received the greatest benefit for themselves and their programs from the overlapping conferences.

Virginia consumer representatives are members of the CIT I Conference Steering Committee and were involved in all aspects of program development and participation at the joint conferences.

Post-Conference outcomes:

- 316 attendees at the CIT conference.
- As a result of the interest in the CIT conference, Virginia was able to quickly create an RFP for six small planning grants (\$20K-\$50K) by re-tasking current state funding. There were 13 applicants for these 6 month planning grants.
- New state funding has been awarded – up to \$600,000 annually for developing CIT assessment sites.
- In October, 2012, DBHDS, DCJS, NAMI-VA and the VACIT Coalition are collaborating to hold a 2nd Annual Virginia CIT statewide training and conference in Charlottesville. This event will specifically focus on veteran's issues, leadership roles, and advanced CIT issues (the initial conference focused on CIT fundamentals). The conference is also partnering with the Virginia Wounded Warrior Program to provide a one day Train the Trainers event giving regions in Virginia the resources to enhance the effectiveness of their CIT response to Veterans involved in the justice system.
- TTI brought together a large set of diverse people who helped to create CIT as a common activity within most parts, but not all, of Virginia. This has allowed Virginia to dramatically expand CIT at a very fast rate.
- A May 22, 2012 planning meeting was held regarding subsequent Virginia CIT activities. Dr. Fred Osher, Council of State Government (CSG) led the meeting, and provided significant information regarding the current state of national efforts, data outcomes and challenges across the BH and CJ spectrum. 120 people from communities across Virginia attended.
- The TTI initiative has helped localities across Virginia improve community readiness to successfully apply for and implement such grant opportunities and enhance CIT program outcomes which will help them to sustain and increase local, state and federal funds.

One bonus activity that arose during the award period was an opportunity for a number of Virginia representatives, including Commissioner Stewart, to go to Montana to meet with various Montana representatives (including law enforcement, prison personnel, and state mental health officials) on the nexus of criminal justice and mental health activities (see the Montana TTI summary for more information on Montana's activities). As a result of this visit, cooperation between Virginia's Department of Criminal Justice and Department of Behavioral Health have dramatically increased, and now includes changes in both agencies' plans and mutual strategic planning.

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Virginia



2013 TTI PROJECTS:

(1) Advanced Directives and (2) Legal outreach and continuing legal education training.

KEY OUTCOMES:

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) had two goals for the Transformation Transfer Initiative (TTI) funding: (A) Further its efforts to incorporate the use of Psychiatric Advanced Directives (ADs) into routine clinical practice throughout its system of care to promote individual self-determination, reduce coercion, and reduce the need for expensive crisis care, including inpatient treatment and incarceration; and (B) Provide much needed cross-systems education about the behavioral health system to Virginia's legal community, including judges, clerks, magistrates, Commonwealth's Attorneys and defense attorneys.

Key Outcomes – Advanced Directives:

- 29 CSBs (community service boards) that have received consultation (there are 40 CSBs statewide) on Advanced Directives from us. Of those 29, 8 CSBs have participated in our Certified Facilitator Training. In addition to the CSB participation, we have made significant progress in engaging CIT providers, hospitals, and peer providers:
 1. Crisis Intervention Teams (CIT): We received Statewide CIT approval for our Advance Directive "Crisis Card". We are also consulting with Region Ten CSB's CIT, and looking to branch out to other CIT teams as training (and subsequent AD use) becomes more prevalent.
 2. Hospitals: We have presented to the Region IV Behavioral Health Partnership Meeting and the Region II Regional Utilization Group (RUG) Meeting, both of which cater to emergency and hospital providers. We are working with Southern Virginia Mental Health Institute) as part of a Region VI large-scale AD Implementation Effort. We present frequently to Northern Virginia Mental Health Institute, and are working with administration to determine what is the best route for making AD facilitation available at the facility. We are also working with Peer Providers at Western State Hospital to make ADs more widely available there.
 3. Peer Programs & Other Entities: The Virginia Organization of Consumers Asserting Leadership (VOCAL) and the disAbility Law Center of Virginia (dLCV) were active in developing our Facilitator Training Curriculum. VOCAL and Mental Health America of Virginia both support our efforts and provide AD information and encouragement to consumers. dLCV attorneys actively assist consumers with AD facilitation. We are working with the aforementioned Peer Groups, as well as NAMI and the University of Virginia to determine the best methods of large-

scale AD promotion and facilitation throughout the Peer Provider “network”.

- Actively worked with the Charlottesville-based Region Ten CSB and its local CIT to determine best practices for collaborating with crisis/emergency services on the utilization of ADs.
- Presented to the Virginia Association of Community Services Boards’ May 2013 training conference on the importance of ADs in community-based services and strategies for implementing ADs as a best practice.
- Scheduled to present at a statewide meeting of Virginia Crisis Stabilization Units and the *Cross Systems Collaboration between Legal & Mental Health Partners* conference in September 2013.
- Created and piloted a certified AD Facilitator Training Curriculum.
- Included staff from 5 agencies in the pilot of the Certified Facilitator Training.

Key Outcomes –Legal

- A 7 module curriculum has been approved by the bar for CLE credits. Each training module takes approximately one hour of live instruction. DBHDS has been approved by the Virginia State Bar to offer 1 CLE credit for each module. Any number of modules can be combined together should a locality wish to receive more than 1 training module at a time (we prefer 2 or more modules at a time). The modules include:
 1. Improving Outcomes for Persons with Mental Illness in the Criminal Justice System: the Sequential Intercept Model;
 2. Explanation of Mental Disorders (or “Mental Health 101”);
 3. Explanation of Relevant Code Sections for Persons with Mental Illness, including Pre-Trial Mental Health Evaluations and Treatment;
 4. Evaluation of sanity at the time of the offense;
 5. Use of Mental Health Courts & Mental Health Dockets as Tools to Address the Needs of Defendants with Mental Illness;
 6. Enhancing Interactions with Clients who Live with Mental Illness; and
 7. Working with Adolescents.
- Provided seven local/regional mental health trainings to attorney groups. A total of 119 participants received the training. Trainings varied from two to four hours in duration. Have facilitated seven more sessions post completion of the grant period. In total we have provided mental health training to approximately 280 lawyers/judges (237 through our training in localities and 43 at our two day conference).
- Developed collegial relationships with Office of the Executive Secretary, Virginia Indigent Defense Commission, and the Virginia Commonwealth’s Attorneys’ Services Council. These agencies are now aware of the availability of this training and will aid us in disseminating the training.
- Began production of DVD of consumer’s discussing their illnesses and personal recovery. DBHDS intends to use this DVD as a teaching tool in future training efforts
- Convened statewide conference. Attendees included judges, Commonwealth Attorneys, defense attorneys, Community Services Boards staff members, state hospital staff members, and special interest groups. Over the two days of training, participants received twelve hours of instruction on mental health/ legal issues. A total of 150 individuals attended the conference. 14 judges, 16 Commonwealth Attorneys, and 13 representatives from the Office of the Public Defender attended. 105 Community Service Board representatives, state hospital staff representatives, and community advocates attended

Lessons Learned:

- While the research that informed our implementation effort found that system-wide implementation was a best practice, we did not foresee the depth and breadth of engagement necessary for the effort to be successful. We began working intensively with emergency services, state hospitals, the legal community, and CSB programs (such as Crisis Stabilization Units) that we had not previously engaged in the implementation effort. The expanded effort not only increased understanding among newly engaged agencies, but improved working relationships with “traditional” CSB entities. Positive outcomes confirmed that cross-systems collaboration is a highly effective tool for ensuring that ADs are promoted, completed, and followed in times of crisis.
- We also realized that preparatory work within an agency must be extensive. For AD to become an effective component of routine care, it is necessary to incorporate one-on-one facilitation of an AD with consumers into an agency’s treatment culture and policies. Training alone is not an effective implementation tool—training must be accompanied by intensive planning and building supportive infrastructures. This requires ongoing engagement of leadership at all levels, which can be challenging in the present behavioral health environment, where outwardly-imposed change is ever present.
- We had assumed that there would be more collaboration (at least in terms of participating in training) between the respective public defenders offices, Commonwealth Attorney offices, and the local judges. It turns out, at least with regard to training; there is little collaboration or cross agency participation. Each agency/office has a different process for participating in training.
- The existing training modules clearly are most of interest to public defenders and we have had very little interest voiced by Commonwealth Attorneys and judges, therefore we need to survey these groups to figure out how we can best meet their training needs.

Future Directions for Project:

- In the last year, we have made significant strides toward statewide adoption of Advance Directives. A majority of the Commonwealth’s CSBs are actively pursuing an implementation effort. In the coming year, we hope to continue supporting our active sites, initiate implementation with sites that have not participated with us thus far, and begin collaborating more with non-CSB sites, such as hospitals, peer-run organizations, and Crisis Intervention Teams.
- While we will not be able to continue funding the Mental Health training coordinator position, DBHDS still will sponsor trainings in the future. We have also approached the Training Committee and the Office of the Executive Secretary about possibly including at least one module in each of the upcoming Circuit Court, General District, and Juvenile & Domestic Relations judges’ trainings.
- DBHDS will make an effort to be included in statewide and regional legal training conferences in order to impart the information to larger audiences
- DBHDS will continue to explore the feasibility of making some of the training DVD or web-based so as to reach a larger audience and sensitize people.

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West Virginia



FY2009 TTI PROJECT:

Integration of physical and mental health at CMHCs and rural primary health care clinics.

KEY OUTCOMES:

- A Statewide “Call to Action” conference was held May 1 and attended by over 100 primary care physicians, nurse practitioners, psychiatrists, CMHC staff, state leaders, and consumers/ families.
 - Keynote-An Avoidable Tragedy: The Relationship of Premature Death and Serious Mental Illness. How Do We Respond? Joseph M. Parks, MD and Dale Svendsen, MDOther Speakers included:
 - Kathleen M. Reynolds, MSW (Director, Washtenaw Community Health Organization/University of Michigan)
 - Jeannie Sperry, PhD (West Virginia University Dept. of Family Medicine)
 - Mary T. Blizotes, RN Larry Dent, JD, and Craig Robinson, MPH (WV Primary Care Assoc.)
 - Daniel Elswick, MD and James Stevenson, MD (WVU Behav. Medicine)
 - John Bianconi (Commissioner, WV Bureau for Behavioral Health and Health Facilities)
 - Hilda Heady, MSW (WVU Associate Vice President for Rural Health)
 - Patricia A. Rehmer, MSN (Commissioner, CT. Dept. of Mental Health and Addiction Srvcs)
 - David Sanders (WV Mental Health Consumer’ Association)
- Clinical partners/clinical sites were established for integration projects including: Valley Health Care Primary Care Clinic (Community Mental Health Setting); and Reedsville, WV Primary Care Clinic (Ambulatory Care Setting). In June, the WVU Department of Behavioral Medicine and Psychiatry, in partnership with University Health Associates, hired a Physician’s Assistant (“PA”) to help with a Serious and Persisting Mental Illness Day Program at Chestnut Ridge Comprehensive Behavioral Health in Morgantown. Residents of Monongalia, Harrison, Preston and Taylor County, West Virginia and Green and Fayette County, Pennsylvania utilize the day program. The PA supports the patients that are seen in this program with a primary care clinic (twice a month). They will be seen by the PA for metabolic monitoring and screening.
- Frank Ghinassi, PhD, Vice President, Quality and Performance, University of Pittsburgh Medical Center, had a site visit to Morgantown on June 25, 2009 and is assisting West Virginia develop a “Dash Board” for Integrative Clinics to submit data. This will be transportable between varying types of centers including academic institutions, CMHCs, and ambulatory primary care clinics.
- West Virginia held a conference in August to provide integrative care training for psychiatry residents, behavioral health staff and psychology trainees at the West Virginia University School of Medicine Department of Behavioral Medicine and Psychiatry Scholarship Retreat. The conference was a continuation of the theme from their statewide TTI conference in May. They addressed the research and scholarship opportunities related to primary care/psychiatric care integration.

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Wisconsin



FY2009 TTI PROJECT:

Integration of trauma informed care into the state system via Trauma Care Champions.

KEY OUTCOMES:

- Collaboration has been a major theme for Wisconsin's TTI activities. The Department of Health Services (DHS) Trauma Services Coordinator has worked successfully with the Department of Children and Family (DCF) staff to participate in parallel to develop trauma-informed care (TIC) within Child Welfare programs.
- On March 31st, Dr. Rob Anda presented the ACE (Adverse Childhood Experiences) Study to a group of seventy-five people representing DHS, DCF and other stakeholder groups.
- On April 22-23, sixteen consumers participated in a Person-Centered Planning/TIC Consumer Champion (PCP/TIC) training.
- On May 11-12, over 430 people (72 teams) attended a statewide Trauma-Informed Care Conference. In order to promote consumer involvement in all aspects of TIC organizational action planning, the PCP/TIC Consumer Champions assisted teams in creating their TIC action plans; teams commented on how helpful it was to have consumer perspectives in the group. Approximately fifty people attended an optional 'TIC educational campaign' focus group held at the close of the conference.
- The Trauma Services Coordinator presented TIC overview on May 15th at the rural Mental Health Summit to fifty participants and a full-day TIC workshop to approximately seventy-five people at the Wisconsin Association of Alcohol and Other Drug Abuse Conference.
- On June 23rd, DHS co-sponsored a Children and Families Public Policy Forum attended by approximately one hundred people featuring Dr. Bruce Perry and Dr. Robert Anda.
- Two hundred and thirty seven people from the May 11th and 12th conference gathered on August 31st. This conference highlighted the PCP/TIC Consumer Champions and their availability to provide consumer-focused Person-Centered Planning and TIC trainings.
- During August and November the Wisconsin Resource Center (WRC – a specialized mental health

facility established as a prison) held a series of trainings. On August 6th, WRC introduced the concept of 'creating sanctuary' using lessons learned from the maximum security psychiatric hospital in Dane County, Wisconsin (Mendota Mental Health Institute). On August 10th, Community Connections staff introduced WRC to 'M-TREM' (Men's Trauma Recovery and Empowerment Model). On November 20th, John Briere presented information on complex trauma to 150 attendees representing seven Wisconsin correctional facilities.

- The Lac Courtes Oreilles (LCO) tribe held a three-day GONA (Gathering of Native Americans) event September 21-23. LCO contracted with 'News from Indian Country' to tape/record the event. People from Indian Country have posted several interviews on YouTube; this can be accessed by going to www.youtube.com and searching for the word "skabewis".
- Over the course of the TTI grant, DHS worked with Witness Justice to create an educational campaign plan to promote trauma-informed care as an effective approach for providers working with trauma survivors. Resulting products include a poster, brochure, handouts, website and a Wisconsin TIC List Serve.
- The Wisconsin Association of Family and Children's Agencies (WAFCA) presented Wisconsin's Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services with the John R. Grace Outstanding Leadership Award for Trauma-Informed Care and Positive Behavior Supports Initiatives. WAFCA identified Wisconsin's highly collaborative and successful approach to reducing seclusion and restraint and infusing trauma-informed care in the network of children providers. In particular, they recognized the work of Marie Danforth and Elizabeth Hudson.

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Wisconsin



FY2012 TTI PROJECT:

Trauma, Parent Peer Specialists and Juvenile Justice

KEY OUTCOMES:

Many of the youth under supervision within Wisconsin's juvenile justice system have experienced neglect, abandonment, physical abuse, sexual abuse, community violence, and sporadic family support. As a result, they enter the correctional system with a variety of complex physical, mental and behavioral issues. A trauma-informed juvenile justice system incorporates this understanding and, as such, is better positioned to assist youth and families with recovery and rehabilitation. Because a young person's success is often contingent on the family's positive involvement and support, the Wisconsin Department of Juvenile Corrections (DJC) has partnered with Wisconsin Family Ties (WFT) to increase family involvement.

The project is overseen by a Steering Committee (SC), which meets monthly to review progress, address barriers and celebrate success. Membership includes representatives from the Division of Juvenile Corrections, Wisconsin Family Ties, WI Dept. of Health Services and WI Dept. of Children and Families.

Lincoln Hills School (LHS) Dubois Cottage (designated placement for young men with substance use issues) is the focus of this innovative project. Though called a 'cottage', Dubois, like most juvenile justice facilities, has housing that is correctional in nature. A total of 40 cells/rooms flank both sides of a central day-room. LHS leadership has organized several TIC-related trainings for a variety of staff (e.g., security, youth counselors, social workers, psychologists and teachers). Specific training themes have included TIC culture change, the role of Parent Peer Specialists (PPS) / Family Driven Care, vicarious trauma/staff self-care, trauma screening/assessment, and the trauma specific intervention 'Seeking Safety'. As a result of training and diligent efforts on the part of LHS leadership, many changes have occurred in the pilot LHS cottage including the following: creation of a comfort room, development of youth TIC profiles and corresponding case plans, creation of a database tracking youth triggers, development of a 'good behavior' program to reinforce positive behavior, and the administration of Seeking Safety pre and post-tests to evaluate youths' use of coping skills. Preliminary results show a significant drop in room confinement (50%) and regular youth use of the calming room. Changes outside the pilot cottage include LHS school staff integrating TIC into Positive Behavioral Interventions and Support (PBIS). The TIC focus in Juvenile Corrections has also had an impact on the Department of Corrections' (DOC) interest in TIC. Staff within the adult correctional system has begun planning TIC training for probation and parole agents, social workers and psychologists. Additionally, the DOC Deputy Secretary has volunteered to work on a state-wide TIC Policy Advisory Committee organized by the First Lady of Wisconsin who has become a trauma champion within Wisconsin, including providing ACE and TIC presentations to the Wisconsin Cabinet).

DJC Training

- 40 staff from Lincoln Hills School (LHS) received a two-day Seeking Safety training in October 2012.
- 50 Copper Lake and Lincoln Hills' security staff received a full day TIC training in October 2012.
- 20 LHS staff participated in an introduction to the role of Family Driven Care and PPSs.
- 4 Cottage leadership staff attended a full day training on vicarious trauma and self-care within corrections.
- Over 100 LHS staff (outside of the pilot site, Dubois Cottage) participated in a full day TIC training (held on two days).

DJC Practice

- DJC has incorporated trauma screening and assessment scales that complement the COMPAS Risk and Need Assessment instrument.
- All Dubois Cottage youth complete an ACE screen.
- Dubois Cottage staff created a comfort room equipped with large supply of sensory items. Youth self-select when they use this room; it is not treated as an alternate to seclusion nor is it a punishment. It has been used 100+ times with very favorable comments from the participating youth. No issues have been reported.
- Dubois staff participates in weekly team meetings where a youth is featured. Staff discusses the young person's trauma history, triggers and successful coping strategies.
- Dubois staff and youth received a laminated list of Coping Skills via the Seeking Safety curriculum. The list is frequently used as a reference in reminding the young men of different available tools to address distress.
- Dubois staff created alternatives to room time which included the use of a container filled with alternative assignments that youth could use instead of receiving 'room time' e.g., isolation. Alternatives included writing a page of reflection related to an inspirational quote, writing a list of self-care strategies, talking with social worker about future alternative responses to difficulty, etc. This resulted in an 80% reduction of 'room time.'
- All Dubois youth received a chess set. Chess is an evidence-based strategy for young people diagnosed with Attention Deficit Disorder.
- LHS school staff meets monthly with TIC consultant to discuss integrating TIC and Positive Behavioral Supports and Interventions (PBIS).
- LHS created an institution-wide TIC Champion Team that meets monthly to strategize on institution-wide TIC implementation.

Wisconsin Family Ties (WFT): All of WFT staff participated in a two day TIC training. A WFT/DJC subcommittee was formed to integrate PPSs into DJC's practices. WFT created a family satisfaction survey and a PPS documentation protocol including type & frequency of family contact, decisions, actions and reflections. The PPS works with 8 families with a primary focus on meeting the families' basic needs (e.g., homelessness, unpaid utility bills, transportation, medical/mental health and long-term care services for the parents, etc.). The PPS has found that many families' intergenerational history of involvement with corrections serves as a barrier (i.e., incarceration has become a family norm). Lessons learned to date include the following: assigning the PPS more than 3 families at once is problematic; the families' answers to the baseline needs/strengths survey do not represent the life circumstances observed by the PPS (i.e., the family circumstances appear to be more troubling than the surveys would indicate); and despite the field agents' explanation to families that their participation in the pilot is voluntary, the PPS experiences difficulty in reaching some families.

The Parent Peer Specialist's involvement brings innovation and new ways to approach relationship building. One example being the PPS's choice to ride the bi-monthly charter bus with family members on their way to visit their children at Lincoln Hills. The PPS submitted her observations to LHS leadership and changes were directly made. These included the following: bus driver was not friendly, food stamps were not accepted at the grocery store near LHS where families purchased food for their visit, age inappropriate DVDs played on the bus's video system (young children accompany caregivers on the trip). LHS leadership now plans to incorporate regular staff accompaniment on the bus to improve family / staff relationships.

Future Activities include: WFT will create a juvenile justice training curriculum for PPS's, DJC and WFT will create a memorandum of understanding pertaining to the provision of PPS support. The initiative will be evaluated for progress and effectiveness. WFT will chronicle their activities in implementing the goals of the grant and will share with other statewide family networks that may want to replicate this initiative.

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Wyoming



FY2009 TTI PROJECT:

Developing a statewide housing network across Wyoming's five regions designed to build a regional provider system for consumers and bolstering that effort with statewide SOAR training.

KEY OUTCOMES:

- A regional housing specialist and a housing planner have been identified in each region to coordinate this project.
- A regional housing task force is now in place in four of five regions.
- SOAR training was held May 4th – 6th in Casper and attended by over forty mental health staff and case workers, including all housing specialist and planners. The training was also attended by several representatives from the Wyoming Social Security office.
- A Housing 101 Training was conducted in April in Cody by two Housing regional specialists from Tennessee. All Wyoming Housing Specialists and planners attended, as did many of the organizations with which the department will be partnering in this project.
- The state's first Statewide Housing Conference was held in July in Lander, Wyoming, with over 100 attendees. Regional plans were drafted and taken back to all five regions.
- The state has leveraged its TTI funding to secure a fulltime, three-year, statewide Housing Coordinator position. This will be the first statewide, full time position in all of state government, and their focus will be housing people with Mental Illness.
- A team of ten will venture to Memphis, Tennessee, for "hands-on" three-day Creating Housing Initiative training. The team will visit projects in Memphis proper and sites in rural Tennessee, meet local officials/partners to glean the processes and nuts and bolts of how to build similar local partnerships and projects in Wyoming. Attendees scheduled to attend include representatives from WY Dept. of Health: MHSASD, Habitat for Humanity, NAMI, and a veterans groups, as well as city housing directors and housing executives.

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