PROCEEDINGS OF THE 2005 SANTA FE SUMMIT THE AMERICAN COLLEGE OF MENTAL HEALTH ADMINISTRATION

David Shern and Lisa Teems

DETAILS

Dates: March 30-April 2, 2005
Program Chairperson: Pamela Greenberg, Executive Director, American Managed Behavioral Healthcare Association

THEME: TRACKING THE TRANSFORMATION

In 2004, participants at the ACMHA Summit examined the threats to the continuing relevance of specialty behavioral healthcare and the need for its systemic and broadly based transformation. Transformational themes from the President's New Freedom Commission on Mental Health (PNFC) helped frame the 2004 conversations. Those deliberations provided the framework for the 2005 Summit, which featured examples of transformational activities underway throughout the nation. Representatives of federal, state and local initiatives were invited to present to Summit attendees both in plenary and small group sessions. Small working groups remained together throughout the Summit in order to develop an ongoing dialogue in which they sought to identify integrative themes and guiding principles that emerged from the presentations of transformational activities. Presentations were selected to include not only the differing levels of government but also key strategic areas that may underlie broader systemic transformation. These areas included: Advocacy, Business, Children, Consumer, Evidence-Based Practice, Family, Recovery, Rural/Local Services, Technology, States, and Service-Based Research.

What follows is a synthesis of the major observations that resulted from these presentations and discussions. Appendix materials include more details on the principles of transformation as well as strategies and recommendations for future work.

_____

David L. Shern, PhD, Dean and Professor, Louis de la Parte Florida Mental Health Institute, University of South Florida
Lisa Teems, DMin, LCSW, Office of Human Resources, US Department of Health & Human Services

SIGNIFICANT POINTS MADE BY KEYNOTE PRESENTERS

Overview and Update of President's New Freedom Commission on Mental Health
Kathryn Power, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Kathryn Power helped to define the boundaries for the discussion of transformation both by providing some definitional material and by outlining some of the specific Federal activities underway to help guarantee its occurrence. She began by presenting a definition from Mazade (2005), transformation "…connotes some process and intent surrounding a profound, deep, intense, and penetrating alteration in the status quo. It implies a formation of and an effort to realize a vision that is palpably different from what existed before—a conscious decision to substantively alter and make a difference in a given reality." As such, it is not a destination but a process that will need to remain continuously responsive to our changing knowledge base. Transformation is a deep and profound process that varies in the ways in which it proceeds. It may occur in

- a few big jumps, such as the development of new rule sets that leverage new ideas (SAMHSA's efforts, for example);
- a series of many exploratory medium jumps (pushing the boundaries of our competencies, for example); or
- continuous, small steps (change in core mission of individual programs, for example).

SAMHSA is aligning its activities/investments with the transformation priorities found in the PNFC report and coordinating them through the Transformation Action Initiative (TAI). The initiative has six major foci for 2005 including:

- Leadership/Consumer Leadership,
- Comprehensive Mental Health Plans,
- Individualized Plans of Care (person-directed planning approaches),
- Disparities Reduction/Elimination,
- Strengthening Science-Service Links and,
- Workforce Development (including consumers as staff).

TAI therefore involves the development of capacities such as leadership skills or person directed planning; expertise on and dissemination of science based practices; infrastructure development in state planning and workforce and a focus on reducing disparities that may reflect discriminatory insurance practices and/or the lack of culturally competent care. SAMHSA also continues to work with their Federal partners on several initiatives for a more coordinated and comprehensive Federal leadership role across the broad domains of federal policy (e.g. labor, education, health, child welfare, social security, etc.).

Transformation Change Model
Karolin Cheboski, Director, Benefit Strategy and Design, US Airways

Drawing on her experience working in several corporate environments during layoffs, including her own, Karolin identified characteristics that are essential to transformation. She contrasted these with characteristics that are associated with change. Change is two dimensional, flat and independent. Transformation is multidimensional, hilly and exhibits great connectivity. It is non-hierarchical and interwoven in much the same way that a head of cabbage is bumpy and inter-related. Some important principles about change and transformation are:

- Structure and design matter. Change does not focus on design while transformation uses design as the foundation upon which it builds. Utilization Management (UM) and Case Management (CM) differ fundamentally in their design. CM is designed to promote multiple linkages while UM is designed prescriptively to control utilization of scarce resources. UM is generally linear and CM isn't.
- Change moves toward simplicity and stability. Transformation embraces complexity and self organizes to use all available information. It seeks to explore variation and not to attain a steady state. As such transformational infrastructure involves elegant environmental adaptation.

It is difficult to use ordinary language to describe the characteristics of transformation. Graphical images may be more effective – describing it as a cabbage, for example, which emphasizes interconnectedness and unity. There are three lessons learned from doing transformation work:

- Language can be limiting (look for new and creative ways to express transformational ideas including graphical images).
- Loneliness - transformation can be a lonely process if it is not woven into the characteristics of the organization. (look for champions and do not work alone).
- Lock into other relationships and develop interconnectedness. People like to participate in transformational work but often find it very difficult to break lose from the dominant organizational paradigm. Locking them in can begin to change the culture.

The Annapolis Coalition
Michael Hoge, Professor of Psychology, Yale University
John Morris, Professor, USC School of Medicine

The Annapolis Coalition is a multi-stakeholder workgroup critically evaluating the behavioral health field's approach to workforce development and developing a

national strategic plan to guide new efforts in this critical transformational area. It is clear that, while we have experienced rapid and wide spread changes during the last ten years in behavioral health and anticipate even more as transformation proceeds, our methods for defining, preparing and supporting the workforce have not kept pace with the change. We confront a number of paradoxes in workforce development.

- We train for a world that no longer exists.
- We offer the most training to those who spend the least amount of time with customers.
- We use pre-service and continuing education methods that we know are not successful in changing practitioner behavior.
- We train where willing crowds gather rather than in representative settings.
- We ignore the largest part of the workforce - consumers and their families.
- We reward students for "doing time" in our educational institutions rather than for the acquisition of specific competencies.
- We hire staff but fail to provide them with ongoing professional career development and supervision - "Just do it!"
- We do not design work environments that support best practices.
- We do not think about career ladders.

It is clear that if we are to achieve system transformation, workforce transformation will be central. The Coalition has been conducting a series of activities to clarify the issues and to develop strategies for addressing them. A national strategic plan for workforce development is being drafted and will be released in the coming year that will cover a range of issues in the specialty behavioral health workforce arena including both topics of special concern and strategies for more effective education, training and support.   Areas being explored include:

- Adult mental health
- Child and adolescent
- Consumers and families
- Co-occurring disorders
- Cultural competency
- Older adults
- Informatics
- Leadership
- Oversight processes
- Prevention
- Professional associations
- Providers: state, regional and local
- Recruitment and retention

- Rural
- Substance use disorders treatment

Some themes are emerging from the work so far:

- Workforce development strategies that focus on primary consumers and families fundamentally transform our discussion.
- Explicit strategies for management and leadership development are critically important.
- It is essential to focus on practical barriers such as financing incentives and disincentives, licensure issues, etc.
- Systematic recruitment and retention strategies must be linked to explicit career ladders.
- Training must emphasize problem focused competencies within a context that embraces life long learning in real situations.
- Data-driven tracking and continuous quality improvement are essential for developing and maintaining skills.
- We must use evidence-based teaching strategies.
- Oversight organizations can drive (or impede) change.

The Annapolis Coalition was stimulated, in part, by an earlier Santa Fe Summit. Its efforts are consistent with and supportive of the principles of transformation.

Panel Discussion: Behavioral Transformation on the State Level
Barbara Shaw, Chairperson, Illinois Children's Mental Health Partnership, Nancy Speck, Coordinator, President's New Freedom Commission on Mental Health, University of Texas, Galveston, Leslie Tremaine, Medical Assistance Division, State of New Mexico

This session focused on various transformational initiatives taking place at the state level.

In **Illinois**, the Illinois Children's Mental Health Partnership was developed to address the mental health needs of children in the state. It was a cooperative effort that involved a number of state agencies and a task force of 150 people. The work of this task force resulted in the passage of the Children's Mental Health Act in 2003, which passed the legislature unanimously. The Partnership was formally created as part of this law and charged with developing a strategic plan with both short and long term objectives. The plan is an attempt to comprehensively meet the mental health needs of Illinois children and adolescents through a multi-sector program that includes prevention, treatment and rehabilitation. It explicitly acknowledges the central, directive role of children and youth, and proactively seeks to deliver early interventions to promote healthy social and emotional development – including the treatment of maternal

depression. The act requires the public education system to develop emotional and social learning standards and policies on how they will be implemented. It also expanded the State's screening program. Finally, the act revised an old law which prohibited the state from offering mental health services to children under the age of 3. The major strategic priorities of the act are presented below.

- Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children's mental health system at the state, regional and local level.
- Advocate for increased children's mental health services and programs.
- Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education).
- Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan.
- Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate.
- Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff.
- Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems.
- Increase early intervention and mental health treatment services and supports for children:
  - Ages 0-5 years;
  - Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice);
  - Who have been exposed to or experienced childhood trauma (e.g., violence);
  - Who need follow-up services in the SASS system beyond 90 days; and
  - Who have mental health problems that are not severe enough to qualify them for public programs.
- Convene a multi-agency and multidisciplinary work group to examine how children's residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate.

- Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children's mental health in such areas as cultural competence, family involvement and consumer-driven care. http://www.ivpa.org/childrensmhtf/

The act and all of the activities associated with it, therefore, may fundamentally alter the place of socio-emotional development in the state's conception of successful maturation and explicitly promote dialogue about how best to assure the well being of Illinois children and adults.

In **Texas**, the Texas State Strategic Health Partnership was developed to address the state's under-funded mental health system and instability in the mental health structure's leadership. The group wanted to improve access to services and outcomes, increase efficiency, reduce fragmentation, simplify the financial system, and increase consumer choice. The Partnership's recommendations include:

- developing policies and regulations defining eligibility and service criteria,
- determining financing options,
- developing and contracting with a provider network, and
- managing state hospital utilization.

It anticipates leadership at the state, regional and local levels and has suggested roles appropriate for each level. It includes a statewide behavioral health authority that will provide the overall direction of the initiative; regional authorities that will administer the programs in sub-state areas (including network development, reimbursement, quality and utilization management); and local authorities that will expand consumer input, assist in local network development, provide prevention and education services and leverage local resources with those from the state or federal sources. In the initiative, mental health is conceptualized as central to health and is now housed in the Texas Department of Health Services.
http://www.healthpolicyinstitute.org/media/tshp.jpg

In **New Mexico**, the entire behavioral healthcare system has undergone a major redesign. The vision is to create a single behavioral health delivery system in New Mexico in which all available funds are managed effectively and efficiently; the support of recovery and development of resiliency are expected products; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers are assisted in participating fully in the life of their communities. In part the vision is operationalized through a management structure in which all behavioral health funds are managed centrally by a behavioral health purchasing collaborative. The Collaborative includes all of

the state agencies that are involved in quality of life for people with behavioral health needs. It is charged with overseeing and managing the behavioral health care system which is explicitly conceived to involve the missions of all human service departments. A quilt metaphor describes the logic of the program since it signifies the 'stitching together' of separate pieces of cloth (agency missions and regulatory structures), each maintaining its individual identity but joined with other pieces of the state human service system to form an integrated whole.

The Collaborative functions as a board and is charged with:

- Inventorying all expenditures for mental health and substance abuse services,
- Creating a single behavioral health care and services delivery system that promotes mental health, emphasizes prevention, early intervention, resiliency, recovery and rehabilitation,
- Managing funds efficiently,
- Ensuring availability of service throughout the State,
- Paying special attention to regional, cultural, rural, frontier, urban and border issues;
- Seeking and considering suggestions of Native Americans,
- Contracting with a single, statewide services purchasing entity,
- Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes,
- Making decisions regarding funds, interdepartmental staff, grant writing and grants management,
- Comprehensive planning and meeting State and federal requirements,
- Overseeing systems of care, data management, performance and outcome indicators, rate setting, services definitions,
- Considering consumer, family and citizen input,
- Monitoring training,
- Assuring that evidence-based practices receive priority, and
- Providing oversight for fraud and abuse and licensing and certification.

The anticipated results of the initiative will address many of the long term problems that have been confronted by public systems. They are hoped to include:

- "Braided", flexible funding,
- Single billing process and consistent data collection and management across state agencies,
- Common age-appropriate assessment process used in all service settings,
- Smooth transition from current systems to single system,
- Local Collaboratives that represent active participatory local voice with

special attention to rural and frontier areas,
- Attention to persons with unique service or access needs,
- Uniform program standards, including common:
  - service definitions and requirements
  - utilization management requirements/criteria
  - system performance measures
  - consumer/family outcomes expectations
  - credentialing of providers
- Sufficient number and distribution of providers,

- A comprehensive and coordinated benefit package, within available funding,
- Emphasis on evidence-based, best practices and practice based evidence.

Local collaboratives are an important part of the design. There are 6 regions that are consistent with the 13 judicial districts in the state. They consist of consumers, families, youth, providers, advocates, and other system representatives, such as courts, schools, churches, child welfare, juvenile/criminal justice, health improvement councils, tribes, vocational/ employment providers, housing authorities, area agencies on aging, local DWI councils, civic organizations, primary care providers, local government officials, and other interested individuals or groups.

The New Mexico initiative is very much a work in progress. At the time of the 2005 Summit, the Interagency Collaborative had been formed, the behavioral Healthcare Planning Council has been established, cross-agency staff workgroups have been activated, an RFP for the statewide administrative entity has been issued and awarded, and common service definitions have been developed. The statewide administrative entity is conceived as more that a fiscal/administrative entity but as a full partner in implementing the vision. The entity has several important functions including:

- Contracting with and paying providers or provider groups,
- Helping to "braid" "blend" or "coordinate" multiple funding streams – increasing flexibility and maximizing resources,
- Credentialing and quality oversight of providers,
- Utilization review (UR) and management (UM),
- Assuring care coordination,
- Assisting with development and nurturing of Local Collaboratives,
- Consumer/family/youth relations,
- Collecting, managing and reporting data.

http://www.state.nm.us/hsd/bhdwg/

SMALL GROUP DISCUSSIONS

Process:
Following the initial plenary presentations, summit participants were assigned to one of six small groups. The groups met six times throughout the summit. At their initial meeting, they reflected on the initial presentations and developed a working description of transformational change that they would continue to refine during the summit. Each group was visited by eight transformational leaders that represented the major areas of focus including Advocacy, Business, Children, Consumer, Evidence-Based Practice, Family, Recovery, Rural/Local Services, Technology, States, and Service-Based Research. The transformational leaders shared their experiences in their respective area of expertise. After each presentation, the small groups considered the guiding principles for each transformation project, how it related to the goals of the New Freedom Commission Report and some of the strategies and recommendations for the field and ACMHA on how to continue and expand on these successful efforts. The transformational leaders and group facilitators are listed in Appendix 1.

Each small group developed two lists for presentation to the large group. One list delineated the guiding principles necessary for transformation. When the principles of all six groups were combined and edited for overlap, they basically fell into one of two categories: Fundamental Overarching Beliefs/Principles and Guidelines/Principles for How to Develop Transformation Strategies. A total of 45 unique principles were developed. They can be found in Appendix 2. Transformation strategies are listed in Appendix 3.

The second list developed by each group contained recommendations for future specific transformational strategies. These strategies fell loosely into several categories including education/training, funding, prevention, technology, data collection, and evidence-based practices. All recommendations specifically targeted for ACMHA action have been combined with the last section of these proceedings. The final composite list of recommendation can also be found in Appendix 4.

INTEGRATION OF THE DISCUSSION GROUP RECOMMENDATIONS WITH THE COMMISSION REPORT
Michael Hogan, Commissioner, Ohio Department of Mental Health and Chair, President's New Freedom Commission on Mental Health

Michael Hogan offered several observations on the deliberations and discussions that he gleaned from visiting the groups and observing the plenary presentations. Among these were the need to:

- *De-stigmatize mental illness through direct contact, education and legislation.* What would the world look like without stigma? Although most of us talk about stigma we haven't developed an effective operational definition of the concept that can lead us to action to reduce stigma.
- *Gauge audiences and tailor effective messages to influence power.* We focus on our individual activity and do little to take it out to the world. There should be media involvement and focused concentration on developing effective messages and staying on message.
- Emphasize successful experiences. We should be working from and recognizing our strength. Continue to showcase successful transformational efforts to provide positive, perhaps inspirational models about how this can be achieved.

- *ACMHA's agenda should include specific skill development to effect transformation.* This idea of specific skills to stimulate and support dramatic change has almost completely disappeared. The Annapolis Coalition is featuring a specific focus on skills within a general framework that is compatible with transformation.
  Align business and financing models. This should include operational alignment of our business objectives (recovery and resilience, consumer and family direction, early identification and intervention, etc.) with the methods that we use to purchase help and/or preventative interventions.
- *Support adaptation of the IOM rules to guide care delivery.* The IOM framework involving safe, effective, consumer centered, timely, efficient and equitable care is compatible with the discussion of transformation. Related principals such a continuity of care, customization based on consumer direction, consumer as the source of control, shared information, evidence based decisions transparency, safety as a system, quality anticipation of needs, continuous decrease in waste and cooperation among clinicians provide an excellent framework for organizing our thinking. The IOM report on Behavioral Health will be the next opportunity to re-energize our transformation of the system.

Several key areas were not fully expressed (they showed up in low frequencies on the lists) in the group recommendations and/or discussion. They were:

- *Recovery.* It was talked about a lot but only mentioned on the list five times. Are we clear about the vision for recovery?
- *Medicaid.* There was only one recommendation about this area but it is the largest MH funding stream. We have gotten "Hooked" on Medicaid and we ultimately won't be successful unless we have a strategy that anticipates and incorporates Medicaid.
- *Information Technology/Internet/Software.* There was only one mention

of new technologies and many believe that these are critical to transformation.

Mike Hogan identified the following potentially provocative questions about the group dialogue*:*

- There was much talk about broadening the net and more completely including multiple perspectives. It was unclear how we open the discussion and action agenda beyond our usual networks. How do we broaden this past the usual suspects?
- It is unclear whether transformation is a process or an outcome. Are we doing the right things and is it enough? The ambiguity in the discussion of this attractive concept make it difficult to gauge the adequacy of our efforts.
- What is the end point of transformation? Is it treatment system changes or a changed societal approach to mental illness, or a changed society that better promotes health and equity? Perhaps the biggest game would be cultural transformation in which the antecedent conditions and consequences of illness would be fundamentally different than they are currently conceived.
- Do we assume transformation and success require more resources? Is this likely and is this right? Typically 'new' initiatives involve new resources but in seeking new resources are we not using a time worn strategy for the expansion of the system. Traditionally, new resources have come with new restrictions on their use. We could argue that this is part of the problem and may frustrate the solution.
- Are transformations stimulated by crisis? Can we do this without crisis? Perhaps a crisis is required to fundamentally shift the frame of the conversation and to evoke more universal interests (as contrasted with more parochial interests) that are needed to transform our approaches.
- Can we learn from our history particularly de-institutionalization and the Carter Commission? We could argue that change following both of these milestones of the 20th Century was incremental and segmented. Given the communality of problems that we continue to confront from these earlier times, how should our approach differ in seeking transformation?

Given the fundamental nature and scope of the challenges that we confront in our nation's behavioral health, the President's Commission was clear that reform of the system was not enough. Transformation was required. Transformation is adaptive change and non-linear, occurring in a punctuated equilibrium rather than a steady state. Transformation is similar to how people recover; it is a process as well as an outcome. As Ed Knight has noted, no one can transform someone else…each must do their own work…hope and supports are essential.

What are our responsibilities? What can leaders do?
Do as little harm and provide as little "energy-sapping" leadership as possible.

- Balance stabilizing and destabilizing forces. If you are in crisis all the time, you cannot transform. However, crises sometimes provide the re-framing that is required for transformation. Maintaining equilibrium at all costs likely will frustrate transformation.
- Be clear about which changes are transformational. What has energy and is moving that we can latch onto? Focus energy on transformational opportunities.
- Create capacity. Don't "roll out." Transformation requires a reframing of thinking and action and is a changed state for individuals and organizations. As such, it can not be implemented in the same way that a program or initiative is implemented. Transformation needs space and stimulation but will be invented in each context uniquely.
- Facilitate "flow." Get into the zone. Enter the conversation with openness to new expressions and ideas. Don't try to control or legislate transformation.
- Be the change we want to see.

In an open microphone session, participants provided recommendations to ACMHA to guide their future work as an organization. These recommendations are found in Appendix 3.

Synthesis of Summit Proceedings: Principles of Transformation

We offer a set of synthetic observations using both the principles of transformation that were identified by the small groups as well as their recommendations. The observations are organized from the most general to the most specific and are not inclusive of all principles or recommendations.

First, transformation fundamentally is about **changing the nature of relationships** among individuals who work in all parts of the behavioral health field. Mutual respect among all participants is essential. A 'strengths based' approach, both for personal and organizational challenges will enable respect for other's interests and perspectives. Changing relationships imply changes in the power structure among individuals and new approaches to care. The consumer and family 'driven' system that is envisioned would involve a fundamental shift in power relationships from providers as prescribers to providers as partners; from one that sees consumers as disabled, non-insightful, disordered individuals to one that appreciates and explicitly values the consumer perspective – including the confusion that can accompany any serious illness. Consumers and families, similarly, should be sensitive to the perspectives of providers and the many roles they must play (e.g. healer, keeper of public safety) as well as the constraints of their perspective and training. The perspectives of government leaders, politicians, accountability entities (like state inspector generals) and all of the performers in the system must be understood and valued. For transformation to

occur, individuals fulfilling these roles must also understand the needs of consumers and families. Perhaps these shifts in relationships, at all levels, are among the most fundamental underpinning of transformation.

Second, as these changing relationships are fully manifested, we must and will experience a **change in the culture of behavioral health.** Cultural changes involve a widespread acceptance of the legitimacy of behavioral health problems and the expectation that individuals can fully recover from their problems. Stigma and misinformation about behavioral problems would be eliminated. Hope would accompany the diagnosis of behavioral health disorders as contrasted with shame or resignation to illness and disability. Relatedly, knowledge about the relationships between trauma, broadly defined to include the effects of poverty, interpersonal violence, natural disasters, etc., and behavioral health difficulties would be accepted more broadly. We will embrace a public health model that explicitly features the inextricable relationship between the health of our communities and our personal well being. Greater availability of preventative interventions and the reduction in the incidence of behavioral health problems would follow as well as a general increase in personal and social productivity.

Third, while these are the transformative changes in relationships and cultural expectations that are most profound, they would likely be preceded by a new awareness regarding the **widespread prevalence of behavioral health problems in all of our human service systems**. As we become increasingly aware of the pervasive nature of these problems, we will form new partnerships with individuals who work in and are served by components of our formal and informal service systems. ACMHA should assertively outreach to individuals from the non-specialty behavioral health sector to engage them in these conversations in order to form partnerships to more appropriately conceptualize, lead, manage and advocate for our human service systems. Developing a consensus regarding the nature of problems and opportunities to address them, a common vocabulary to describe them and a shared vision of a desired end state would be transformative.

Fourth, in order to accomplish these changes in relationship and culture, we need **new skills and perspectives in the workforce**. Our approaches to professional and paraprofessional education must reflect the real world, science based skills necessary to work across human service sectors as well as within the specialty sector. Higher education must be engaged in this changed educational approach to train caregivers and system leaders in techniques that embrace the transformed culture and effectively utilize systematic information in improving their practices. Our continuing education and accreditation standards must reflect the competencies associated with science based care in real world behavioral health contexts. Skills in leadership and innovation will be a part of this mix as will an appreciation of the importance of imparting hope and equality of voice among all participants in this enterprise.

Fifth, **funding systems must reflect these new realities.** The continuing problems with funding institutionalize the inertia to transformation. The very nature of the program specific funding, which has been the mainstay of public funding in behavioral health, reinforces categorical restrictions on resources and creates constraints on the assistance that individuals with complex problems require. As we approach behavioral health issues sequentially and with specific, categorical programs, we create an ever more complicated and constrained resource environment. We have, by far, the most expensive health care system of any nation in the world that produces only mediocre health outcomes is a testament to the poor functioning of this constrained system. Our approach to funding must be transformed.

One of the fundamental challenges for the behavioral health community will involve fully engaging the health care system. Our continuing attempts to carve out behavioral health funding underscores the separate nature of behavioral health rather than the need for its fundamental integration with health care. A guiding tenet of the New Freedom Commission and the Surgeon General's Report is the fundamental link between health and mental health. Perhaps a first step in this process involves leadership in the behavioral health system to abandon its efforts to protect earmarked behavioral health resources for a more integrated approach to health care. While ending insurance discrimination against behavioral health disorders is fundamental to this integration, insisting upon equal treatment as an additional entitlement may also further underscore the division of behavioral health from health.

Finally, **ongoing research and evaluation is essential**. It is critical that we operationalize the key concepts in transformation (such as recovery) and systematically monitor the degree to which transformed systems increase the likelihood of their occurrence.   The concept of a 'learning organization' reflects a desire that the process of transformation be transparent and that all constituents have access to it. The risk aversion that is characteristic of large organizations and that causes opacity in organizational behavior is at the heart of this component of transformation. To the degree to which we can adopt open dialogue with regard to system and interpersonal functioning, the process of transformation will be enhanced.

Also, to the degree to which we can discipline ourselves to develop measures of these key concepts, we will advance the dialogue regarding the nature of transformation. If we conceptualize measurement as a process to refine our thinking and not become overly enamored with quantification, the process of designing a measurement system will sharpen our thinking and provide constant feedback regarding our process. The sense of the meeting was that this must be a measurement driven process with access from all constituents to support both accountability of the process and the continuing development of our thinking.

Appendix 1
Summit 2005
Facilitator and Transformational Leaders

Table A: Facilitator Assignments to Small Groups

Groups	Facilitators
Group One	• Areta Crowell, NMHA of Greater LA • Marc Perry, Santa Fe, New Mexico
Group Two	• Tom Bornemann, The Carter Center Mental Health Program • Paula Comunelli, Felton, California
Group Three	• Joyce Burland, NAMI Education, Training and Peer Support Center • Nicki Glasser, Boston, Massachusetts
Group Four	• Eunice Hartman, Hartman and Associates • Shela Silverman, Las Vegas, New Mexico
Group Five	• Susan Phipps, Alaska
Group Six	• Carole Farley Toombs, Strong Behavioral Health • Nick Ossorgin, Santa Fe, New Mexico

Transformational Leaders:

Advocacy:	Andy Hyman, National Association of State Menial Health Program Directors Dick Van Horn, National Mental Health Association of Greater Los Angeles
Learning Collaboratives:	Betta Owens, Network for the Improvement of Addiction Treatment
Consumer:	Anne Donahue, Legislator, State of Vermont
Business:	Ron Finch, National Business Group on Health
Evidenced Based Practice:	Wayne Stelk, ValueOptions
Pharmacy:	John R. Hayes, M.D., Eli Lilly & Company
Family:	Fred Sandoval, Secretary, NAMI National Board of Directors
Recovery:	Jean Campbell, Research Associate, Missouri Institute for Mental Health
Organizational & Financing Solutions:	Glen Stanton, Magellan Health Services
Local:	Nancy Wieman, Montgomery County, PA. MH/MR/D&A/Behavioral Health
Rural:	David Proefrock, Georgia Psychological Services

APPENDIX 2
PRINCIPLES OF TRANSFORMATION

Fundamental Overarching Beliefs Guiding Transformation
− It is consumer and family driven/youth guided.
− There is mutual respect among all stakeholders.
− There is a united stand against the stigma of mental illness.
− The process embraces diversity and diverse communities.
− Reflects cultural competency.
− Recovery can happen; HOPE; recovery is a continuum.
− It has a strength-based focus and strategy which promotes recovery, resiliency and optimal quality of life.
− Change starts with a "burning platform", a declaration, reason, impetus, and passion for change.
− There is an understanding about the value of the workforce (moral capital).
− All people deserve first class treatment regarding housing, jobs, relationships, and individual care plans.
− Transformation is not a destination; it is a process.
− It involves collaboration with all agencies/programs/people that impact consumer lives.
− It embraces inclusion; no one is marginalized.

Guidelines/Principles for How to Develop Transformation Strategies
− ind local level solutions.
− When working with coalitions, understand their values.
− Work through effective partnerships and sponsors across multiple entities.
− Be nimble and responsive; be observant for strategic opportunities and be prepared to respond immediately.
− Adopt public health approaches to mental health.
− Develop and promote integrated delivery systems.
− Challenge assumed constraints.
− Change the power structure.
− End fragmentation and duplication.
− Embrace a top down as well as the down up approach to transformation.
− Imagine the change that has been decided; imagine the specifics of what it is, what it will look like to consumers, to the workforce and to administrators. This will help define roles clearly and specifically.
− Anticipate and meet resistance. Identify those who can act as champions.
− Stay away from structure. Stay with design, with people, with services.
− Use data to inform change.
− States are KEY to the transformation process. There are good models to examine and learn from.
− Consumers and their families must be involved at all levels of transformation.
− Process has to be non-linear.

APPENDIX 2 (Cont.)

- Take risks.
- Value system/transformation "irritants."
- Understand that interpersonal relationships are active ingredients of transformation.
- Embrace patience and persistence.
- Adapt to the environment.
- There is system transparency.
- Use our strengths/successes to leverage our position as we approach collaboration possibilities.
- All elements of change (persons, groups, agencies, governments, etc.) must own the transformation and be accountable for its implementation.
- Don't stop with what we know. Look outside your own agency and learn from other industries.
- Value the work that is necessary to change perceptions; they can be barriers.
- Shift from "talking the talk" to "walking the walk" by developing strategies that shift/share power.
- To effect transformation and power sharing, make quality and outcome information available to consumers/families so that they can make informed choices.
- Develop strategies that promote social transformation.
- The elimination of disparities guides the transformation.
- Consumers, youth and families drive the design and implementation of mental health recovery services.

APPENDIX 3
SPECIFIC RECOMMENDED TRANSFORMATION STRATEGIES

− Develop outcome data, including success measures so that there is accountability. Build in ways to evaluate the transformation process to maintain accountability throughout the process. Include outcomes for WRAP and other self-help tools.
− Do research.
− Find ways to integrate all services including health, mental health, and other human services.
− Educate and train, particularly around advocacy. Include consumers and family members.
− Define and operationalize "recovery" both in terms of its processes and its outcomes.
− Eliminate the barriers of funding that are created by "medical necessity."
− Realign financial incentives with recovery transformation. Include rewards.
− Develop a funding system that is rational; current funding stream create barriers to transformation. Align purchasing with this system.
− De-stigmatize mental illness through direct contact, education and legislation.
− Develop a clear national vision that can be shared by all involved in transformation.
− Survey the environment and gauge the audience; then develop a tailored message that can be used to market transformation and influence power.
− Closely monitor Medicaid and other funders of MH services so that we can be better informed and determine strategies to partner.
− Create a culture shift to achieve transformation.
− Identify good consultants and others "helpers" to assist with the process of transformation.
− Find out the brutal facts of the state of the MH field and the need to transform it. This will determine where to start the transformation process.
− Develop a social marketing strategy and a more sophisticated advocacy plan. Find partners outside the MH field (such as criminal justice, housing, unions, pharmacists, employment, etc.) to assist with this.
− Develop methods to help behavioral health staff recover from their resignation.
− Develop protocols for transformation.
− Align leadership with transformation goals.
− Identify success opportunities and places to acknowledge good work.
− Delete archaic practices from the system.
− Develop a national plan for transformation. This should include dissemination and measurement strategies.
− Develop prevention and early intervention strategies.
− Make technology available to consumers. This can help mobilize advocacy efforts.
− Be at the table in the next design phase of healthcare financing.

APPENDIX 3 (Cont.)

− Use the New Freedom Commission report to focus decisions about transformation and to judge the appropriateness of funding decisions.
− Develop evidence-based practices that have common agreement, that have a broad view of service delivery and consumers, that integrate cultural perspectives, and align with accountability goals. Eliminate those practices that do not work.
− Use the IOM rules to guide direct care delivery strategies.
− Assess the shift of perceptual change among consumers, families and providers.
− Infuse the world with the recovery/resiliency paradigm in training, interventions, policy, schools, funding agencies, and so forth.

APPENDIX 4
SPECIFIC RECOMMENDATION FOR ACMHA'S FUTURE WORK

− Bring new blood into ACMHA; broaden our coalitions.
− Keep the image of the quilt; look at how all this can be woven together; provide a structure for the weave.
− ACMHA can do mentoring and training for leadership. Include innovation and transformation skill development.
− Help the states with leadership forums.
− ACMHA website should be useful. Look at NIATx as example.
− Look more in-depth into strategies; expand them out.
− "Success-Off" should happen next year.
− Should be a collaborative learning approach.
− We need to start talking about Social Security recipients; how can we help them achieve mental health.
− ACMHA should think in a revolutionary, not evolutionary, way.
− There is a hunger for the type of dialogue found in this summit; take it out to the world; perhaps regional summits.
− Learn about the people and groups who do not care about transformation; they should be part of ACMHA's political strategy.
− There needs to be a technological way to communicate with each other between summits.
− There should be one ACMHA activity that runs throughout the year.
− Evaluate what has happened in California and discuss it at conference next year because it is revolutionary.
− We underestimate the public support for our efforts.
− The planning process is also about transformation.
− Invite others to summit next year who are outside our field; we can learn from them.
− Have fund-raising dinners, conferences for ACMHA.
− Provide technical assistance to those coming up against barriers in the transformation process. Use the word "inspirational assistance" instead of technical assistance.
− Whatever ACMHA develops around leadership should be taken out into the world.
− Build champions of change.
− Find $ to bring 20-30 year olds to summit. They will have fresh ideas.
− Embrace Appreciative Inquiry; find out what is working and what is possible.
− Target the substance abuse field for ACMHA membership.
− Hold conference calls and "interest circles."
− Using the Freedom of Information Act, request copies of the original sub-committee reports of the New Freedom Commission.
− Make sure that future summits are consumer and family driven. Increase diversity at next summit.
− Ask summit attendees to commit to some kind of transformation work at home

APPENDIX 4 (Cont.)

and come back next year with poster board/description of effort.
− ACMHA can support states by tracking transformation changes and making this information available on the web.
− Find ways to partner with groups outside of MH field such as criminal justice, for-profit companies, etc.
− For next year's summit, integrate physical and mental health in the program.
− Develop a technical assistance center for transformation initiatives.