Pierce County Behavioral Health System Study

Final Report

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This document was prepared for the Pierce County Council as part of the Pierce County Behavioral Health System Study contract.

About the Human Services Research Institute

The Human Services Research Institute (www.hsri.org) is an independent, nonprofit research institute that helps public agencies develop effective, sustainable systems to deliver high-quality health and human services and supports in local communities. In the behavioral health space, our goal is to deliver actionable, viable, and culturally relevant strategies that empower service users and promote wellness and recovery.

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Executive Summary

In recent years, stakeholders in Pierce County have increasingly called for improvements in the County's behavioral health system, citing unmet treatment needs and missed opportunities for prevention. This report presents the findings from the Pierce County Behavioral Health System Study, conducted by the Human Services Research Institute for the Pierce County Council. The main questions to be addressed in this project were:

1. What is the prevalence of behavioral health issues in the county?
2. What is the extent of services available to address behavioral health issues in the county?
3. What services, policies, or practices should the county pursue to address gaps in the system that would provide the best return on investment?

Study Methodology and Approach

The study team synthesized quantitative and qualitative data from a number of sources to produce as comprehensive a picture as possible of treatment and prevention needs, resources, utilization and gaps in Pierce County. These data sources included key informant interviews, surveys on needed services and reasons for unmet needs, service utilization figures, and community feedback.

The report opens with a review of the prevalence of mental health and substance use disorder service and prevention needs in the County. In Section 3, we describe behavioral health resources in Pierce County, including those provided through the behavioral health organization (BHO) network and those provided outside the BHO. These resources include:

- Community education and prevention initiatives
- Mental health and substance use disorder treatment
- Social support services
- Crisis and inpatient services
- Initiatives targeted to individuals involved with the criminal justice system
- Current and planned prevention initiatives.

In Section 4 we discuss system-level challenges, including information specific to certain population groups in Pierce County. Next, we describe the results of a process we used to gather community feedback from stakeholders regarding their views on the County's most pressing priorities. The report closes with a series of recommendations regarding service and support enhancements and infrastructure-building activities to improve the behavioral health system in Pierce County.

Key Findings

Although the prevalence of diagnosed mental health and substance use disorders in Pierce County is similar to state and national figures, other indicators—such as responses to national wellness surveys as well as rates of suicides, opioid deaths, and crime—point to a higher-than-average need for behavioral health services in the County.

The County has a number of effective initiatives (and promising planned initiatives) to prevent and treat behavioral health disorders. Some standouts include:

- Tacoma Whole Child Initiative
- Optum Peer Support Services, offered throughout the BHO network
- Mental Health Co-Responder Program
- Tacoma/Pierce County Methadone Maintenance Program
- Community Re-Entry Program and Jail Transition Services
- District Court Behavioral Health Unit
- Prevent-Avert-Respond Initiative

While the above services appear to be having a positive impact, we found a need to expand these services to ensure broader access. In particular, individuals who do not qualify for behavioral health treatment through the BHO[1] face significant barriers to accessing needed treatment. Across the service array, we identified high levels of unmet need, with the proportion of those receiving services being far less than the prevalence of serious behavioral health conditions.

Pierce County is also grappling with issues that are common to behavioral health systems around the nation, including:

- Fragmentation of service systems
- Limited availability of key data for tracking and addressing disparities in access, quality of care, and outcomes across population groups
- Staffing and workforce shortages

We also observed a need for more coordinated, cross-system efforts in community education, school-based prevention, screening and assessment in primary care and other social service settings, employment and housing supports, crisis alternatives, and coordination with the criminal justice system. We identified opportunities for meeting the needs of military veterans and service members, who make up a sizable proportion of the Pierce County population, and for supporting families of people with behavioral health conditions. Finally, we discuss the importance of promoting shared decision-making and other strategies to enhance service-user engagement and education, and we discuss the importance of ensuring a trauma-informed system.

Recommendations

Our analysis highlights the variety of challenges faced by the Pierce County community as it seeks to ensure adequate access to behavioral health services and support recovery and well-being of Pierce County residents. As mentioned above, many of these challenges are common to county-based behavioral health systems around the country: issues of fragmentation, disparities in access, a rapidly changing policy environment, multiple levels of government, and limited resources. There is no single "cause" of the myriad problems faced by Pierce County residents with behavioral health needs; accordingly, there is no single solution to "fix" the system. Our recommendations build on existing strengths and address gaps while being mindful of limited resources.

[1] The Washington State DSHS contracts with behavioral health organizations (BHOs) to administer publicly funded mental health and substance use treatment services for those with serious behavioral health conditions. In Pierce County, the BHO is operated by Optum Pierce. Among those who have Medicaid, Optum BHO services are available to individuals who meet the state's Access to Care standards, which is defined as having a serious behavioral health disorder that impacts daily functioning.

We've broken out our recommendations into two categories. **Service and Support Recommendations** relate to expanding access, adjusting the service array, and ensuring a recovery-oriented, culturally competent and trauma-informed system. **Infrastructure Recommendations** relate to the development of a responsive, dynamic infrastructure that could build on the County's current resources to set priorities, coordinate action, and carry out system improvement activities.

Service and Support Recommendations
1. Invest in Prevention
1.1. Sustain Comprehensive and Robust Community Education Efforts
1.2. Adapt and Expand School-Based Prevention Activities
1.3. Expand Mental Health and SUD Screening in Primary Care and Social Service Systems
1.4. Add Evidence-Based Services for First-Episode Psychosis
2. Extend and Expand the 2-1-1 Behavioral Health Specialist Services to Establish 2-1-1 as a Universal "Front Door"
3. Increase Outpatient and Community-Based Service Capacity
3.1. Improve Provider Recruitment and Retention and Expand Access to Specialty Behavioral Health Care for Non-BHO Populations
3.2. Support and Coordinate with Efforts to Enhance Availability of Behavioral Health Outpatient Services in Primary Care
3.3. Partner with FQHCs and Similar Health Centers as Participants in the Delivery of Behavioral Health Outpatient Services
3.4. Join in Efforts to Ensure Behavioral and Physical Health Parity
3.5. Develop and Expand Crisis Alternatives
3.6. Address Housing Needs Alongside Behavioral Health Needs
3.7. Promote Employment among Behavioral Health Service Users
3.8. Support State Efforts to Align SUD and Mental Health Services in the Medicaid State Plan
3.9. Coordinate with the State Efforts on Medicaid Benefit Plan Options
3.10. Expand the Scope of Peer Services, Particularly for Non-BHO Populations
3.11. Target Resources Strategically to Reduce Inpatient Utilization
4. Expand the Use of Remote Health Interventions
5. Enhance Service User Engagement, Activation, and Self-Management
5.1. Promote Shared Decision-Making
5.2. Track and Promote Patient Activation
5.3. Encourage Establishment of Mental Health Advance Directives
6. Develop and Implement a Criminal Justice System Strategy Building on Existing Resources and Best Practice
6.1. Ensure Collaboration and Communication between Criminal Justice and Behavioral Health Service Systems
6.2. Promote Behavioral Health Training among First Responders and Continue to Expand the Mental Health Co-Responder Program

	6.3. Build Upon Local Best Practices for Behavioral Health Criminal Justice Partnerships
	6.4. Support State Efforts to Expand Behavioral Health Services for Incarcerated Individuals
7.	**Expand Support and Education for Families of People with Behavioral Health Conditions**
8.	**Foster Coalitions to Meet the Needs of Veterans and Service Members**
Infrastructure Recommendations	
1.	**Establish a Central Coordinating Body**
	1.1. Ensure Full and Active Inclusion of Service Users in All Planning and Oversight Activities
	1.2. Capitalize and Build upon Current Initiatives
	1.3. Develop an Organized System for Identifying and Responding to Funding Opportunities
2.	**Support Current Efforts to Enhance and Integrate Provider Data Systems**
3.	**Develop System Metrics to Track Progress on Key Goals**
4.	**Conduct Further Data-Driven Assessments of Need and Access**
5.	**Ensure a Culturally Competent and Trauma-Informed System**

The bottom-line conclusion generated from this analysis is that there is no single entity ensuring a seamless and effective behavioral health system for ALL Pierce County residents. There is, however, a proliferation of promising initiatives and coalitions of talented individuals committed to improving the system. A single entity with a defined mission and legal authority is in the best position to define the vision and the goals for this effort, with the diverse array of other stakeholders in the community contributing as partners. Moreover, it is critical that the current fragmentation and discontinuity of behavioral health services be addressed by establishing a comprehensive and well-integrated data system for overall monitoring of system performance and to help identify opportunities for improvement.

This study and this report is only one step in Pierce County's assessment and analysis efforts. We hope it can provide the basis for future planning efforts to create an improved behavioral health system throughout Pierce County.

1. Background and Approach

In recent years, stakeholders in Pierce County have increasingly called for improvements in the County's behavioral health system, citing unmet treatment needs and missed opportunities for prevention. These challenges are not unique to Pierce County. The lived experience of people with serious mental health conditions and substance use disorders is characterized by lower rates of employment and education [1 ,2, 3] and a lower quality of life [4] than the general population. Additionally, people with serious mental illness and substance use disorders have a higher incidence of preventable medical conditions [5, 6]. In fact, people receiving publicly funded behavioral health services die an average of 25 years earlier than the general population [7]. At least 7% of the population with serious mental illness are in prison or jail each year, and adults with psychiatric disorders are at substantially increased risk for re-incarceration compared to inmates with no history of psychiatric disorders [8].

Mental health and substance use disorders are highly disabling, ranking #1 in years lost to disability worldwide [9]. Not counting losses associated with incarceration, homelessness, co-morbid medical conditions, and early mortality, the economic burden of serious mental illness in the form of lost earnings, healthcare expenditures, and public assistance amounts to $317.6 billion per year, which is approximately $1,000 per person nationwide [10].

Across the nation, an estimated 32.7% of people receive minimally adequate treatment for behavioral health disorders. Levels of unmet behavioral health service needs are higher among more disadvantaged sub-groups, including older adults, racial and ethnic minorities, people with lower socioeconomic status, and individuals living in rural areas [11, 12]. There is a clear "quality chasm" for services and supports for behavioral health disorders, as documented by the Institute of Medicine. Those who do receive care experience a fragmented service system, with separate silos delivering mental health, substance use, general health, and social welfare services [13].

The Human Services Research Institute (HSRI) was commissioned by the Pierce County Council to conduct a study to better understand the particular challenges for the behavioral health system in Pierce County and to identify areas where the County can focus its improvement efforts in the future. The main questions to be addressed in this project were:

1. What is the prevalence of behavioral health issues in the County?
2. What is the extent of services available to address behavioral health issues in the County?
3. What services, policies, or practices should the County pursue to address gaps in the system that would provide the best return on investment?

About HSRI

HSRI is a 501(c) (3) nonprofit corporation, formed in 1976. We help public agencies develop effective, sustainable systems to deliver high-quality health and human services and supports in local communities. We help create positive change by taking a person-centric approach. We believe that systems are more effective—and less costly—when service users have a direct say in the services they receive and help define their desired outcomes.

Across our focus areas, we work to:

- Help design data systems and analytics solutions that help agencies produce actionable insights
- Partner with leaders and change agents to identify best practices, add value, and solve problems
- Help design robust, sustainable systems based on qualitative and quantitative data, engaging service users, self-advocates, and other stakeholders early and often
- Assist organizations in building the capabilities they need to sustain systems change

In the behavioral health space, our goal is to deliver actionable, viable, and culturally relevant strategies that promote wellness and recovery. We examine the entire interplay of community factors and supports that influence behavioral health—not just the formal systems. By taking such a broad view, we're able to identify and highlight a range of existing strengths, assets, and successful practices. On the flip side, this approach enables us to pinpoint barriers related to access, discontinuity of care, system fragmentation, and more.

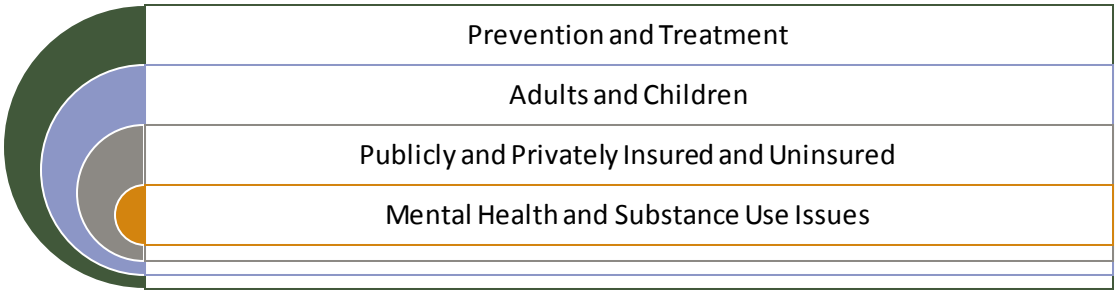
Our Approach

The primary goals of this study were four-fold:

1. Understand the behavioral health-related needs in Pierce County
2. Examine currently available resources to meet those needs
3. Determine gaps between community needs and available resources
4. Provide recommendations for a comprehensive, cost-effective, recovery-oriented system that meets the unique needs of Pierce County residents

This study's scope is intentionally broad and is designed to aid the Pierce County Council in gaining a better understanding of the system—or systems—that promote the social and emotional well-being of Pierce County residents with behavioral health issues. Therefore, the study covers both prevention and treatment activities for individuals across the lifespan, regardless of insurance type or whether there is a primary mental health or substance use disorder diagnosis (Figure 1).

Figure 1. Pierce County Behavioral Health Study Scope



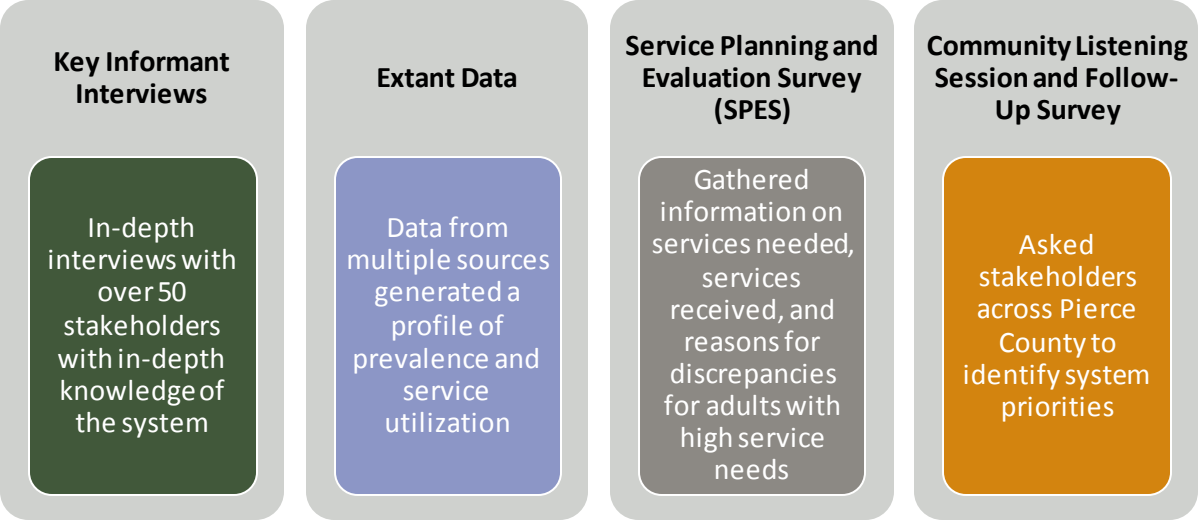
We believe this scope is appropriate because each of the dimensions depicted in Figure 1 are interrelated, and decisions regarding one aspect of the system are likely to impact others. For example, focusing on prevention and early intervention for young people experiencing psychosis for the first time will have long-lasting repercussions for their involvement in the adult treatment system. Further, focusing in great detail on one particular aspect of the system will result in an

incomplete picture of the needs of the community as a whole. For example, a first glance at the relatively robust service array offered by the behavioral health organization (BHO) might lead one to believe that there are adequate behavioral health services in the County. But, many of these services are only accessible to a small proportion of the population with serious mental health conditions who are insured by Medicaid.

Beginning in June 2016, a team from HSRI began gathering data from a variety of sources, depicted in Figure 2. Each of these sources and the methodologies for data gathering and analysis are described in detail in Appendix A and a list of key informants and partners can be found in Appendix B. Appendix C describes relevant local and state initiatives that provide context for this study, and a detailed description of the Service Planning and Evaluation Survey findings can be found in Appendix D. This report is a result of a synthesis of data from these multiple sources. It presents a blend of quantitative and qualitative information to provide as comprehensive a picture as possible of the treatment and prevention needs, resources, utilization, and gaps in Pierce County.

To the extent possible, we corroborated information gained from key informant interviews with other types of data to determine accuracy and completeness of this qualitative data. In the final draft stages, we engaged partners with expertise in public and private behavioral health systems, affordable housing, and human services to review our recommendations for completeness and accuracy.

Figure 2. Behavioral Health Study Data Sources



HSRI's Institutional Review Board (IRB) reviewed all protocols for key informant interviews and SPES data collection to ensure that all activities were conducted in accordance with federal, institutional, and ethical guidelines. Key informants and survey participants were given descriptions of the study activities, including a detailed discussion of potential benefits and risks of participation, and each provided informed consent before participating in study activities.

Organization of This Report

This report opens with a review of the prevalence of mental health and substance use disorder service and prevention needs in the County. In Section 3, we describe behavioral health resources in Pierce County, including BHO and non-BHO mental health and substance use disorder treatment, social support services, crisis and inpatient services, initiatives targeted to individuals involved with the criminal justice system, and current and planned prevention initiatives. In Section 4 we discuss system-level challenges, including information specific to certain population groups in Pierce County. Next, we describe the results of a process we used to gather community feedback from Pierce County behavioral system stakeholders regarding their views on the most pressing priorities for the behavioral health system. The report closes with a series of recommendations regarding service and support enhancements and infrastructure-building activities to improve Pierce County's behavioral health system.

Notes About Language

In this report, behavioral health refers to both mental health and substance use. Those who receive services are typically referred to as "service users." Those stakeholders who participated in key informant interviews as part of the study are referred to as "key informants." Other individuals who gave informal feedback are referred to as stakeholders. The term "peer" is used to refer to individuals with personal experience with mental health or substance use issues, typically in the context of peer support.

2. Behavioral Health Service and Prevention Needs

When examining prevalence of behavioral health conditions, it is important to keep in mind that, for most people, behavioral health issues are not static. There are multiple ways of understanding the prevalence of behavioral health related-needs in a community. Understanding rates of diagnosable conditions is a starting point, but it is also important to examine factors that put individuals at risk for developing disorders in the future. A comprehensive behavioral health system attends not only to the intensive needs of those with serious mental health conditions and substance use disorders but also to the sub-acute needs of individuals who carry other behavioral health diagnoses and, critically, to the social and emotional well-being of the majority of the population who have not been diagnosed with a behavioral health condition, including children and young adults. This section explores prevalence of mental health disorders, rates of substance use and substance use disorders, and additional community indicators of behavioral health need.

Prevalence of Mental Health Conditions

An estimated 19.5% of adults (about 123,130 people based on 2014 population estimates) in Pierce County meet the criteria for a mental health disorder. A total of 4.6% (29,046 people) have a serious mental illness, defined by the Substance Abuse and Mental Health Services Administration (SAMHSA)[2] as a diagnosable behavioral or emotional disorder that significantly impacts day-to-day functioning [14]. These figures are consistent with national estimates [15, 16]. The Washington State Department of Social and Health Services (DSHS) estimates the prevalence of severe emotional disturbance among youth aged 17 and younger in the state at 7% [17]; SAMHSA defines severe emotional disturbance as a diagnosable mental, emotional, or behavioral disorder among children and youth resulting in impaired functioning and significant interference in regular activities. An estimated 11.4% of youth aged 12 to 17 in Pierce County experienced a major depressive episode in the past year, slightly higher than the national estimate of 10.4% [18].

Although the prevalence of diagnosed mental health conditions is similar to state and national figures, other indicators suggest the mental health of Pierce County residents is poorer than others in the state. According to the 2014 Behavioral Risk Factor Surveillance System (BRFSS) data presented in a report by the Tacoma-Pierce County Health Department (TPCHD), 17.0% of Pierce County adults reported their mental health was "not good" for two weeks or more within the past 30 days; this is far higher than the Washington state percentage of 10.9% [19]. According to the 2014 Healthy Youth Survey (HYS) data presented in another report by TPCHD, 38.3% of Pierce County 10th graders reported feeling so sad or hopeless for two weeks or more that they stopped doing their usual activities; this compares with 29.8% in the U.S. [20, 21]. As depicted in Figure 3, the average number of unhealthy mental health days[3] for adults is slightly higher in Pierce County than in Washington, and has increased over time.

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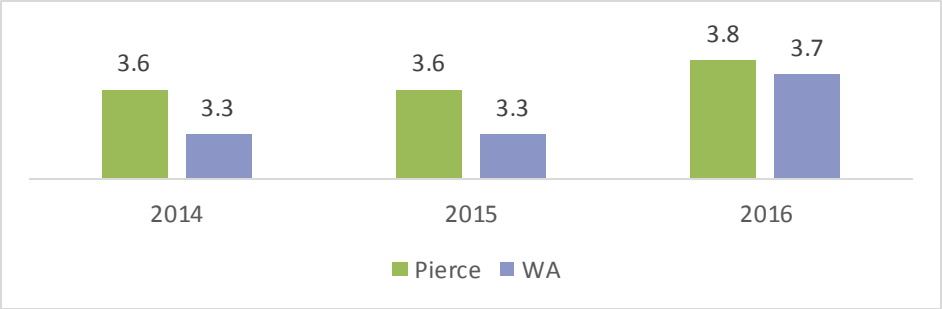
[2] The Substance Abuse and Mental Health Services Administration (SAMHSA) is within the U.S. Department of Health and Human Services. SAMHSA's priority is to reduce the effect of substance abuse and mental illness on communities and to advance the behavioral health of the nation.

[3] This measure is based on the responses to the BRFSS question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Figure 3. Average Number of Mentally Unhealthy Days Among Adults in the Past 30 Days, Pierce County and Washington State, 2014 – 2016

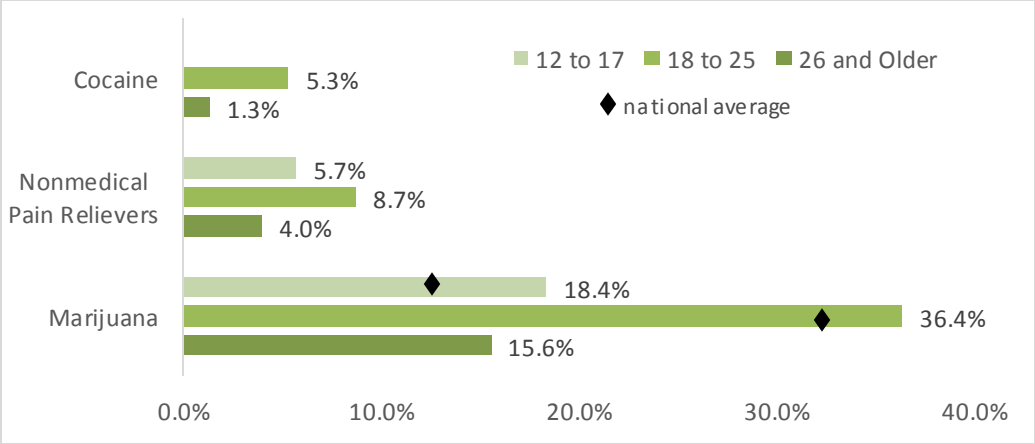


Source: Robert Wood Johnson Foundation, County Health Rankings, 2016

Substance Use and Substance Use Disorder Prevalence

Use rates of most legal and illicit substances in Pierce County are similar to national averages. Among Pierce County residents aged 12 and older, past year use of marijuana was more prevalent than past year use of cocaine or nonmedical prescription drugs (Figure 4). Of these illicit and non-illicit substances, young adults aged 18 to 25 were the most likely to use in the past year. Pierce County and Washington state have similar prevalence of marijuana use; however, both are above the national average. The estimated past year use of cocaine and nonmedical pain relievers in Pierce County is similar to Washington state and national averages.

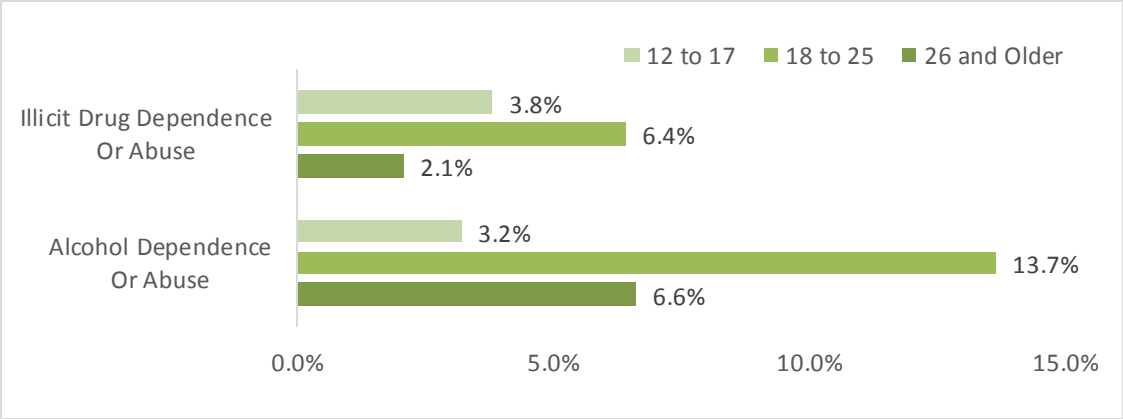
Figure 4. Rates of Past Year Substance Use in Pierce County, by Age, 2012 – 2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2012, 2013, and 2014. Note: No estimate is reported for cocaine use for ages 12 to 17 because of low precision. The state estimate for this age group is 0.7%.

Prevalence of substance use disorders—defined as meeting diagnostic criteria for dependence and abuse—is depicted in Figure 5. Pierce County youth aged 12 to 17 are more likely to have a dependence on or abuse illicit drugs rather than alcohol. The opposite is true for adults aged 18 and older; they are more likely to have a dependence on or abuse alcohol.

Figure 5. Past Year Substance Use Disorders in Pierce County, by Age, 2012 –2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2012, 2013, and 2014. Note: Illicit drugs include marijuana/hashish, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically.

In 2014, adults in Pierce County and Washington state engaged equally in binge drinking, with 17.1% adults having four or more drinks in the past month [22]. Washington scores in the third highest quantile for the estimated prevalence of binge drinking compared to states [23]. Although binge drinking is equally prevalent in Pierce County and Washington, the percentage of alcohol-impaired driving deaths during 2016 in Pierce County was 41%, slightly higher than Washington state's 37% [24].

Several key informants noted that Pierce County is currently facing a "heroin epidemic." The rise in admissions for heroin over the past ten years (discussed in Section 2) suggest this is the case, as does the fact that Pierce County, like other counties in Washington state and across the nation, has seen steady increases in rates of opiate-related deaths. Notably, between 2002 and 2013, Pierce County saw a 32.3% increase in opiate-related deaths [25].

Additional Indicators of Behavioral Health Needs

A number of other individual- and community-level factors provide a more detailed picture of behavioral health needs in Pierce County, including factors impacting physical health, employment, housing, and quality of life as well as rates of suicide and violent crime.

A growing body of literature documents the importance of social determinants of health [26] and mental health [27], pointing to a complex relationship between the health of communities and of individuals. Factors that are likely to have a bearing on behavioral health include physical wellness, access to physical and behavioral healthcare, educational attainment, and socioeconomic status. Table 1 depicts key health indicators identified by the Robert Wood Johnson Foundation in 2016[4] for Pierce and King Counties and Washington State as a whole.

[4] The Robert Wood Johnson Foundation, County Health Rankings are based on a model of population health that highlights health factors and outcomes that influence the overall well-being of communities across the nation. County-level measures from an array of national and state data sources are standardized then combined using weights. Counties are then ranked based on these measures within states. http://www.countyhealthrankings.org

Table 1. Health Outcome and Health Factor Measures for Pierce County, King County, and Washington State, 2016

	Pierce County	King County	Washington State
Premature Death (per 100,000 population, age-adjusted)	6,400	4,500	5,500
Poor or Fair Health	14%	10%	16%
Preventable Hospital Stays (per 1,000 Medicare enrollees)	44	30	36
Adult Obesity	31%	22%	27%
Physical Inactivity	20%	15%	18%
Sexually Transmitted Infections (per 100,000 population)	529.0	338.3	361.8
Teen Births (per 100,000 female population ages 15-19)	31	17	28
High School Graduation	78%	78%	78%
Some College	63%	78%	68%
Unemployment	7.2%	4.6%	6.2%
Children in Poverty	18%	14%	18%

Source: Robert Wood Johnson Foundation, County Health Rankings, 2016

Suicide, a significant health issue nationwide, is a serious concern in Pierce County. According to the Washington Department of Health, Center for Health Statistics cited in a recent report of the TPCHD, over 150 Pierce County residents committed suicide in 2014; of these, 80% were men [28]. This report also stated that the rate of suicide in Pierce County—at 18.5 per 100,000 residents—is higher than that of Washington state (15.4 per 100,000).

Crime, particularly rates of violent crime[5], has an important bearing on the behavioral health of communities. Pierce County has consistently had the highest rate of violent crime offences compared to all other counties in Washington since at least 2011 [29]. In 2015, the annual violent crime rate in Pierce County was 5.1 per 1,000 residents, well above the state's rate of 3.2 per 1,000 residents. In addition to violent crime, the annual homicide rate in Pierce County during 2015 was 4.3 per 100,000 residents, also higher than the state's rate of 2.6 per 100,000 residents [30]. The 2013 *Health of Washington State Report – Domestic Violence* places Pierce County with the highest rate of domestic violence in Washington state, with over 1,000 offenses per 100,000 people [31].

This discussion of crime is not to suggest that behavioral health conditions are the *cause* of violent crime. In fact, research consistently demonstrates that likelihood of violent crime can be predicted by sociodemographic and economic variables and to some extent substance use disorders, but not whether a person has a mental health diagnosis [32]. However, those with serious mental health conditions are far more likely than others to be victims of violent crime [33]. Violent crime does, however, contribute to traumatic stress, which has a negative impact on health, including behavioral health.

[5] According to the FBI's Uniform Crime Reporting (UCR) Program, violent crime is defined as offenses which involve force or threat of force.

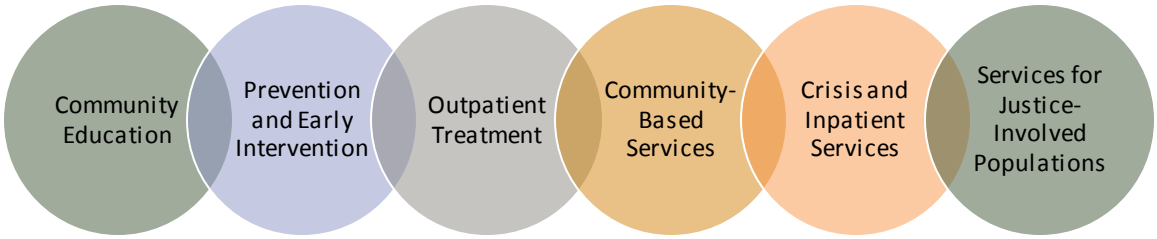
Summary

Although the prevalence of diagnosed mental health and substance use disorders in Pierce County is similar to state and national figures, other indicators—such as responses to state and national wellness surveys as well as rates of suicides, opioid deaths, and crime—point to a higher-than-average need for behavioral health services in the County.

3. Available Resources, Capacity, Utilization, and Gaps

Information regarding available resources, capacity, and utilization was gathered from multiple data sources, including public datasets, data provided by key informants, key informant interviews, and the SPES-CM and SPES-SU. This section is organized by service/prevention activity category and includes wellness and community education, prevention and early intervention, outpatient and community-based mental health and SUD treatment services in and out of the BHO network, crisis and inpatient services, and behavioral health/criminal justice system initiatives (Figure 6). This organization reflects national best practices for a comprehensive behavioral health service array [34, 35].

Figure 6. Example of a Behavioral Health System Service Array



Although this section spans a multitude of service types geared toward many populations, it is not meant to be an exhaustive catalog of all resources in the County. Rather, we seek to provide a general sense of available resources and highlight the use of evidence-based and promising practices[6] in the County [36]. In conducting this study, the HSRI research team made every effort to verify the information presented here, and the team corroborated information using multiple sources when possible. We have been impressed by the richness and breadth of the ongoing work of stakeholders throughout Pierce County to enhance and improve the behavioral health system, and this section represents our best effort to characterize this work.

Community Education

A large body of literature documents the negative effects of stigma on life chances related to employment, housing, legal status, health, and quality of life for people with behavioral health conditions [37, 38, 39, 40, 41]. Key informants identified a need for public education to combat misperceptions and stereotypes regarding mental health and substance use disorders so that

[6] The Institute of Medicine defines evidence-based practices as the integration of best-researched evidence and clinical expertise with the values of service users. Promising practices are defined as interventions that are less thoroughly documented than evidence-based practices but are promising based on preliminary data and local context.

members of the public understand that these disorders impact many Americans, and that those with behavioral health conditions are capable of participating meaningfully in society.

Prevent-Avert-Respond Initiative

Prevent-Avert-Respond (PAR) is a mental health prevention initiative led by CHI Franciscan Health and funded through a Catholic Health Initiatives Mission and Ministry Fund Grant[7]. PAR began in July 2016 and will end June 2019. The PAR initiative's aim is "to reduce mental health crises in Pierce County, through a full population approach benefitting residents with all types of mental health problems and crises, socioeconomic status, age, racial and ethnic background, and insurance (or lack)." The initiative's goals are to:

- **Prevent** mental health crises through early detection of emotional distress and mental illness, and supportive resources for people with high crisis risk;
- **Avert** emerging mental health crises through evidence-based recognition, referral, and intervention skills; and
- **Respond** effectively to community members in serious mental distress to facilitate the best possible outcomes.

The PAR initiative is based in the Spectrum of Prevention framework[8] and was developed based on over 200 interviews with community stakeholders in Pierce County. PAR includes strategies that work at the level of individuals, providers, organizations, and policies. According to the PAR initiative director, PAR strategies were chosen based on identified needs and gaps as well as areas where success is most likely. A fact sheet that describes PAR and its components can be found in Appendix E, and PAR strategies are referenced throughout this report. Several key informants—including the PAR project director—expected that the PAR Initiative will enhance training, prevention, and public education in Pierce County. Most strategies are designed to be self-sustaining and at low or no cost to the community.

The PAR initiative includes a number of activities aimed at educating the public about mental health and offering members of the community a chance to build skills in supporting those with mental health-related needs. These include a series of Wellness Recovery Action Planning (WRAP)[9] facilitator trainings, an evidence-based prevention and wellness program. The PAR initiative will also train 30 people in Pierce County in Mental Health First Aid (MHFA)[10] in partnership with the National Council for Community Behavioral Healthcare, which will significantly expand the availability of this resource within the community. In the second year of the PAR initiative, there will be a suicide prevention campaign that will include online resources for the public.

PAR involves collaboration with the early psychosis initiative at the DSHS, Division of Behavioral Health and Recovery. Called "Get Help Early,"[11] this initiative is designed to increase community awareness, reduce stigma, provide education, and increase early identification of psychosis [42].

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[7] The grant is designed to fund community-based initiatives in collaboration with community partners to meet identified community health needs.

[8] http://injuryprevention.bmj.com/content/5/3/203.short

[9] http://mentalhealthrecovery.com/wrap-is

[10] http://www.mentalhealthfirstaid.org/cs/

[11] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/signs-early-psychosis

Prevention and Early Intervention

In recent years, leaders in healthcare have increasingly called attention to the critical importance of prevention to promote population health, including behavioral health [43]. Mental health and substance use disorders result from a combination of genetic and environmental factors. The landmark Adverse Childhood Events (ACEs) study documents the key role of traumatic or toxic stress—including abuse, neglect, and exposure to violence—on health and behavioral health [44, 45]. When children experience multiple risk factors, this results in a "cascade of risk" which, in turn, predisposes them to a variety of general health and social problems, including mental health and substance use disorders. Emerging research in neuroscience demonstrates that screening and early intervention can help build resilience, avert the development of behavioral health problems, and prevent existing behavioral health problems from worsening [46]. And failing to intervene represents a lost opportunity to avoid the enormous personal and societal costs associated with behavioral health conditions [47].

In Pierce County, a variety of activities across the spectrum of prevention are taking place, and some of these activities are discussed below. Key informants described current and planned prevention activities, or small-scale prevention activities that may be expanded in the future; however, they were also quick to state that there is a need for prevention activities on a larger scale, coordinated across systems, within the County.

Prevention Within School Districts

Pierce County's most sweeping school-based behavioral health prevention and promotion effort is the Tacoma Whole Child Initiative, a 10-year project involving the Tacoma School District and the University of Washington Tacoma's Center for Strong Schools.[12] The goal of the Whole Child Initiative is to help kids feel healthy, safe, engaged, supported, and challenged. Its focus goes beyond academic learning to social and emotional development. The project's activities include professional development for school staff in areas such as social emotional learning and trauma-informed care as well as system-level infrastructure support to ensure sustained implementation of project activities.

As part of the Whole Child Initiative, Comprehensive Life Resources—a local behavioral health provider agency—was engaged to provide mental health services within Tacoma schools. Children in the school district are assessed for behavioral health needs. Those who demonstrate minor but concerning behavioral health issues go into a 6-week evidence-based social skills group counseling program called *S.S.GRIN*. Children who are assessed as needing higher levels of care are referred into one of two evidence-based programs called *Check In Check Out* and *Check and Connect*.

The Whole Child Initiative includes an evaluation that assesses system capacity to support the initiative, fidelity to evidence-based practices, use of data for school decision-making, and school progress toward strategic goals [48]. According to one key informant in the Tacoma Public School District, the district's ultimate goal is to have mental health services available within the school buildings and to forge communication pathways to respond to emergent behavioral health issues. The Mental Health and Chemical Dependency Tax (described in Appendix C: Pierce County Context) provided $600,000 in funding for the Tacoma Whole Child Initiative.

[12] https://www.tacomaschools.org/student-life/Pages/TWCI.aspx

Other school-based mental health initiatives include the Jordan Binion Project[13] and two programs of the National Alliance on Mental Illness (NAMI)[14], *NAMI Basics* and *Parents and Teachers as Allies*. The previously mentioned PAR initiative also includes planned efforts to expand school-based prevention activities throughout Pierce County in the coming years. These efforts include partnering with the Washington State Office of Superintendent of Public Instruction and the Jordan Binion Project to implement an evidence-based stigma-reduction and prevention high school curriculum throughout Washington state. It involves training 40 people as volunteer teacher trainers who will train teachers in 25 high schools to deliver an 8- to 12-week curriculum in their classes.

In regard to substance use disorder prevention in schools, Pierce County has established prevention programs in Franklin Pierce, Orting, and Lakewood, which are situated in areas the state identified as having youth at particularly high risk for substance use. These programs are part of the Community Prevention and Wellness Initiative[15], which is funded by a SAMHSA grant and administered by the Washington State DSHS. It involves supporting coalitions within local school districts to develop and implement evidence-based prevention strategies in their communities.

Screening and Assessment

Nationwide, screening and assessment for mental health and substance use issues have been proven to be a critical step toward population health. Additionally, they are key in identifying and eliminating disparities in access to treatment [49]. A number of screening initiatives are either planned or under way in Pierce County:

- The Tacoma-Pierce County Health Department provides mental health screenings through its nurse home visiting, early childhood, and parenting support programs. The department also plans to include mental health screenings in opioid substitution maintenance and monitoring services.
- The Korean Women's Association, a large social service provider that specializes in multicultural, multilingual services to underserved populations in Pierce County, has a grant from the state DSHS to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT)[16] within Asian American communities in the County. This evidence-based practice aims to quickly identify substance use problems and includes a mental health component. The initiative will include working with primary care and behavioral health provider organizations to build capacity to launch these programs within their practices [50]. This effort will provide the County with important data regarding racial and ethnic disparities in prevalence and treatment for behavioral health disorders.
- The PAR initiative includes plans to implement depression and anxiety screenings at every Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) appointment and establish a referral process for treatment. This program is intended to reach approximately 2,000 to 3,000 women receiving WIC services in Pierce County.
- CHI Franciscan is currently launching a "Zero Suicide initiative"[17] within its hospital network, including hospitals in Pierce County. This approach, based on national best practices, is

[13] http://www.jordanbinionproject.org
[14] http://www.nami.org/Learn-More/Public-Policy/Mental-Health-in-Schools
[15] https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/22-1464.pdf
[16] http://www.samhsa.gov/sbirt
[17] http://zerosuicide.sprc.org

designed to support health systems in changing organizational culture, providing staff training, and implementing screening and treatment activities to identify and support those at risk of suicide. To date, six to eight staff have been trained in this model and are working to adapt the model to meet the needs of Pierce County residents. As part of this initiative, CHI Franciscan staff have been using the Patient Health Questionnaire (PHQ-9), a depression screening, in the past six months.

Access to Behavioral Health Services in Pierce County

Prior to discussing the availability of behavioral health treatment services in Pierce County, a brief discussion relating to access is needed, particularly in regard to mechanisms that connect those with behavioral health needs to services and how behavioral health services are organized in Pierce County.

Connecting to Services

A first step to connecting with behavioral health treatment services is often a helpline or resource directory. These mechanisms inform those with behavioral health service needs about available resources and connect them to those resources as appropriate. United Way of Pierce County operates a helpline[18], South Sound 2-1-1, that connects people to a variety of human services.

Although counseling and mental health service resources are available through 2-1-1, some service user and family member key informants we spoke with were not aware that this resource existed. Other key informants noted that 2-1-1 is not widely utilized among people seeking help for mental health or substance use problems. For example, one family member key informant noted that when s/he called 2-1-1 for a behavioral health need, s/he did not find the resources helpful and was ultimately instructed to call the Crisis Line instead. This key informant said, "You have to know what you are wanting, and they give you a bunch of numbers, and half the time the numbers don't work." These observations are consistent with research completed preparatory to the PAR initiative, which resulted in the conclusion that "2-1-1 phone staff (half permanent, half work-study students and volunteers) don't have the longevity, professional abilities, or time required to thoroughly map all county mental health services, maintain up-to-date knowledge of these services, and proactively share that knowledge to aid county planning to improve the mental health system of care."

As a result of this identified need, the PAR initiative involves the creation of a behavioral health specialist position within 2-1-1 to educate the community about mental health resources, build relationships with area service providers, and promote 2-1-1 as a mental health resource. The behavioral health specialist will also be tasked with upgrading and maintaining the 2-1-1 database so the public can more easily rely on it, and with ensuring that knowledge is transferred to 2-1-1 staff so they are better-equipped to connect callers with appropriate resources. Promotional materials will be developed in multiple languages directing individuals with a mental health need to connect to services and supports through 2-1-1 (language interpretation services are available through 2-1-1).

Although this position represents a promising opportunity to fill a clear need, there are limitations to the effort. Importantly, the funding for the behavioral health specialist in the 2-1-1 program is limited to three-year PAR grant funding. Public funding would be needed to fund this position after

[18] http://www.uwpc.org/let-us-help

the grant ends. Additionally, the position is focused on mental health, not substance use, and there is no funding to ensure that substance use disorder resources are available through 2-1-1.

For individuals and families experiencing a behavioral health crisis in Pierce County, the first point of access is the Crisis Line. Callers who are over 18 are typically referred to the Mobile Outreach Crisis Team (MOCT), and those under 18 are referred to a crisis response team at Catholic Community Services. The multidisciplinary MOCT teams include designated mental health professionals, county-designated clinicians who assess crisis situations to determine whether there is a need for involuntary mental health treatment. One family member key informant described the crisis line as a helpful resource, and another noted that s/he was unaware the crisis line existed until only recently, despite having experienced behavioral health-related crises for several years. Other key informants, community listening session participants, and community survey respondents expressed frustration with crisis response services, particularly in regard to the lengthiness of the process.

Organization of Behavioral Health Services

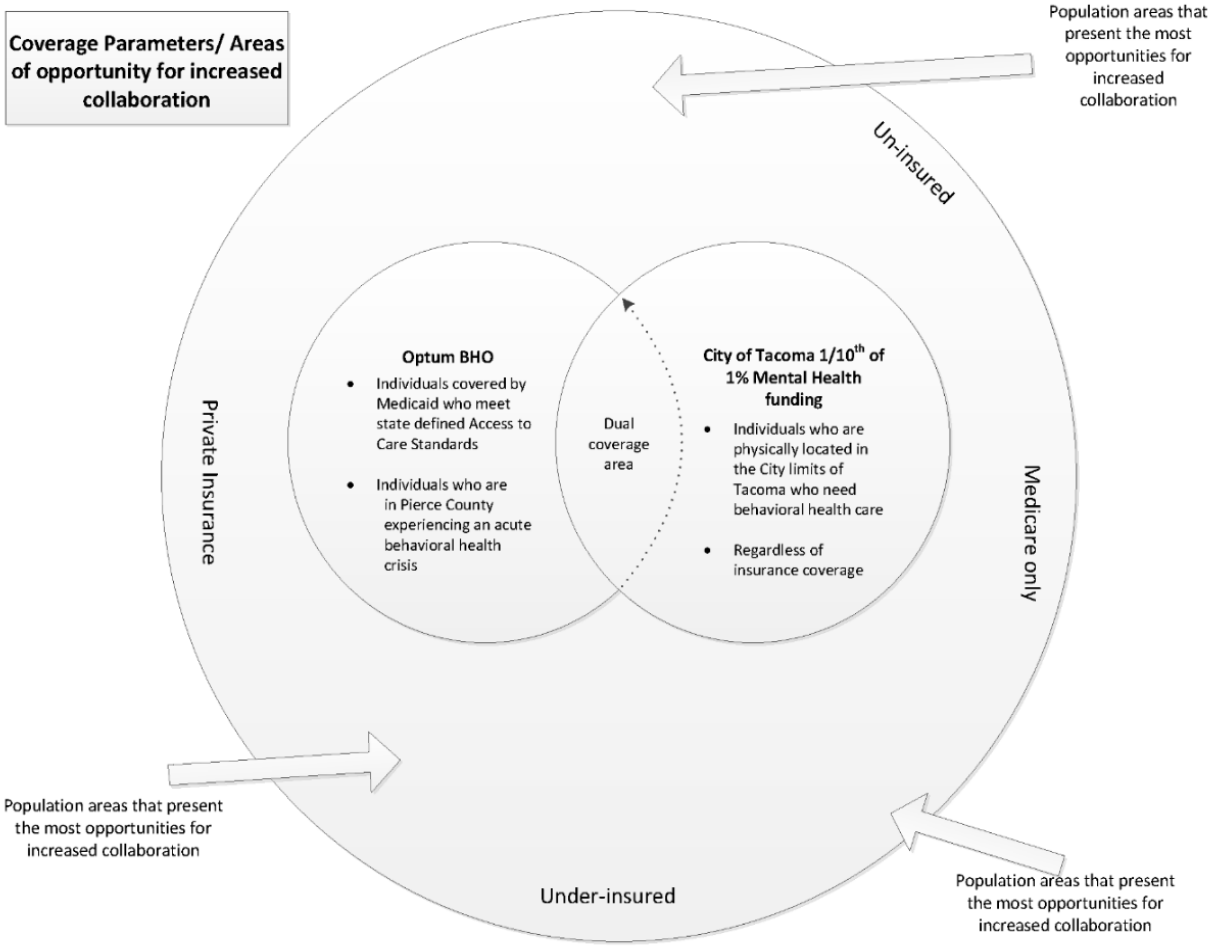
The Washington State DSHS contracts with behavioral health organizations (BHOs) to administer publicly funded mental health and substance use treatment services for those with serious behavioral health conditions. In Pierce County, the BHO is operated by Optum Pierce. The BHO is responsible for subcontracting with licensed behavioral health agencies to provide services and for managing crisis services throughout the County.

Approximately 215,000 individuals in Pierce County have Medicaid, which is roughly 25% of the county population. Among those, Optum BHO services are available to individuals who meet the state's Access to Care standards, which is defined as having a serious behavioral health disorder that impacts daily functioning [51]. Therefore, the Optum Pierce BHO outpatient service network is accessible only to a portion of the Pierce County population: those with the most serious behavioral health conditions who qualify for Medicaid.

Optum's crisis services are available to any Pierce County resident, though they must be assessed by the MOCT as currently experiencing an acute behavioral health crisis. Those residing in the City of Tacoma have access to a more expanded network of behavioral health services funded through the Mental Health and Chemical Dependency Sales Tax (described in Appendix C), regardless of payer type; however, these services are not accessible to those seeking treatment outside of the City of Tacoma.

These coverage parameters result in large numbers of Pierce County residents—well over 75% of the total County population—with no access to the broad array of outpatient and community-based BHO services described in this report. Those with limited access include individuals with Medicare only, those with private insurance, those on Medicaid with less severe mental health conditions, and individuals without insurance. These individuals, who may be living with a range of mild to serious behavioral health conditions, are expected to receive behavioral health services through their primary care network or elsewhere in the community. Figure 7, developed by Optum, depicts these populations and indicates that it is those individuals with limited access to BHO services—particularly individuals outside the City of Tacoma—for whom there may be unmet behavioral health service needs.

Figure 7. BHO Coverage Parameters



Source: Optum Pierce

Outpatient Mental Health Services

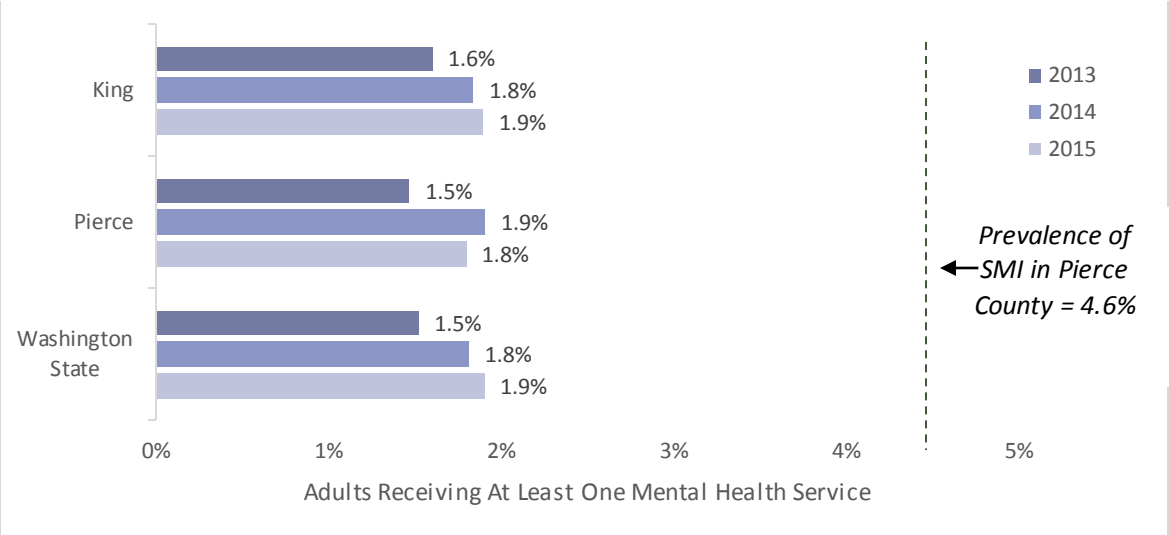
This section catalogs types and availability of mental health outpatient treatment services in Pierce County. For the purposes of this report, we define outpatient services as those delivered in community-based settings, including services delivered in outpatient clinics such as medication management and monitoring and psychotherapy as well as services delivered in other community settings, such as employment and housing supports. Although this section focuses primarily on services delivered in outpatient clinic settings, the utilization information in Figures 8 and 9 include some housing and peer support services as well as services designed to transition individuals from institutional settings back to the community. These services are discussed in more detail in later sections of the report.

Adult Outpatient Mental Health Services

The BHO administers a range of outpatient mental health services throughout Pierce County. These services include medication management and monitoring, individual and group psychotherapy, case management, and intensive wraparound supports such as Assertive Community Treatment, an evidence-based approach designed to help individuals with complex behavioral health needs to live in the community [52]. Many of these services include a peer support component (discussed in the next section).

Figure 8 depicts the proportion of the population in Pierce and King Counties and in the state who received any publicly funded outpatient mental health service in the past three years. In all localities, fewer than 2% of the population received any of these services. For reference, we include the prevalence rate for serious mental illness (SMI) in Pierce County (the prevalence rate for any mental health disorder is 19.5%).

Figure 8. Percentage of the Adult (18+) Population Who Received Any Publicly Funded Non-Crisis Outpatient Service, 2013 - 2015



Sources: System for Communicating Outcomes, Performance & Evaluation (SCOPE), WA State DSHS DBHR/Looking Glass Analytics (2016) for service estimates and U.S. Census Bureau, Population Division Release Date: June 2016 for population estimates

Importantly, Figure 8 does not include information regarding the receipt of outpatient mental health services funded through private insurance, nor does it include all mental health services delivered in primary care settings, either publicly or privately funded. Unlike the data available through the state DSHS, there is no central data source that describes mental health or substance use disorder service utilization among individuals who receive services outside the publicly funded system—a majority of the Pierce County population as noted above. Therefore, in this study we are only able to provide a partial picture of service capacity and unmet need for outpatient behavioral health services.

However, the majority of key informants and many others who provided feedback for this study indicated high levels of unmet need outside of the BHO network, suggesting that the gap between utilization and prevalence highlighted in Figure 8 is not filled by privately delivered specialty

mental health services and mental health treatment delivered in primary care settings. Key informants with significant experience serving individuals outside of the publicly funded specialty mental health system emphasized that mental health needs are complex and require a range of services and supports, many of which are restricted when compared to those behavioral health services accessible through the BHO. They also expressed concern with the range of specialty services currently available outside of the BHO network. For example, key informants from the Tacoma Area Coalition of Individuals with Disabilities (TACID) and from NAMI noted that they have received calls from Pierce County residents wanting to get connected to Dialectical Behavioral Therapy—an evidence-based practice for the treatment of Borderline Personality Disorder—but there are few providers offering this modality in Pierce County.

In contrast with the BHO clinics, which have same-day walk-in appointments for outpatient mental health services, key informants reported lengthy wait times for scheduling services outside of the BHO network. Multicare, which is the largest provider of outpatient commercial mental health services in the County, reports that it receives 500 referrals to mental health care for non-Medicaid clients each month, and that the average wait time to receive first service after referral is four weeks.[19] Another mental health provider that serves a large number of children and families reported that 50 to 60 people per month are unable to schedule appointments; this group consists of primarily Medicaid enrollees outside of the BHO network as well as those who are privately insured or uninsured.

For many, attempts to schedule outpatient treatment are their first experience with the behavioral health system, and lengthy wait times send a message of limited resources and limited hope that their needs will be addressed.

Stakeholders consistently reported lengthy wait times for outpatient specialty mental health services, particularly for individuals with sub-acute needs who were not enrolled in Medicaid. For many, attempts to schedule outpatient treatment are their first experience with the behavioral health system, and the lengthy wait times send a message of limited resources and limited hope that their needs will be addressed. These wait times can result in disconnection from the system and increased reliance on emergency behavioral health treatment, and can contribute to tragic outcomes such as suicide.

Key informants also described a need for more mental health resources to be available through primary care, particularly for individuals with mild to moderate needs, who are underserved in the current system. One key informant noted that there is minimal training and support for the primary care workforce, even though these are often the first people patients come to with a behavioral health-related need. Another key informant noted that primary care physicians may discriminate against individuals with serious mental health diagnoses because of perceptions that these individuals will be difficult to engage with, making it even more difficult to get connected to needed services. Key informants also noted that there is no level in between primary care and BHO specialty services. For example, individuals who are typically stable on medications but need follow-up to maintain that stability would not meet Medicaid Access to Care standards (if they are enrolled in Medicaid) but have needs for specialty mental health services, such as medication management and monitoring and psychotherapy, that cannot be met by a primary care physician alone.

[19] Personal communication, Tim Holmes, July 28, 2016

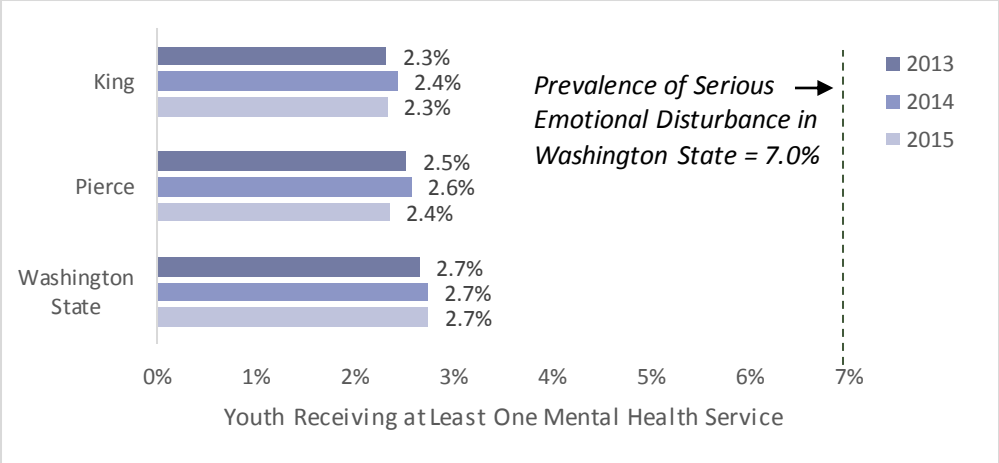
Providers we spoke with described some new initiatives that are aimed at building the capacity to address behavioral health needs in primary care settings and to facilitate referrals to appropriate services if those needs cannot be met through primary care. Seamar, a large community provider, has created a behavioral health specialist position in its primary care clinics; this position is tasked with coordinating referrals from primary care to behavioral health. Seamar also offers some brief behavioral health interventions in their primary care clinics, typically involving three to six visits. CHI Franciscan has only minimal outpatient behavioral health services, but it does plan to expand its outpatient service array for individuals with mild behavioral health issues in Pierce County in the next three years. Three CHI Franciscan clinics have behavioral health specialists as part of a new grant-funded initiative targeted at evaluation and treatment of short-term, mild behavioral health conditions. The initiative includes plans to refer out any long-term treatment needs.

Children and Youth Mental Health Outpatient Services

Within the BHO network, a continuum of care is available for children with behavioral health issues; it ranges from traditional outpatient treatment to 90-day intensive wraparound services and residential care. According to Optum Pierce, a goal of these services is to support families in the community as long as "clinically necessary" and avoid out-of-home treatment whenever possible.

Figure 9 depicts the percentage of the general population under age 18 in King and Pierce Counties and Washington State as a whole that received at least one publicly funded non-crisis outpatient mental health service. Pierce County is similar to King County in its penetration rate for outpatient youth mental health services, and both counties and the state as a whole provide publicly funded services well below the estimated prevalence of 7% serious emotional disturbance in the state. As with the adult figures depicted in Figure 8, these figures do not capture outpatient services delivered through the privately funded system or mental health interventions that may have been delivered in primary care. Our findings in regard to outpatient youth mental health services outside of the publicly funded system are similar to those for adults; there is no data that enables a systematic examination of unmet behavioral health needs in the privately funded and primary care settings, but anecdotal evidence from key informants suggests that such services are difficult-to-access and/or in short supply in Pierce County.

Figure 9. Percentage of Children and Youth (0 to 17 Years) in the Population Who Received Any Publicly Funded Non-Crisis Outpatient Mental Health Service, 2013 - 2015

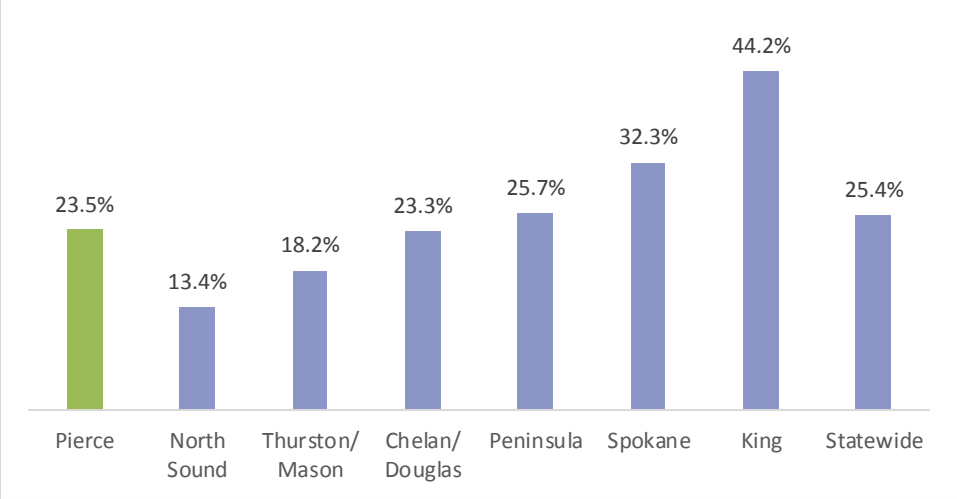


Sources: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016) for service estimates and U.S. Census Bureau, Population Division Release Date: June 2016 for population estimates

A recent gap analysis of children's publicly funded mental health services in the state included an identification of "treatment deserts"—areas of the state in which children cannot access an evidence-based treatment within 30 minutes. The report identified two "treatment deserts" in Pierce County: in Northern Pierce, there is a treatment desert for depression, and Eastern Pierce county has a treatment desert for anxiety [53]. Compared to other counties, however, Pierce County had relatively good capacity to treat local need through the publicly funded system. Pierce was ranked as having sufficient capacity to treat adjustment, anxiety, and trauma, and insufficient for depressive disorders, ADHD, and conduct disorder [54].

Key informants noted the importance of the availability of mental health services in schools. One key informant, a parent of children who receive publicly funded behavioral health services, described the difficulty of bringing his/her children to appointments during the day, particularly when appointments are difficult-to-schedule and located in many different parts of the County. This key informant noted that having mental health services available through the schools has been critical to ensuring access. Notably, these school-based services are only available in some parts of the County and only to some children who meet the Access to Care standards for those services. In 2015, 23.5% of Pierce County children and youth on Medicaid who received any community outpatient mental health services received those services in a school setting (Figure 10). This is slightly lower than the state average of 25.4% and well below King County's 44.2%.

Figure 10. Proportion of Medicaid Community Outpatient Service Users Ages 0 to 17 Who Received Mental Health Services in School in 2015, by Region



Source: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

Peer Support Services

Peer support services are delivered by individuals with personal experience as service users of behavioral health services. Peer support services are theorized to help service users to develop self-advocacy skills and build confidence to pursue their goals through establishing trust and rapport built on shared experiences. A recent review of 20 studies of peer support services concluded that

peer support is associated with improved quality of life, hopefulness, activation[20], and therapeutic relationships and reduced inpatient hospital use [55].

Optum Pierce has been recognized as a national leader in its use of peer support services across its service network, employing approximately 200 peer support specialists in a range of settings. In a recent national review of peer support services commissioned by the U.S. Department and Health and Human Services Assistant Secretary for Planning and Evaluation, Optum Pierce was highlighted as an organization that has successfully integrated peer support throughout its services, particularly in regard to services designed to reduce inpatient hospitalization and emergency room use [56]. According to the report[21], the infusion of peer support services into their service network has resulted in an estimated $21,600,000 cost savings in Pierce County, with much of this savings attributed to reduced hospitalization [57].

Optum's peer services include the Community Builders program, designed to help individuals transition from residential treatment to independent housing, and the Peer Bridger program (described in greater detail later in this report), designed to connect individuals transitioning from inpatient settings back to the community. A Recovery Support Line[22], staffed by peer specialists at Recovery Innovations, provides non-emergency peer-to-peer support between 3pm and 11pm seven days per week regardless of payer type. Peer support services are also available in a number of emergency rooms in the County, and these are discussed in a later section as well. This year, Optum contracted with Multicare Good Samaritan Outreach Services to provide peer support services through the MOCT with the goal of establishing trust and rapport with individuals in crisis and providing education to individuals and their families.

Feedback we gathered from key informants as well as through the SPES-CM and SPES-SU indicate that although the BHO's peer support network is relatively robust, there remains additional need for peer-delivered services. As one peer specialist put it, "There's much more that we could do." In the SPES (described in detail in Appendix D), 46% of service users and 69% of case managers identified an unmet need for peer support services among service users within the BHO network. The primary reasons for these unmet needs differed by respondent type: 81% of case managers attributed it to service users refusing the services, whereas service users attributed it to a variety of factors, the most common being that they were not offered the service.

Key informants noted that there are insufficient positions for peer staff members who can be available to work with individuals in the community to connect to services and supports, both clinical and non-clinical. This includes services like the Peer Bridger and Community Builders programs but also more flexible community-based peer supports, such as support getting people connected to dental and vision appointments and support with transportation needs. Perhaps because of a perceived need for peer support services across the service spectrum, several key informants voiced that the Peer Bridger program is too short in duration and not intensive enough to meet the complex needs of individuals returning to the community from hospitalizations.

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[20] "Patient Activation" is a widely recognized concept that describes the knowledge, skills and confidence a person has in managing their own health and health care

[21] *An Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions*, available at https://aspe.hhs.gov/sites/default/files/pdf/205411/PeerSupServ.pdf

[22] 1-877-780-5222 and 1-253-942-5655

Social Support Services

Key informants emphasized the importance of services that support social determinants of health, including housing stability, economic well-being, and community integration. This assertion is consistent with the conclusions from seminal reports released at the federal level in recent years, notably SAMHSA's *Description of a Good and Modern Mental Health and Addictions System*, which outlines a rationale for a continuum of social support services that include employment, housing, and self-help alongside clinical treatment [58].

Employment Supports

Research suggests that people with serious mental health conditions—even many who are psychiatrically disabled—want to work. Further, research suggests that if given adequate supports, people with serious mental health conditions are capable of attaining and maintaining competitive employment [59, 60]. However, despite the desire and capacity to work, people with psychiatric disabilities have the highest rates of unemployment among those with disabilities; nationally, an estimated 15% of people with psychiatric disabilities are employed, while 65% of this population name employment as a goal [61]. In Pierce County, 13.9% of working-age adults who received publicly funded outpatient mental health services were employed at any time in 2015.[23]

> People with psychiatric disabilities have the highest rates of unemployment among those with disabilities.
>
> In Pierce County, 13.9% of working-age adults who received publicly funded outpatient mental health services were employed in 2015.

Nationwide, people with behavioral health conditions face significant challenges finding and maintaining employment, including a lack of appropriate support services, labor force discrimination, work disincentives caused by state and federal policies, and ineffective work incentive programs [62]. Key informants identified several of these issues as significant in Pierce County.

There are few employment support services available in Pierce County, and supported employment is not currently a Medicaid reimbursable service. Supported employment involves provision of support services to assist individuals with serious mental health conditions to locate, attain, and maintain competitive employment in the community. Individualized Placement and Support (IPS) is an evidence-based supported employment program that has been shown to help individuals achieve employment and retain that employment over time [63]. The Medicaid Transformation Waiver includes creating a supported employment benefit based on IPS [64]. Target populations will include individuals with serious mental health conditions, substance use disorders, or co-occurring mental health and substance use disorders, as well as youth in transition who have a behavioral health diagnosis [65].

Optum does not contract for any employment support services; however, it does report some collaboration with local vocational rehabilitation programs. Another key informant indicated that there is minimal collaboration and coordination between behavioral health services and the Department of Vocational Rehabilitation.

[23] SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

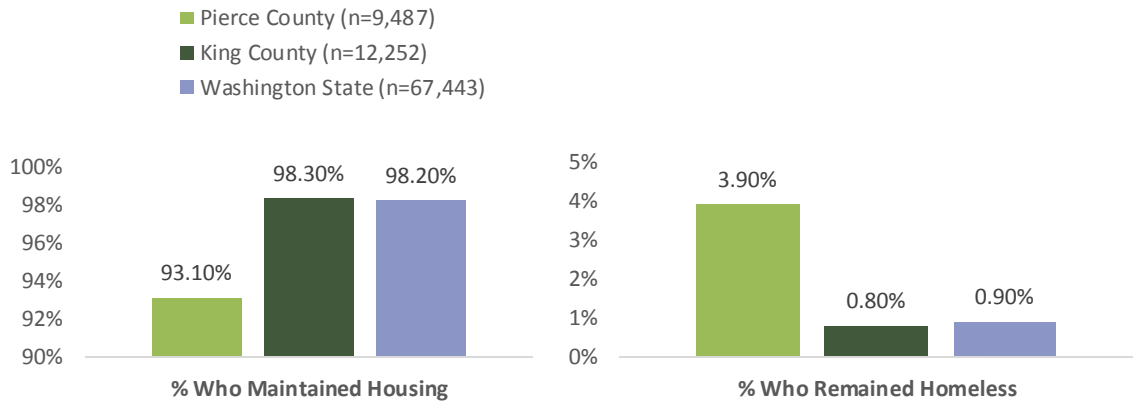
Key informants and SPES respondents articulated unmet needs for job development and skill building. In the SPES, 19 service users identified a need for employment supports, and case managers indicated that 35 individuals had a need for supported employment, with a majority of those needs unmet. One unemployed service user interviewed reported that in his/her lengthy experience receiving behavioral health services, employment was never discussed. Another key informant described meeting service users who had given up on obtaining employment because the process was too difficult. Key informants also identified a need for education and resources for employers regarding supporting employees who have mental health issues to reduce stigma, promote the use of reasonable accommodations, and increase hiring of people with mental health conditions.

Housing Supports

Nearly all key informants indicated that unstable housing and homelessness has a negative impact on behavioral health outcomes as well as access to appropriate treatment for many Pierce County residents. This was the most commonly cited challenge in our key informant interviews. Housing was named "the number one unmet need" for people with behavioral health issues. Another key informant noted, "Housing is a cornerstone for people to access services and sustain treatment programs." Key informants said that individuals leaving residential substance use disorder treatment programs who are discharged to the community without a stable place to live are at particularly high risk of beginning the cycle of addiction again; in the words of a formerly homeless person, "No one gets clean on the streets."

An examination of data from the SCOPE-WA system indicates that gaining and maintaining housing is particularly challenging among users of publicly funded outpatient mental health services in Pierce County. As shown in Figure 11, a smaller proportion of adult outpatient mental health service recipients maintained housing over the course of 2015: 93.1% in Pierce County compared with 98.2% statewide. Among those who were homeless, a larger proportion of those in Pierce County remained homeless than those statewide; in Pierce County, 3.9% (366 mental health service users) compared with just 0.9% statewide.

Figure 11. Percentage of Adult Outpatient Service Recipients Who Maintained Housing and the Percentage Who Remained Homeless in 2015



Source: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016). Note: Sample includes all adult publicly funded mental health outpatient service recipients who had two or more recorded living situations in 2015.

These figures likely underestimate behavioral health needs of individuals who are homeless as they include only those who received some outpatient mental health treatment and, importantly, do not include those with unmet mental health treatment needs and those who use substance use services but not mental health services.

There at least two important aspects of housing and behavioral health. The first is the lack of affordable housing units in Pierce County in general, which impacts those with behavioral health needs who are homeless. According to a report of the Washington State Department of Commerce, there are approximately 10 available and affordable housing units for every 100 households earning 30% or less than the median family income, which was approximately $17,732 in 2015 [66]. Most individuals who rely on public benefits fall into this low-income group, as do those who are unemployed (as noted above, only 13.9% of working-age adults who received publicly funded outpatient mental health services were employed in 2015).

A second related issue is a lack of supportive services geared toward helping individuals with behavioral health issues maintain stable housing in the community. As several key informants noted, for many individuals, supportive, wraparound services are needed alongside housing to ensure that housing placements can be maintained over time. Community Connections, the lead housing provider in the County, noted that the highest rate of return to homelessness after housing is among people with behavioral health issues. This outcome may be related to inadequate housing support services as well as limited availability of and access to outpatient mental health treatment services.

Community Connections, the agency that supports a range human services throughout Pierce County, coordinates an array of services aimed at helping individuals to maintain, reestablish, or obtain housing, both short-term and long-term. Some of its services are described on the following page.

Table 2. Housing Outreach and Support Services in Pierce County

Program	Description	Capacity/ Utilization	Approximate Cost	Impact
Diversion	Work with families to stabilize and reestablish housing	235 families in 2015	$1,300 to re-house within 30 days	5% average return-to-homelessness rate
Emergency Shelter	Temporary (up to 90 days) beds for families and individuals	550 beds available year-round, 300 seasonal beds	$1,500 per individual per stay	80% of guests exit to an unknown destination or homelessness
Rapid Rehousing	Rent support and supportive services to move homeless individuals back into housing (average 6 months stay)	550 households in 2015	$4,750 per household per stay	Average return to homelessness rate of 18% (consistent with national average)
Permanent Supportive Housing	Scattered site and project-based housing connected to long-term supportive services (including mental health and substance use disorder treatment) for those who are chronically homeless	380 units	$13,000 per year per unit	Average housing retention of four years with the longest residencies over 10 years; 6% of PSH return to homelessness after leaving housing
Positive Interactions	24-hour hotline for businesses and outreach and engagement to individuals who are homeless in Tacoma, financed by the MHCD Tax	249 hours of business outreach and 119 hours of direct client outreach in the first six months of 2016	$120,000 per year in staffing costs	In first six months of 2016: 12 business property clean-ups 283 individuals connected to services and 30 connected with housing services
Projects for Assistance in Transition from Homelessness (PATH)	Outreach and support for individuals with serious mental health conditions who are homeless or at risk of homelessness, funded by SAMHSA	185 clients per program	$100,000 per year per program in staffing costs	Between October 2014 and December 2015, 182 individuals received mental health services and 29 persons attained housing in one program

Source: Pierce County Community Connections, Comprehensive Life Resources, and Greater Lakes Mental Health Care

Individuals with behavioral health conditions may access any of the above services, but those with more significant behavioral health treatment needs are typically referred into Permanent Supportive Housing (PSH). PSH is an evidence-based practice involving the provision of support services alongside independent housing for individuals with serious mental health and substance use disorders. Numerous studies, including seven randomized controlled trials, have documented that PSH decreases homelessness, lengthens housing tenure, and reduces inpatient and emergency department utilization. Moreover, service users consistently rate PSH as preferable to other housing models [67]. A recently published report described similar outcomes for the Permanent Options for Recovery-Centered Housing (PORCH) program, a Pierce County PSH program funded by a SAMHSA Mental Health Transformation Grant [68]. The Positive Interactions program and PATH also provide critical outreach and engagement services to people who are homeless. In particular, the PATH program is part of a national initiative to address the housing needs of people who are homeless.

About half of Pierce County's 380 PSH units are located in the city of Tacoma, with the remaining units located in University Place, Lakewood, Puyallup, Fircrest, and Spanaway.[24] Currently, the services component of PSH is financed through a combination of funding sources, including a federal SAMHSA grant, BHO Community Reinvestment Funds, and Medicaid for specific behavioral health service modalities that are reimbursable, such as peer support. The Tacoma Mental Health and Chemical Dependency Tax (described in Appendix C) also funds some PSH services (it cannot be used to fund units) in Tacoma. Although Medicaid covers supported housing in some states, it is not yet included in Washington state's Medicaid benefit. However, the Washington State Medicaid Transformation Waiver includes establishing a Medicaid benefit for supportive housing services to support individuals to prepare for, transition to, and maintain housing in community settings [69]. Eligible populations would include adults 18 or older who have frequent or lengthy institutional contacts, including psychiatric inpatient hospitalizations [70].

Self-Help and Mutual Support Groups

One service user credited a mutual support group as instrumental in his/her network of support. Prior to involvement in this group, the person did not know where to go for resources; now, the person feels connected and supported. This story is consistent with the literature on mutual support for people with behavioral health conditions. A 2008 review of 12 studies examining the effectiveness of mutual support groups for people with mental health problems concluded that such groups are associated with positive changes in psychological and social functioning, with two studies finding that the benefits of mutual health groups were equivalent to costlier professional interventions [71]. Mutual support for individuals with substance use disorders—most notably Alcoholics Anonymous—has been associated with similar benefits [72].

> Our survey findings highlight a need to help raise awareness of available support group resources in the County.

A number of mutual support groups are available in Pierce County. NAMI Pierce County is an all-volunteer organization made up of people living with mental health conditions and family members of people living with mental health conditions. NAMI offers two weekly support groups for people with mental health conditions, and TACID oversees a peer support program with a specific focus on

[24] Community Connections; Tess Colby email

behavioral health. Although these services are freely available to anyone in the County, our SPES findings suggest that they may be underutilized. In the SPES, 25 service user respondents indicated a need for social club or drop-in services, and case managers identified a need among 47 clients. In total, 52% of service users noted that these needs were unmet, and case managers indicated 87% of the service users' needs for drop-in and social club services were unmet. While a majority of case managers attributed these reasons to service users refusing the service, service users' reasons were more varied and included that they were not offered the service, they were not aware the service existed, and they didn't know what the service was. These findings suggest a need for efforts to raise awareness among service users regarding this resource in the community.

Residential Mental Health Treatment

In regard to residential facilities, there are two levels of services for adults with serious mental health conditions in the BHO network. The 24-hour staffed residential care facilities are rehabilitative in design. Individuals typically stay in these facilities for 18 months or less and receive all services within the facility. There are three facilities of this type—one with 70 beds and the other two totaling 45 beds. Congregate care facilities function as longer-term residences and are less rehabilitative in focus. Importantly, these services are only available to individuals on Medicaid who meet Access to Care standards. As with outpatient services, there are no data sources that provide information regarding availability and utilization of privately funded residential mental health treatment. One provider representing the commercial arena noted that there are many with commercial insurance who have serious mental health conditions but no access to ongoing residential care. Anecdotally, one key informant described a family with private insurance who sent their child out of state to receive residential behavioral health treatment that was paid for out-of-pocket because there were no options for the family in Pierce County.

Crisis and Inpatient Services

The BHO provides crisis services to any individual who needs them in Pierce County, regardless of payer source. As noted in Section 3, for many in crisis in Pierce County, the first step is to call the Crisis Line, which may result in evaluation by the Mobile Outreach Crisis Team (MOCT). For others in crisis, the first contact may be with first responders. Others may present at a hospital emergency room or a crisis alternative program such as the Recovery Response Center. If individuals are determined to be in need of voluntary or involuntary inpatient treatment, they may receive that treatment at an Evaluation and Treatment Center or in an inpatient hospital. Finally, those leaving inpatient hospitals may receive services to support their transition back to community living. These services are discussed in this section.

First Responders and Behavioral Health

Stakeholders made it clear that first responders—police, fire, and medical—are frequently the front line of response for behavioral health crises in Pierce County. In key informant interviews, community listening sessions, and through discussions, we heard stories of individuals with mental health or substance use issues being involved with law enforcement officers and transported to jails when treatment would have been more appropriate. Key informants emphasized a need to divert these individuals to treatment rather than bringing them to jail or to the emergency room. These discussions often involved two interventions: training and support for first responders, and

embedding mental health co-responders to work alongside police officers when their response involves mental health-related issues.

Behavioral Health Training for First Responders

Crisis Intervention Team (CIT) training is a police-based model designed to improve police officers' interactions with individuals in mental health-related crisis. Through classroom-based and experiential training, officers learn how to deescalate crisis and redirect individuals to treatment rather than the criminal justice system. The model is used widely throughout the U.S., and research studies have documented effectiveness in diverting individuals to treatment, improving officers' attitudes toward and knowledge about mental health issues, lowering arrest rates, and reducing criminal justice system costs [73]. CIT trainings have taken place throughout Pierce County in recent years; most recently, NAMI sponsored a 40-hour CIT training with 20 Tacoma Police Department officers that was funded by the Mental Health and Chemical Dependency tax.[25] In 2015, the Washington State Legislature passed SSB 5311, establishing CIT training (8 hours of CIT training and 2 hours of refresher training each year) as a requirement for all police officers.[26] The Washington State Criminal Justice Training Commission also makes available a 40-hour CIT course to 25% of patrol officers in the state. These trainings are currently underway throughout the state, including in Pierce County.

Mental Health Co-Responder Program

One key informant, a service provider working in an unincorporated part of the County, noted a need for more mental health professional availability to assist first responders in evaluating individuals in crisis and determining the level of care needed. This individual expected that if such a resource were available, fewer people would utilize emergency departments. In Tacoma and Lakewood, such a resource is available: The Mental Health Co-Responder Program.

In the Mental Health Co-Responder Program, mental health professionals are embedded within the police department and act as "go to" resources when police identify that an individual may have a mental health-related need. The mental health professionals provide support and consultation for officers and respond alongside officers to calls that appear to be mental health-related. In Tacoma the program began in April 2015 with one co-responder, a second was hired in September 2015; both are Designated Mental Health Professionals who can make a determination to involuntarily commit a person, though this is not a requirement of the position. The co-responders have a designated office within the police department and have their own cars. The program is connected to the MOCT, and the programs are able to share information about individuals to facilitate referrals. Tacoma plans to expand to four co-responders in the coming year. Funded by the Mental Health and Chemical Dependency tax in Tacoma and a grant in Lakewood, the program costs roughly $400,000 per year.[27]

Stakeholders expressed satisfaction with the Mental Health Co-Responder programs in Lakewood and Tacoma, and it appears as though the programs have been successful in improving the capacity of law enforcement to help individuals with mental health needs and reducing trips to jails and hospitals. Between April 2015 and June 2016, the Tacoma Police Department Co-Responder Program provided services to 316 individuals. Of these, 267 were eligible for diversion from the criminal justice system. Figure 12 depicts where the 267 individuals were diverted to after

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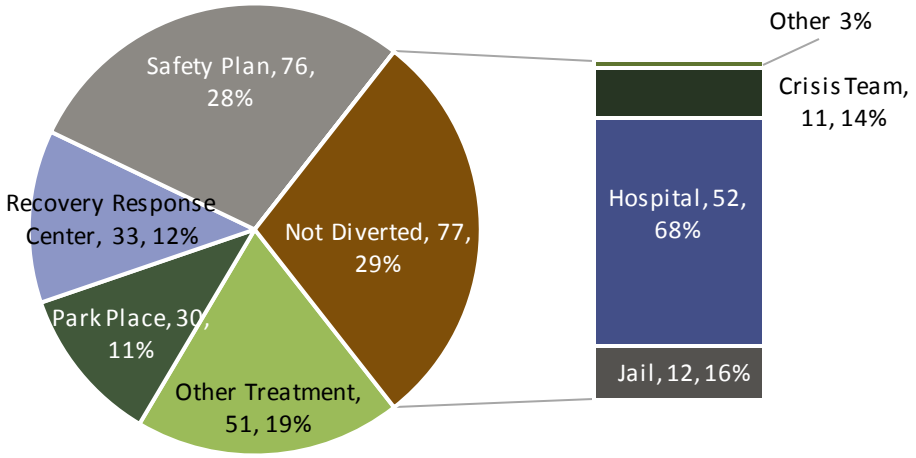
[25] Described in Appendix C

[26] https://fortress.wa.gov/cjtc/www/images/2015_New_Uploads/Advanced_Training/New%20CIT%20Training%20Requirements%20SSB%205311%20Fact%20Sheet%20-11-2015.pdf

[27] Source: Interview with former Program Coordinator, June 2016

police/co-responder contact. In total, 71% were diverted to treatment: 30 people to Park Place, a residential treatment facility operated by Comprehensive Life Resources that has beds dedicated to the Mental Health Co-Responder program; 33 people to the Recovery Response Center, a crisis residential program operated by Recovery Innovations; and 51 people to another form of mental health treatment. Another 76 individuals developed a safety plan with the co-responder. Of the 77 individuals who were not diverted, a majority were taken to the hospital (52 people), and 12 individuals were taken to jail.

Figure 12. Diversion Results from the Tacoma Police Department Co-Responder Program, April 2015 to June 2016



Source: City of Tacoma

Emergency Rooms and Crisis Alternatives

As one stakeholder emphasized, training and support for first responders to divert individuals to treatment rather than to jail are critical, but for those interventions to be effective, there need to be treatment options to divert people to. In Pierce County, stakeholders noted that such treatment options/resources are in short supply. As a result, many individuals seeking behavioral health treatment services resort to the emergency room. Table 3 depicts the proportion of emergency department encounters in Pierce County hospitals that were related to a behavioral health need based on an analysis of diagnosis codes in hospital clinical reporting systems. Approximately 8% of emergency department visits in Pierce County are related to a behavioral health need, which is consistent with national trends [74, 75].

Table 3. Behavioral Health Emergency Department (ED) Encounters in Pierce County, October 2012 to March 2014

Facility	BH Encounters	Total ED Encounters	BH as % of Total ED Encounters
Tacoma General Hospital	6,550	53,562	12.2%
Allenmore Hospital	3,206	26,458	12.1%
Good Samaritan Hospital	8,503	80,824	10.5%
St. Joseph Medical Center	5,852	73,634	7.9%
St. Clare Hospital	3,479	65,925	5.3%
St. Anthony Hospital	1,090	33,715	3.2%
Mary Bridge Children's Hospital	1,164	41,414	2.8%
Total	**29,844**	**375532**	**7.9%**

Source: Multicare CHI Franciscan Certificate of Need. Note: "BH Encounters" were derived from Behavioral Health ICD-9 Diagnosis codes within the hospitals' clinical reporting systems

There are some behavioral health resources for individuals who present in Pierce County emergency rooms with behavioral health-related needs. Psychiatric assessment teams are available in most emergency rooms to determine whether individuals should be held involuntarily (involuntary commitments are discussed further below). Additionally, the BHO contracts with both Greater Lakes Mental Healthcare and Multicare Good Samaritan Outreach Services to provide peer support services in the emergency rooms at Multicare Good Samaritan Hospital, St. Joseph Medical Center, and St. Clare Hospital. As shown in Table 4, Optum Pierce reports that the peer specialists see between 37 and 50 individuals per month, and between 4% and 13% of those who receive peer services in the emergency department are ultimately psychiatrically hospitalized.

Table 4. Peers in the Emergency Department Program Outcomes, July 1, 2015 to March 31, 2016

Program	Average # of Peer Support Contacts per Month	Hospitalizations	Hospitalization Rate
Multicare Good Samaritan Hospital	49	17	4%
St. Joseph Medical Center	50	51	11%
St. Clare Hospital (program began in early 2016)	37	10	13%

Source: Optum Pierce

Although stakeholders expressed that resources within emergency rooms such as psychiatric assessment teams and peer support services were generally effective, they also noted that they were in short supply. Additionally, they noted that the current volume of behavioral health needs in the emergency room places stress on emergency room staff, who don't have adequate training in this area. These circumstances may result in negative outcomes for individuals, such as being restrained in an emergency room for hours or days awaiting transfer to an Evaluation and Treatment Center (discussed in a separate section below).

These inefficiencies and challenges with the current reliance on emergency departments for behavioral health crises led stakeholders to express a need for other options. Several stakeholders expressed a need for a "receiving center" or "crisis triage center" that can accommodate those with

high acuity needs as well as individuals with lower acuity needs who may be headed toward crisis. Such centers could serve as a point of connection to a range of resources, including community-based services. CHI Franciscan and Multicare are considering plans to include a crisis stabilization unit as part of the planned hospital (discussed below), although it would require additional funding.

Key informants also spoke of a need for a full continuum of services ranging from voluntary services to intensive support services for individuals before they are in full-blown crisis. Recovery Response Center, operated by Recovery Innovations and located in Fife, is one such resource. The Recovery Response Center follows a "living room model," wherein peer specialists (who comprise 70% of the staff team) work alongside clinicians to provide support in a homelike setting. Individuals are referred to the Recovery Response Center by first responders and emergency departments, and the program serves approximately 2,500 guests per year. Optum estimates that the Recovery Response Center has reduced inpatient and emergency admissions by 32.3% and readmissions by 26.5% over three years [76]. One key informant felt that the supports available at the Recovery Response Center may not be intensive enough to meet the needs of some individuals headed toward crisis, and another key informant noted that the Recovery Response Center is in too remote a location to be an effective option for many Pierce County residents. For these reasons, law enforcement may be less likely to transport individuals there.

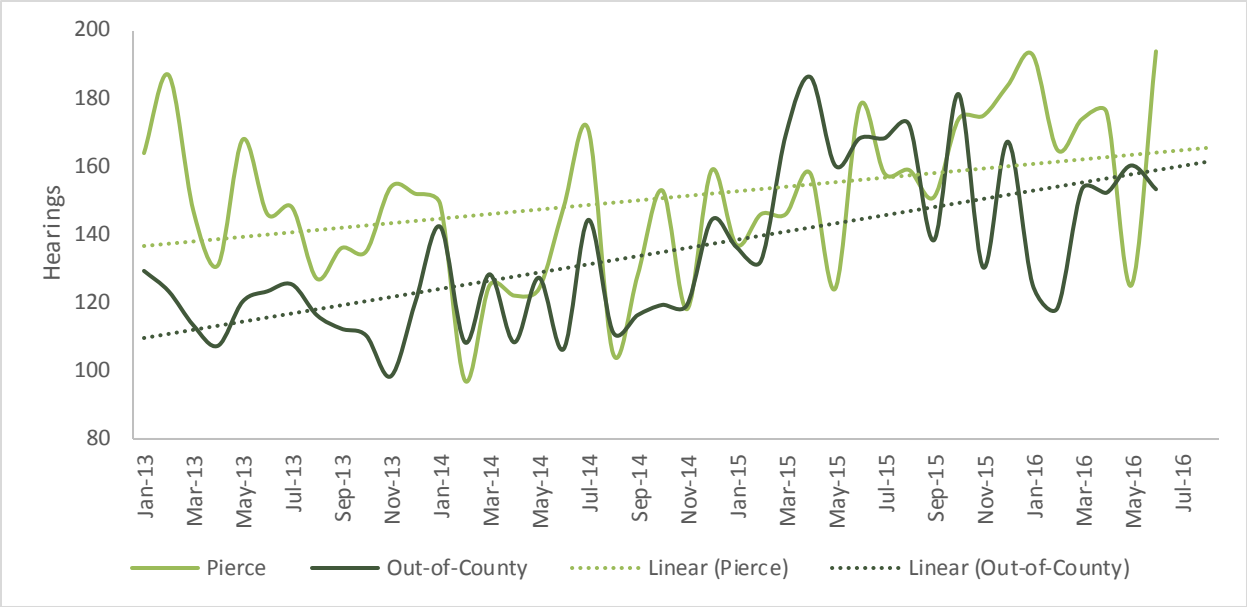
Evaluation and Treatment Centers and Inpatient Hospitals

Those who have been assessed as meeting criteria for involuntary commitment[28] may be detained involuntarily at emergency rooms or Evaluation & Treatment centers (E&Ts) for 72 hours. Pierce County has four 16-bed E&Ts, and these facilities are often the first stop for individuals who have been assessed as meeting criteria for involuntary commitment. Individuals may be detained involuntarily at the E&Ts for 72 hours, and if more treatment is deemed necessary, providers can petition the courts for a 14-day hold.

If individuals require even more treatment, they may be transferred to a community hospital or to Western State Hospital (WSH) for a 90-day commitment. If there are no available inpatient beds, however, individuals may remain at the E&Ts during this extended period. In these circumstances, the E&Ts must apply to get a single bed certification for 30 days at a time. Key informants identified that limited inpatient capacity leads to "bottlenecks" at the four E&Ts. Further contributing to this limited capacity, according to key informants, is that E&Ts are accessible by people from all over the state, not just Pierce County. As depicted in Figure 13, the numbers of involuntary treatment hearings at the Pierce County Superior Court have increased in recent years. Further, out-of-county petitions at WSH and Pierce County's E&Ts have seen a modest increase relative to Pierce County-based petitions.

[28] In Washington State, a person can be involuntarily detained on any of three grounds: likelihood of serious harm to others, likelihood of serious harm to self, or grave disability, defined as "a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety" http://app.leg.wa.gov/rcw/default.aspx?cite=71.05

Figure 13. Pierce County Superior Court Involuntary Treatment Hearings by County, January 2013 to June 2016



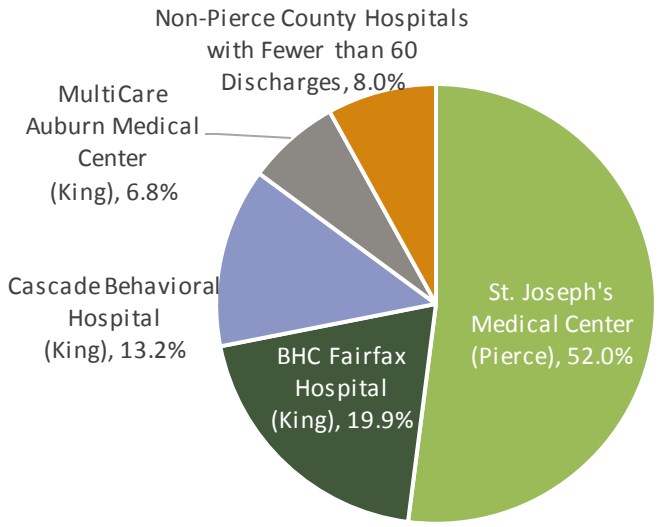
Source: Pierce County Superior Court

Another reason for these "bottlenecks" may be related to there being few treatment resources in the community to aid in hospital diversion. When individuals involved in misdemeanor courts are determined to be not competent to stand trial, individuals may either be detained and processed through the courts for a civil detainment, or they may be released back into the community. Key informants from the courts noted that this puts them in a difficult position because there are minimal community services to which they can release people. In other words, there is a perception among those in the court system that there are no services between "nothing" and involuntary institutional care. Key informants in the community observed a similar dynamic, with individuals being sent from the courts directly to inpatient hospitals instead of being referred to less intensive services that may be more appropriate.

A 2014 study ranked Washington state as having the third fewest psychiatric inpatient beds per capita, 8.3 beds per 100,000 people compared with the national average of 26.1 beds per 100,000 [77]. In Pierce County, CHI Franciscan operates a 23-bed inpatient psychiatric unit at St. Joseph Medical Center in Tacoma, which is the only such facility in the County. Pierce County's psychiatric inpatient bed ratio is 2.8 per 100,000. This ratio is the lowest among counties in Washington State with any psychiatric beds.

As depicted in Figure 14, Pierce County residents receive inpatient psychiatric services in several hospitals, some of which are located in Pierce County and some of which are not. In 2015, approximately half of inpatient psychiatric hospitalizations of Pierce County residents were provided at Saint Joseph's Medical Center, and the remaining half were provided in psychiatric hospitals in King County and elsewhere in the state.

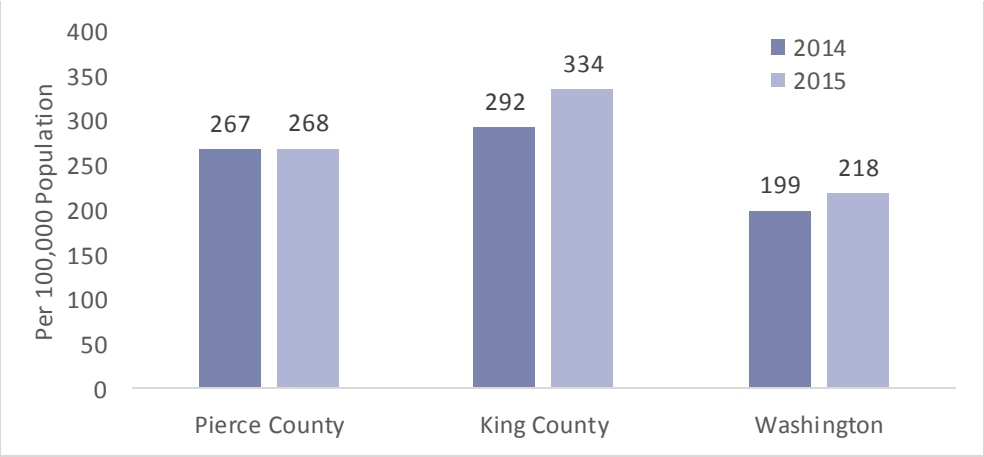
Figure 14. Pierce County Residents' Psychiatric Inpatient Utilization, By Hospital and Hospital County, 2015 (discharge n=2,264)



Source: 2015 CHARS Reports, Patient Origin Both Census and Charges by Zip Code. Notes: Includes all Pierce County residents (WA ST County=27) where CHARS Units=Psychiatric or Psychiatric Unit. Data from St. Joseph's were not included in CHARS reports and were provided by the hospital directly

Another way of understanding psychiatric bed utilization in Pierce County is to examine the penetration rate, meaning the proportion of the population that used the services. In 2015, Pierce County residents' inpatient penetration rates were lower than those of King County but higher than the state average, despite Pierce County's more limited inpatient bed capacity.

Figure 15. Psychiatric Inpatient Discharges per 100,000 Population by County and State, 2015 and 2014



Source: CHARS Reports FY 2014, Patient Origin Both Census and Charges by Zip Code. Notes: Data from St. Joseph's were not included in CHARS reports and were provided by the hospital directly; Includes patient discharges for CHARS unit 'Psychiatric Unit' and 'Psychiatric'

Earlier this year, CHI Franciscan and Multicare received a certificate of need approval from the Washington State DSHS to open a 120-bed psychiatric hospital on the current Allenmore Hospital site in Tacoma. Scheduled to open by the end of 2018, the hospitals were approved to spend $40.5 million to build the facility. It will include a mix of voluntary and involuntary beds, and hospital administrators expect the average length of stay will be 7 days, according to the Certificate of Need completed by the two health systems last year. Individuals from across the state will have access to the hospital, although the BHO or the state may purchase bed capacity reserved for Pierce County residents. Key informants noted the collaboration between two major health systems to pursue solutions to community problems as a positive step for the County as a whole. Key informants also expected that the addition of the new hospital will have a significant impact on the community, including relieving some of the bottlenecks at E&Ts and reducing the number of behavioral health encounters in emergency rooms. Without appropriate outpatient support after discharge, however, it is possible that these new beds will "bottleneck" as well.

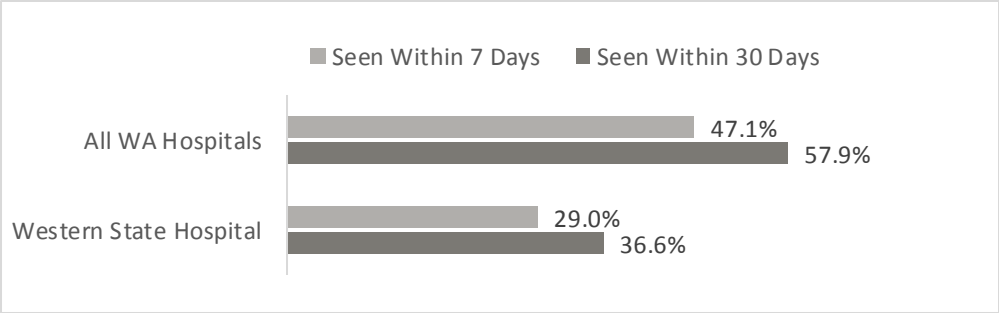
Services Supporting Transition from Institutions to Community

Services that support transition from inpatient treatment to community-based settings have received increasing focus in recent years. Such services are recognized as a critical step in the provision of inpatient care as they create linkages between inpatient and outpatient care environments and have a goal of reducing recidivism and system costs associated with avoidable readmissions.

The previously mentioned Peer Bridger program is a short-term intervention intended to serve as a "bridge" back to the community after a psychiatric hospitalization. It typically involves visits with a peer specialist to establish a relationship and rapport, create a transition plan, and connect individuals with appropriate outpatient services. Peer Bridger support is typically provided for 7 days, but can be extended for up to 14 to 30 days if there is a specific need. Optum reported that its Peer Bridger programs in New York and Wisconsin resulted in 30% reductions in inpatient days and health cost savings of 24% [78]. In Pierce County, Peer Bridgers are stationed at each of the four E&Ts and are available to Medicaid enrollees only. Thus individuals with Medicare, private insurance, and those who are uninsured do not have access to this resource.

Key informants also spoke of a need for additional transition services, particularly for those not eligible for the Peer Bridger program. In particular, key informants highlighted a need for more comprehensive, population-specific, culturally relevant transition services for veterans and for individuals being discharged from WSH into Pierce County. Examination of data from the SCOPE-WA system shows that among people discharged from WSH in 2015, 29% were seen in publicly funded outpatient services seven days following discharge, and 36.6% were seen within 30 days of discharge. These figures are significantly lower than for all hospitals in the state.

Figure 16. Percentage of Individuals Discharged from WA Hospitals Seen in Publicly Funded Outpatient Services Within 7 and 30 Days of Discharge in 2015



Source: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016). Note: This figure does not include individuals who receive outpatient services outside of the publicly funded system, such as services paid for through private insurance

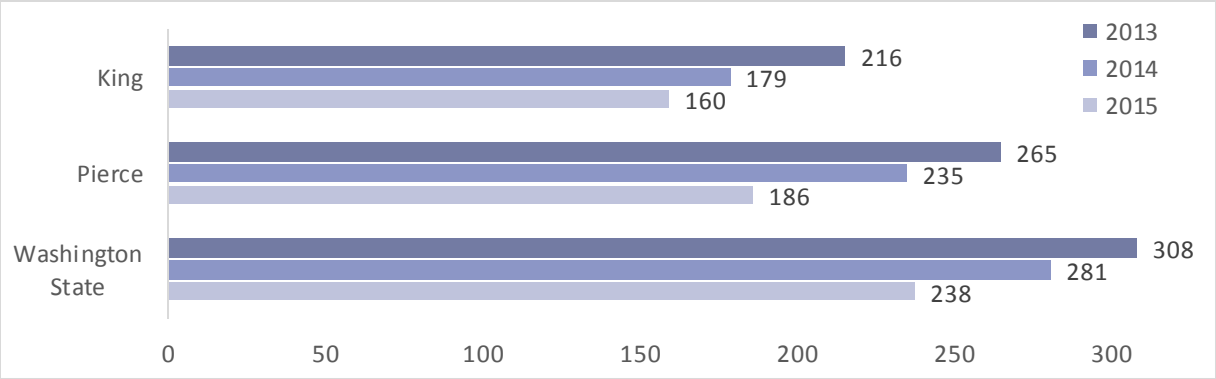
The PAR initiative includes an effort to expand the Peer Bridger program to people outside of the BHO system regardless of payer type. The PAR director noted that in order to accomplish this goal, it will be necessary to establish funding support and to develop shared data monitoring strategies between the BHO and private pay systems. Such cross-system data sharing is one of several implementation recommendations that will be discussed in Section 6 of this report.

Substance Use Disorder Treatment

As described in Appendix C, the integration of mental health and substance use disorder (SUD) treatment services in April 2016 represented a major shift in the way SUD treatment is financed and organized in Pierce County. This transition is very much still underway as the BHO only recently assumed responsibility for the majority of SUD treatment in the County. In Pierce County, Outpatient SUD treatment services include diagnostic and assessment services and substance use counseling. Opiate substitution treatment, which includes counseling and administration of methadone or other approved substitute drugs for individuals who are dependent on opiates, is also part of the outpatient SUD service array in Pierce County. More intensive services include acute detoxification services and withdrawal management services. A number of specialized programs are targeted to particular groups, including youth and pregnant and parenting women.

Figure 17 depicts the number per 100,000 population of youth who received any outpatient SUD treatment services in King and Pierce Counties and the State. In Washington State, the number of publicly funded outpatient treatment admissions for youth declined between 2013 and 2015, a trend that was evident in both Pierce and King Counties. In 2015, 186 youth for every 100,000 in the youth population received any outpatient SUD treatment, 29.8% fewer than in 2013. A small number of youth (75) also received residential substance use disorder treatment in Pierce County in 2015, which is consistent with the state penetration rate for this service.

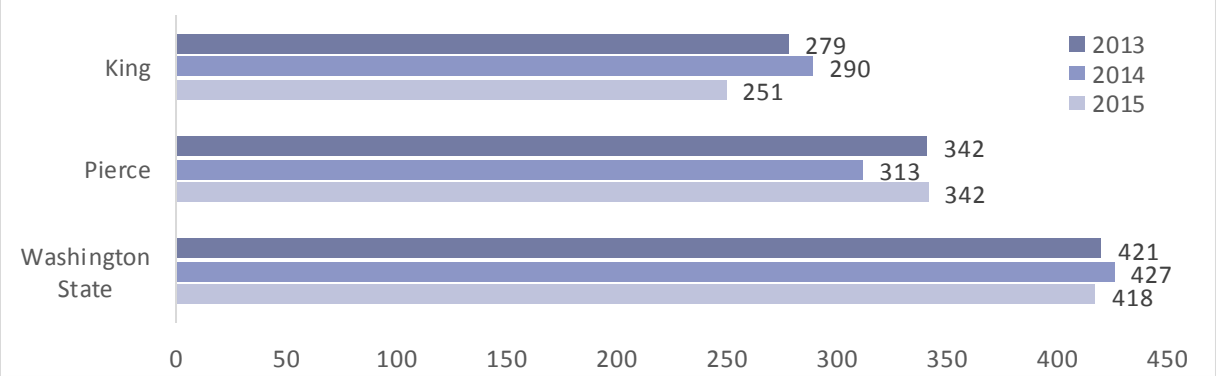
Figure 17. Number of Youth (under 18) per 100,000 Population Who Received Any Publicly Funded Outpatient SUD Treatment, 2013 to 2015



Sources: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016) for service estimates and U.S. Census Bureau, Population Division Release Date: June 2016 for population estimates. Note: Does not include admissions paid for by the Department of Corrections or private-pay admissions.

This statewide reduction in youth SUD treatment was not observed for the adult population, whose rates of publicly funded outpatient SUD treatment remained fairly consistent between 2013 and 2015 in Pierce County (Figure 18).

Figure 18. Number of Adults (Age 18+) per 100,000 Population Who Received Any Outpatient SUD Treatment, 2013 to 2015

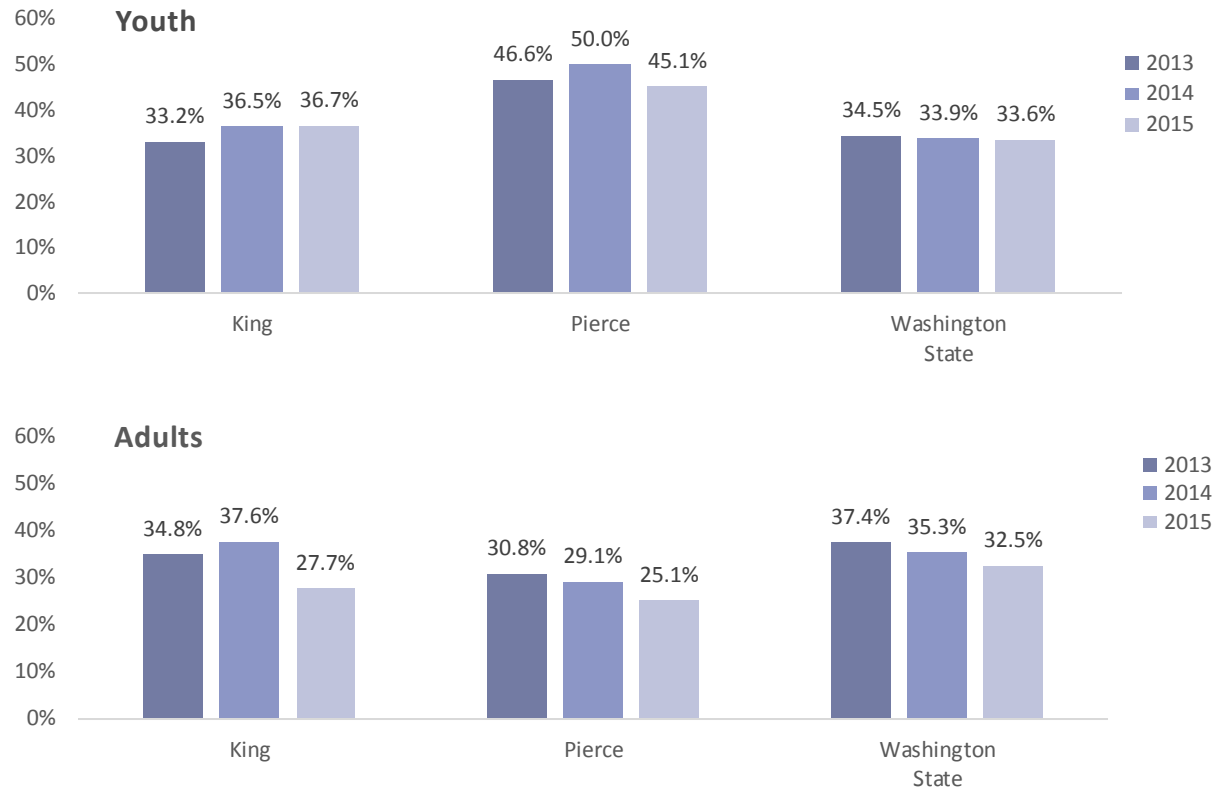


Sources: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016) for service estimates and U.S. Census Bureau, Population Division Release Date: June 2016 for population estimates. Notes: Does not include admissions paid for by the Department of Corrections or private-pay admissions.

In addition to outpatient treatment, 830 Pierce County residents were admitted into residential SUD treatment in 2015, and 660 were admitted into a detoxification service; these figures are consistent with state utilization rates. Even accounting for residential and detox use and privately funded services that are not captured in the above figures, the rates of SUD treatment utilization are likely to be well below the estimated prevalence rates for substance use disorders among youth and adults in Pierce County, which range between 2.1% and 13.7% depending on age and primary substance.

In addition to low rates of any SUD treatment utilization, the rates of outpatient treatment completion suggest that even among those who receive treatment, a sizable proportion do not complete that treatment (Figure 19). Fewer than half of adults across the state complete publicly funded outpatient treatment, and this number has fallen to approximately one in four adults completing outpatient treatment in Pierce County in 2015. A slightly higher proportion of youth complete treatment, and Pierce County youth complete treatment at higher rates than youth in King County and in the state on average.

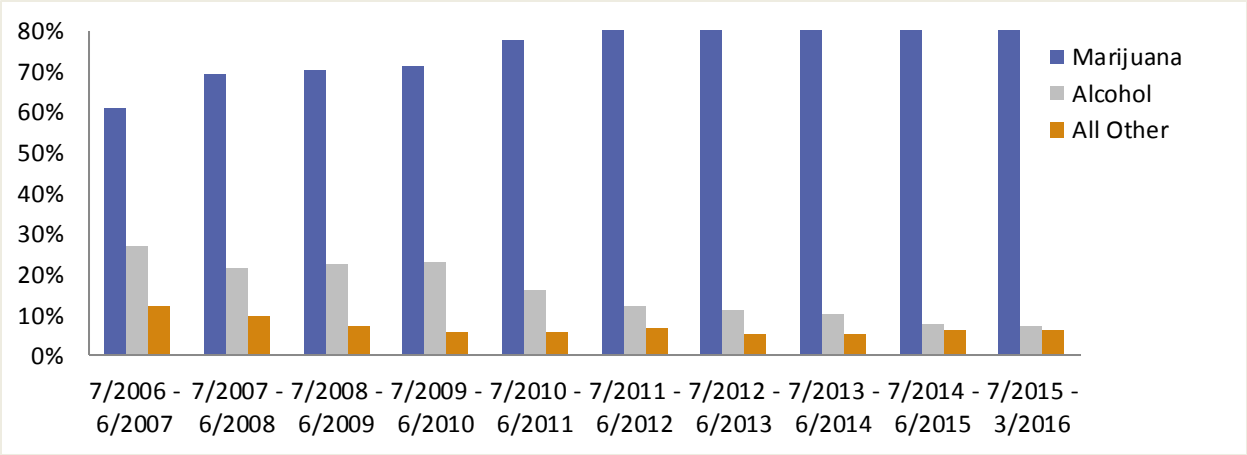
Figure 19. Percent of Youth (under 18) and Adults (Age 18+) Completing Publicly Funded Outpatient Treatment, 2013-2015



Source: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

Among Pierce County individuals who received publicly funded treatment for a substance use disorder, the primary drug used differed by age group, as depicted in Figures 20 and 21. For a majority of youth, the primary substance used is marijuana, with alcohol decreasing steadily as the primary substance since 2006. Other substances, including heroin and other opioids, account for a relatively small proportion of outpatient admissions.

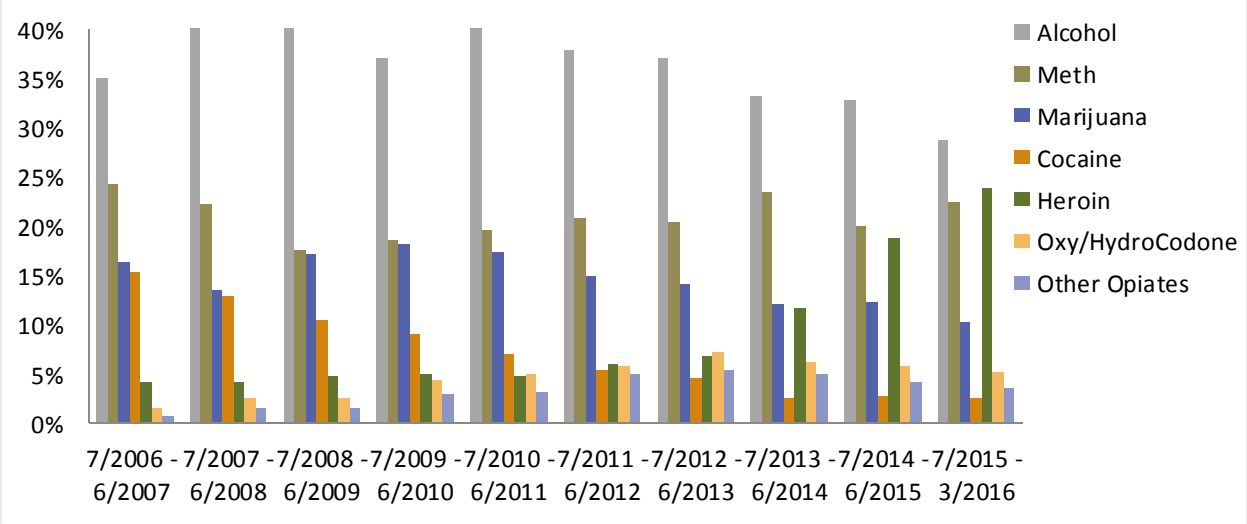
Figure 20. Primary Substance Used Among Youth (under Age 18) Publicly Funded Outpatient SUD Admissions, 2006 to 2016



Source: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

For youth, rates of treatment for marijuana dependence or abuse increased steadily in the past ten years, while alcohol treatment rates steadily decreased.

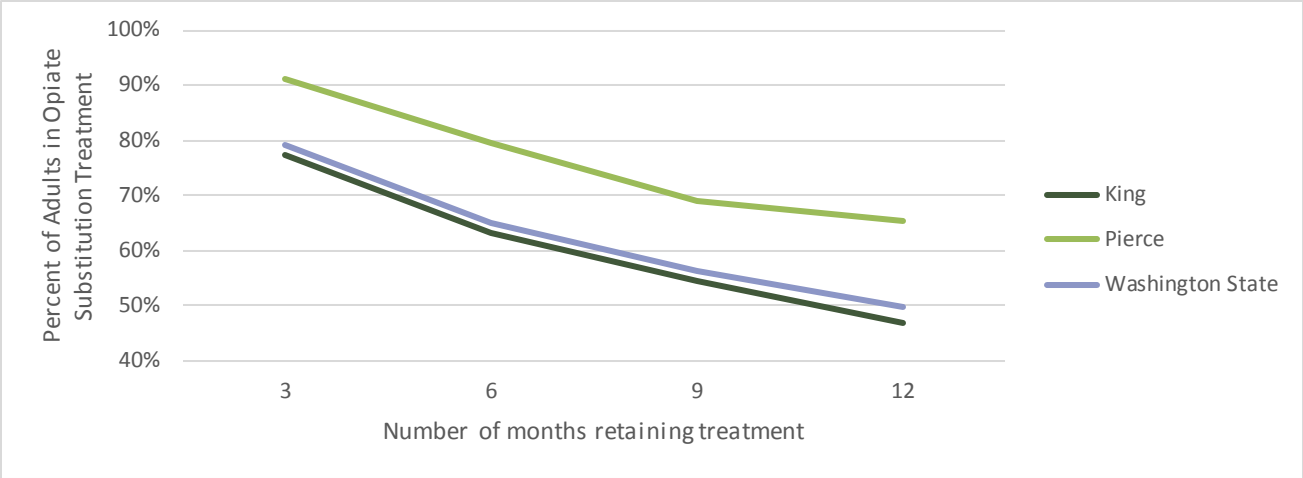
Figure 21. Primary Substance Used Among Adult Outpatient SUD Admissions, 2006 to 2016



Sources: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

For adults, there has been a marked increase in rates of heroin use, particularly in the past three years. Pierce County has been relatively successful compared to King County and the state in retaining adults in opiate substitution treatment over time. Figure 22 presents the percent of adults in Pierce and King Counties and the state who remained in opiate substitution treatment at three, six, nine, and twelve months.

Figure 22. Opiate Substitution Treatment Retention by Number of Months Retaining Treatment, 2014



Sources: SCOPE, WA State DSHS DBHR/Looking Glass Analytics (2016)

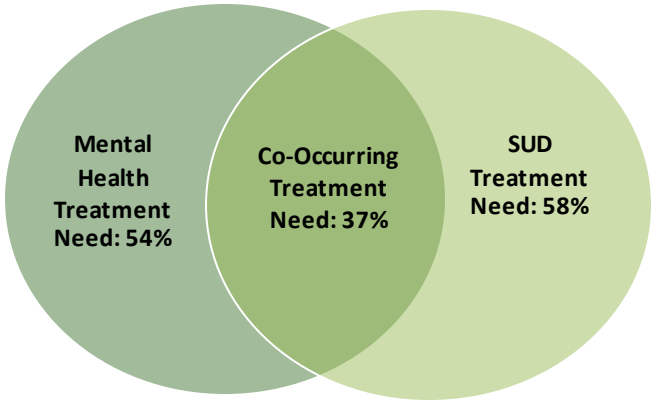
The low rates of utilization and completion in Pierce County and Washington State, while certainly concerning, are consistent with national research that has documented that SUD treatment ranks lowest among a range of medical conditions in terms of minimally adequate amounts and quality of care [79]. Many key informants noted that SUD services were underfunded compared to mental health services across the service spectrum, and this is true nationwide. This sentiment appears to be consistent with the conclusions of the Chemical Dependency/Mental Health Integration Workgroup of the Washington State Adult Behavioral Health System (ABHS) Task Force[29], which described a need to bring SUD services in alignment with mental health services.

Behavioral Health and Criminal Justice System Initiatives

A recent analysis of 2013 Medicaid claims data examined behavioral health treatment needs for the subset of individuals booked into Washington State jails who were enrolled in Medicaid the prior year [80]. In Pierce County, 34% of the 12,421 individuals booked into jail had prior Medicaid enrollment. Treatment needs of that subgroup are depicted in Figure 23. These figures are consistent with the percentage of inmates with behavioral health needs in Washington State.

[29] The ABHS Task Force is described in Appendix C and referenced throughout this report. The final report of the ABHS Task Force can be downloaded at: http://leg.wa.gov/JointCommittees/Archive/ABHS/Documents/ABHS%20TF%20Final%20Report.pdf

Figure 23. Behavioral Health Treatment Needs of Medicaid Enrollees Booked into Jail in Pierce County in 2013 (n=4,235)



Source: Washington State DSHS Research and Data Analysis Division

Behavioral health needs are also prevalent among justice-involved youth. According to Pierce County juvenile court officials, 20% to 40% of youth detained in Pierce County need a mental health referral [81].Several recent reports and initiatives in Pierce County have described the importance of collaborations between courts, criminal justice entities, and behavioral health treatment providers. There are a number of current and planned initiatives, described below, to meet the behavioral health needs of justice-involved individuals in Pierce County.

Therapeutic Courts

Therapeutic courts provide an opportunity for individuals charged with crimes to participate in court-monitored treatment instead of incarceration. Pierce County's Felony Adult Drug Court was established in 1994 and was one of the first in the country. It serves adults 18 years or older charged with felonies and operates three and a half days per week. According to key informants from the Superior Court, a majority of drug court participants are under the age of 27. The Court also operates a Family Recovery Court for parents who have been charged with child abuse or neglect as a result of substance use problems. The funding for the Family Court is year-to-year, so long-term fiscal sustainability is an issue. Key informants from the drug courts also noted that participants frequently have co-occurring mental health issues such as depression and anxiety, often related to trauma histories and experience of adverse childhood events. Key informants also observed that drug court participants who are unstably housed are less likely to be successful in drug courts than those with stable housing.

The Felony Mental Health Court for adults with serious mental health conditions who have been charged with felonies was established in February 2015. Enrollment is capped at 40 individuals. The treatment provider, a Felony Forensic Assertive Community Treatment Team (FFACT) is affiliated with Greater Lakes Mental Health. According to the key informants from the Superior Court, 84% of the current group of participants have co-occurring substance use issues. Although there is a chemical dependency professional on the mental health court treatment team, many of these individuals receive SUD treatment services in the community with no formal communication with the FFACT team. Key informants noted that individuals in mental health courts face a multitude of barriers similar to others with serious mental health conditions in the community. Such barriers include unstable housing, difficulty securing outpatient treatment (long wait times,

infrequent medication management appointments), and limited availability of co-occurring mental health/SUD treatment.

While some key informants believe that the mental health court should be more robust, others questioned a need for expanded mental health courts. For example, a key informant observed that if barriers to community treatment were removed, it is possible that many mental health court clients might have done just as well without having been involved in the courts at all; in other words, if individuals with serious mental health conditions received regular support services from the community—including jail transition support, help with housing, counseling, and medication management—there may be reduced need for a mental health court.

Jail-Provided Services and Jail Transition Program

One key informant stated, "Jail is the worst place for people with mental health conditions." And other key informants echoed similar concerns. On the other hand, some key informants noted that many receive more comprehensive mental health services in jail than in the community because there are mental health professionals in the jails providing medication management services to inmates regardless of payer source.

One important factor is that inmates who are enrolled in Medicaid lose their insurance when they go to jail. The state's ABHS Task Force discussed the issue in its 2014 and 2015 meetings, and concluded that "individuals in crisis should not have their care and support disrupted – regardless of whether they are incarcerated," noting that such termination results in barriers to treatment once released. The ABHS Task Force adopted a "high priority" recommendation that the state suspend rather than terminate Medicaid benefits [82]. A key informant from the criminal justice system also observed that young adults previously on their parents' insurance who have a no-contact order with their parents upon release need assistance getting connected to resources and navigating the system.

The BHO offers two programs that appear to be successful in supporting individuals with mental health needs in jails to return to the community: The Community Re-Entry Team and Jail Transition Services program. The Community Re-Entry Team targets individuals with mental health and or co-occurring mental health and substance use conditions who have had five or more arrests in a one-year period. Comprehensive wraparound services are provided by a mental health professional, peer specialists, nurses, and case managers. The program has reported a 76% reduction in jail recidivism to the Adult Behavioral Health System Task Force in 2015 [83].

The Jail Transition Services program, administered by Greater Lakes Mental Health, involves embedding a mental health professional, peer specialist, and case manager in the jail to engage with individuals and provide support services after their release. Such services include assistance with public benefits, housing, and transportation as well as connection to behavioral health treatment services. The program emphasizes the development of partnerships with the jail and community treatment providers. Although key informants universally endorsed the program's success, many indicated that Jail Transition Services has inadequate capacity to meet the needs of the population, and noted that its success is limited by the lack of available treatment options in the community.

District Court Behavioral Health Unit

In 2014, the County Council asked the District Court to conduct an assessment of whether to create a mental health court within the District Court. The report concluded that, rather than creating a mental health court, the District Court should establish a program to provide behavioral health

support to individuals on probation [84]. This assessment resulted in the Court's creation of a Behavioral Health Unit. Key informants from the District Court described the program for this study. In the Behavioral Health Unit, two specially trained probation officers coordinate community mental health services for District Court probationers with behavioral health issues. To be eligible for the program, individuals must have a primary mental health disorder and be in need of intense supervision. Most of the probationers in the Behavioral Health Unit have co-occurring substance use problems. Judges may recommend probationers to be screened by the Behavioral Health Unit. Ideally, individuals are connected with the Behavioral Health Unit prior to release from jail to plan for needed services; however, individuals may also be connected with the Behavioral Health Unit after jail release.

Although judges set parameters of each case, the probation officers in the Behavioral Health Unit typically have more flexibility than under traditional court arrangements to work with a person's individual needs. They have scheduled appointments with probationers but also have an open-door policy in regard to emergencies, which is not typical in most probation programs. Once a person is connected with the Behavioral Health Unit, the probation officers discuss services with the individual's providers, family members, etc. They work with individuals to map out a plan that includes getting housing, SSI, and reconnecting the person with the behavioral health system.

The Behavioral Health Unit is currently at maximum enrollment. One officer has a caseload of 60, and the other a caseload of 40 with additional time spent developing and maintaining relationships with providers in the community. Individuals are on probation between two and five years. Key informants from the District Court believed that 40 cases per officer is high given the needs of the population; a smaller caseload would enable the officers to spend more time with probationers and be more available in times of crisis. The key informants from the District Court also noted that other probationers not referred into the Behavioral Health Unit with less severe behavioral health needs could benefit from some level of behavioral health support.

One of the key informants integrally involved in the creation of this program shared some factors s/he believed to be important to the success of the program. One key element has been the development of relationships and strong communication with behavioral health service providers in the county; these relationships engage providers to act as partners in the effort. The District Court Behavioral Health Unit has been able to overcome communication barriers while working within federal privacy laws through sustained relationships with provider agencies in the community. For example, good relationships have been built between the mental health co-responders and the Behavioral Health Unit. This way, co-responders are aware that a person is connected with the Behavioral Health Unit and can alert the probation officer if they come in contact with the police. Further, it has been important to work with the BHO to identify creative solutions. For example, the Behavioral Health Unit put together a successful proposal to the BHO to permit direct referral from the Behavioral Health Unit to an outpatient program that offers intensive wraparound services, resulting in more seamless access for Behavioral Health Unit participants.

4. System Challenges

In addition to service gaps, we identified a number of challenges facing the Pierce County behavioral health system through key informant interviews and a review of the literature, including state and local reports as was as national reports and published articles. These system-wide issues and challenges are discussed in this section, and these challenges inform the recommendations presented in Section 6.

Fragmentation of Service Systems

One overarching theme that emerged from this investigation is that there is no single "behavioral health system" in Pierce County. In reality, there are multiple sub-systems that deliver specific kinds of services to specific populations, such as the BHO for Medicaid enrollees who meet Access to Care standards, private health systems, federally qualified health centers, non-profit organizations, the criminal justice system, and school districts—all providing some kind of service for individuals with behavioral health needs. While there is clearly overlap in some of the populations served by these agencies, there are also many individuals with limited or no access to any services at all, and individuals at risk of developing behavioral health issues that are unidentified and unaddressed. Although the gaps in the system are interconnected, they are not addressed in a coordinated way.

Further, individuals in need of services rarely need services from only one sub-system. For example, a high school student experiencing mental health challenges may benefit from proactive outreach and assessment through the school system, along with screening and early intervention in primary care, and a referral to specialty behavioral health services; additionally, the student's family members may need education and support to better understand the student's challenges and avoid crisis. Changes can and often do occur in Medicaid eligibility, health plan enrollment, and covered benefits, resulting in the need for a more comprehensive and coordinated "touch" with the behavioral health system at large.

This study is taking place in the midst of a number of national, state, and local initiatives that will have significant impacts on the delivery and financing of behavioral health treatment and prevention activities in the near future and in the long term in Pierce County. These initiatives are described in more detail in Appendix C and include the BHO's integration of substance use disorder and mental health treatment, the Accountable Communities of Health Initiative, and a move toward health homes for individuals with chronic health conditions, including serious mental health conditions. Many stakeholders expressed uncertainty about what these initiatives will look like in the coming years. Providers and health systems were concerned that some of their successful practices might not be sustainable in the integrated healthcare environment of the future. One key informant noted that there are many great initiatives, but sometimes it is hard to tell who is coordinating what. Another key informant noted concern about duplication of resources and initiatives absent effective coordination.

The absence of such a coordinated and cohesive system with one entity providing oversight and direction results in disconnected and bifurcated care and, ultimately, poor behavioral health outcomes—including people in crisis—and an overreliance on public responders, the criminal justice system, and crisis and emergency services. As one family member noted, "No one is on first

for county-wide behavioral health…There is no centralized body to advocate to for changes." Key informants called for a "backbone organization" to serve as a coordinator of system change and create an integrated network to move people through care. Key informants also identified a lack of opportunities for meaningful public input into service delivery systems, policies, and practices.

Although there is a need for integration and coordination across multiple silos and geographic areas, key informants also stressed that interventions that may work in one area will not work in another area. For example, exporting initiatives implemented in the Tacoma School District to other school districts without careful consideration of the local populations and context would likely be ineffective.

These findings are not novel. In 2013, the Tacoma-Pierce County Health Department conducted an assessment of the local public health system and determined that while the County's public health system "encompasses a wide web of critical service providers and partners," there is a need for increased coordination and a clearer vision in multiple areas, including policy development, education, advocacy, linking people to services, assuring a competent workforce, evaluating services, and investigating health problems [85].

Limitations of Current Data Systems

As noted throughout this report, fragmented data systems make it difficult to generate a comprehensive picture of prevalence and service utilization for all Pierce County residents. The availability of such data currently depends on payment structure, and there is no central data source for health or behavioral health in the County. While DSHS maintains a relatively comprehensive accounting of publicly funded services, this information is nonexistent for populations who are privately insured and those with public insurance receiving behavioral health treatment through the primary care system. A comprehensive picture of need and prevalence would require examining data from a multitude of sources related to screenings, prescriptions, inpatient admissions, and primary care encounter data. Currently, there are no processes in place to facilitate such coordination, nor are there incentives in place to report, store, and share data collaboratively between systems and sub-systems. Further, there are few data sources that reflect or measure system gaps pertaining to prevention, including information regarding rates of screening and behavioral interventions in schools, the criminal justice system, and other social service systems.

Key informants asserted that in order for a coordinated behavioral health system to be effective, there needs to be shared access to important data to identify gaps, take steps to close them, and track disparities system-wide. Data sharing is also needed to facilitate referrals and ensure communication between providers delivering care to the same individual. This data sharing needs to take place within the behavioral health system but also between behavioral health and other systems. One key informant stressed that both quantitative and qualitative data are important.

Disparate Access by Payer Type

As discussed in an earlier section, the uninsured, the privately insured, and those on public insurance who do not meet Access to Care standards have access to a far more limited array of outpatient behavioral health services than do those within the BHO network. However, these challenges extend beyond the availability of outpatient services. When a person is discharged from a psychiatric hospitalization and does not qualify for Medicaid, key informants noted that it is

particularly challenging to connect them with outpatient behavioral health services, including medication management and monitoring. One key informant noted that although there is a "no wrong door" system for those in immediate crisis and people on Medicaid who meet Access to Care standards, people with private insurance "can't even find the front door." The same can be said for those without insurance and those who are underinsured.

The uninsurance rate in Washington State has dropped precipitously since the expansion of Medicaid eligibility in the Affordable Care Act in 2012. However, according to a report of the Washington State Office of the Insurance Commissioner, 8.3% of Pierce County remained uninsured.[30] According to the report, this uninsured group is more likely to be younger (aged 18 to 34) and have lower income and less education. Hispanics are overrepresented among those who are uninsured, with 19.2% of Hispanics uninsured. One provider who serves a high proportion of uninsured individuals noted that the state's safety-net funding is still needed for some populations, including immigrants who are new to the country and have yet to enroll in health insurance and undocumented persons.

Even among those who are insured, many remain underinsured, facing high deductibles that limit access—particularly for behavioral health services. Key informants described limited access to medication management and individual therapy providers who accept public insurance plans. One key informant reported that it was "impossible" to find behavioral health service providers for a family member on Medicare. A service user key informant spoke about receiving very limited behavioral health benefits after switching Medicaid health plans. After enrolling in the new plan, the person lost access to services that were previously available, precipitating a psychiatric hospitalization. The person had two more psychiatric hospitalizations before getting reconnected to services. Another service user who is on an expansion plan stated "They only cover you while you are in crisis. That is a serious problem."

Prior to the integration of mental health and substance use disorder treatment services this year, individuals whose income is between 138% and 200% of the Federal Poverty Level (FPL) received publicly funded substance use disorder treatment services through the County. However, under the new integrated arrangements, these individuals are not eligible to receive these services through the BHO network. These individuals are still low income and may face challenges related to accessing affordable substance use disorder treatment services.

Finally, key informants identified that benefit disruption and frequent changing of insurance plans is a barrier to accessing treatment in a timely manner and maintaining connections to needed treatment. One key informant representing a community service provider pointed out that when individuals are first enrolled in insurance, it can be a period of weeks or months before they can be seen by a primary care physician. Once the primary care physician is seen and a referral to behavioral health services is made, it can be another several weeks before they can be seen by a behavioral health professional—so it can be a matter of months before a person with a behavioral health need is connected to services.

[30] https://www.insurance.wa.gov/about-oic/reports/commissioner-reports/documents/2014-2015-state-of-uninsured.pdf

Staffing and Workforce Shortages

Another system-level challenge that was commonly cited by key informants is related to finding and retaining a qualified behavioral health workforce throughout the system. As shown in Table 5, there is one mental health provider—including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advance practice nurses specializing in mental health care—for every 280 individuals in Pierce County. Although this ratio is lower than the state's 380:1, it may reflect the presence of WSH, which serves residents from all over the state. In primary care, Pierce County's ratio of 1,440 individuals per primary care physician is well above the state average and even further above King County's. Given the importance of identifying and addressing behavioral health needs in primary care, this relative shortage is of concern.

Table 5. Mental Health Providers and Primary Care Physicians in Pierce County, King County, and Washington State, 2016

	Pierce County	King County	Washington State
Mental Health Providers	280:1	320:1	380:1
Primary Care Physicians	1,440:1	840:1	1,190:1

Source: Robert Wood Johnson Foundation, County Health Rankings, 2016

Although commercial and Medicaid managed care networks are required to maintain an adequate number of providers, it is often the case that the published provider lists do not present an accurate picture of availability, as independent practice providers may accept only a limited number of patients or maintain unacceptably long waiting lists. A 2008 study indicated that this was one factor limiting access to mental health services for children in Washington state [86].

Key informants cited lengthy recruitment periods needed to fill vacant positions and pressure to pay maximum salaries in order to retain personnel. A representative from a large health system noted that in particular, psychiatrists and psychiatric nurses are difficult to recruit. As mental health prescribers are difficult to recruit, their compensation rate goes up, which makes it more difficult to balance limited resources with a need to recruit and retain these professionals. Nurse practitioners interviewed for this study noted that compared to other specialties, pay for mental health nurses is low, and the job is perceived as more challenging than other fields, which dissuades many nursing students from pursuing that path.

Key informants, including provider key informants, identified low Medicaid reimbursement rates as a significant barrier to retaining mental health professionals in Pierce County, and several indicated a shortage of providers that accept Medicaid. The ABHS Task Force named insufficient behavioral health reimbursement rates as a "major challenge to the system," impacting both staff recruitment and retention. The Task Force adopted a "High Priority" recommendation that the Legislature increase Medicaid and non-Medicaid funding [87].

Contributing to difficulties in hiring and retaining qualified behavioral health professionals is that there are many behavioral health employers in Pierce County (hospitals, clinics, WSH, the military base) vying for a limited pool of professionals. One key informant from a provider organization reported high numbers of clinicians reporting burnout, vicarious trauma, a lack of support, an over-focus on productivity, and limited focus on professional development, all factors that impact the behavioral health workforce. Another provider key informant said that clinical training seems not

to be valued or funded, and clinicians seem "starved" for additional training and professional development opportunities.

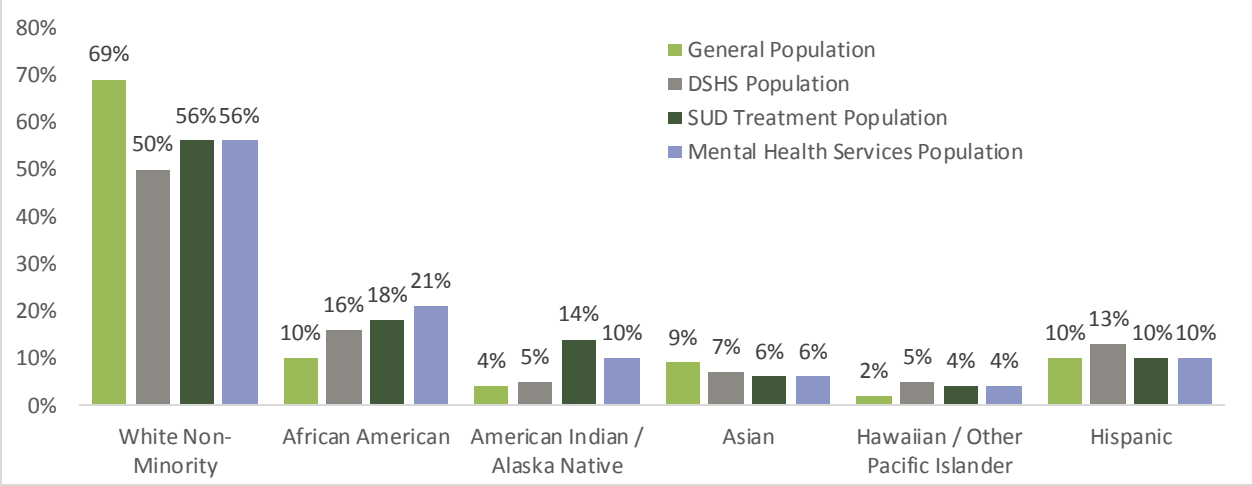
Population-Specific Disparities

Although a detailed analysis of disparities related to access, quality, and outcomes for population groups in Pierce County is beyond the scope of this study, a number of data sources suggest that such an analysis is needed, particularly for racial and ethnic groups; lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) populations; and those living in rural parts of the County.

Racial and Ethnic Minorities

Figure 24 compares the racial and ethnic composition of the Pierce County general population and the population of individuals receiving any services funded by the state's DSHS. Compared to the general population, white non-minorities and Asian Americans are underrepresented in the DSHS population, and African Americans, American Indian/Alaska Natives, and Hispanics are overrepresented. These dynamics could be attributable to numerous factors, among them issues related to cultural and linguistic appropriateness of services, outreach and education needs, and cultural stigma related to behavioral health conditions.

Figure 24. Comparison of Race/Ethnicity of Pierce County Population and DSHS Population, FY 2014



Source: DSHS Client Data

Key informants expected that perceptions and/or misconceptions about behavioral health among racial and ethnic minority groups may impact health-seeking behaviors, contributing to disparities in access. In particular, key informants identified high levels of stigma among African American and Asian American communities in Pierce County. As a result, some individuals with behavioral health problems from these communities do not seek treatment. According to one key informant, members of racial and ethnic minority communities may not seek services until they are in crisis, resulting in access to services that is "too late and too expensive."

Key informants had much to say about racial and ethnic disparities in Pierce County. Two key informants noted that historically, Pierce County has inadequately served the Asian/Pacific Islander population and that there are cultural as well as linguistic barriers to adequately serving this population. Other key informants identified that Native American populations have high unmet service needs. Several key informants identified a range of immigrant communities facing barriers to access, including barriers to enrolling in Medicaid, which may contribute to the fact that a higher proportion of Hispanics are uninsured compared to the general population.

Provider key informants noted a need for interpreters who can facilitate communication between service users and providers during care encounters, including behavioral health treatment. One key informant said that these interpretive services are in short supply because state funds previously used for this purpose have been decreased in recent years.

One provider key informant noted that many evidence-based practices are not always culturally appropriate. For example, group-based modalities for treatment are not appropriate for cultures in which people don't typically share such information with strangers. Two provider key informants spoke of challenges recruiting clinicians with the right licensures who speak the same languages and share cultures with the populations they serve. As the population of Pierce County becomes more and more diverse, the need for providers who can deliver a range of culturally and linguistically appropriate services increases. One provider organization described a strategy of creating teams with a mix of different disciplines and cultural/linguistic backgrounds, and also focusing on professional development of staff members who come from underrepresented groups.

Racial and ethnic disparities in access and quality may translate to differences in outcomes. For example, among publicly funded mental health outpatient service users in Pierce County, 11.6% of African Americans are employed and only 5.7% of Native Americans are employed, compared with 13.9% of all individuals.[31] In terms of homelessness among publicly funded outpatient mental health service users, 12.8% of Native Hawaiian/Pacific Islanders were homeless in FY2015 compared with 7.7% of the total population.

Importantly, key informants also pointed out that current data on race and ethnicity is not sufficiently disaggregated. This issue is explored in a 2015 report of the Korean Women's Association. The authors note that Washington's Department of Health reports mortality statistics for Japanese, Chinese, and Filipino Americans along with "Other" Asian Americans—which include individuals of Korean, Vietnamese, American Indian, and Cambodian descent (Figure 25). These "Other" Asian Americans have far higher early mortality rates than Japanese and Chinese Americans [88]. Importantly, the composition of the "Other Asian American" group differs from county to county. For example, in Pierce County, 25% of the Asian American population is Korean, compared with 9% in King County, and 12% is Cambodian, compared with 3% in King County [89].

The reasons for these disparities are likely complex and variable by population group and may include disparate access to insurance and screening as well as higher rates of substance use problems. A more detailed discussion of potential disparities and limitations of aggregated race and ethnicity data is available in the Korean Women's Association report [90].

[31] SCOPE-WA

Figure 25. 2013 Mortality Statistics by Age for Asian Americans in Washington State

Age Group	Japa-nese		Chi-nese		Filipino		Other Asian	
State Total	**331**		**297**		**376**		**1,074**	
35-44	4	1%	4	1%	8	2%	72	7%
45-54	8	2%	10	3%	25	7%	100	9%
55-64	28	8%	30	10%	59	16%	169	16%
65-74	34	10%	48	16%	84	22%	208	19%
75-84	85	26%	78	26%	95	25%	228	21%
85-94	142	43%	96	32%	76	20%	157	15%
95 and over	26	8%	23	8%	13	3%	33	3%

Source: Center for Health Statistics, Washington State Department of Health 2014 displayed in Ansara and Pak 2015

Another data-related limitation is that racial and ethnic disparities may be underreported because of the methods used for gathering community health information. For example, the Tacoma-Pierce County Health Department (TPCHD) community health survey is typically a telephone survey administered in English and Spanish, which leaves out members of non-Spanish-speaking racial and ethnic groups with limited English proficiency. According to a key informant from the Korean Women's Association, the TPCHD has started to integrate data from the Korean Women's Association into their reports. However, there remains a need for more detailed data collection for these and other racial and ethnic minority communities. Understanding the needs of specific populations is a first step to reducing disparities; if population-specific needs are unobserved, it is likely they will be unaddressed.

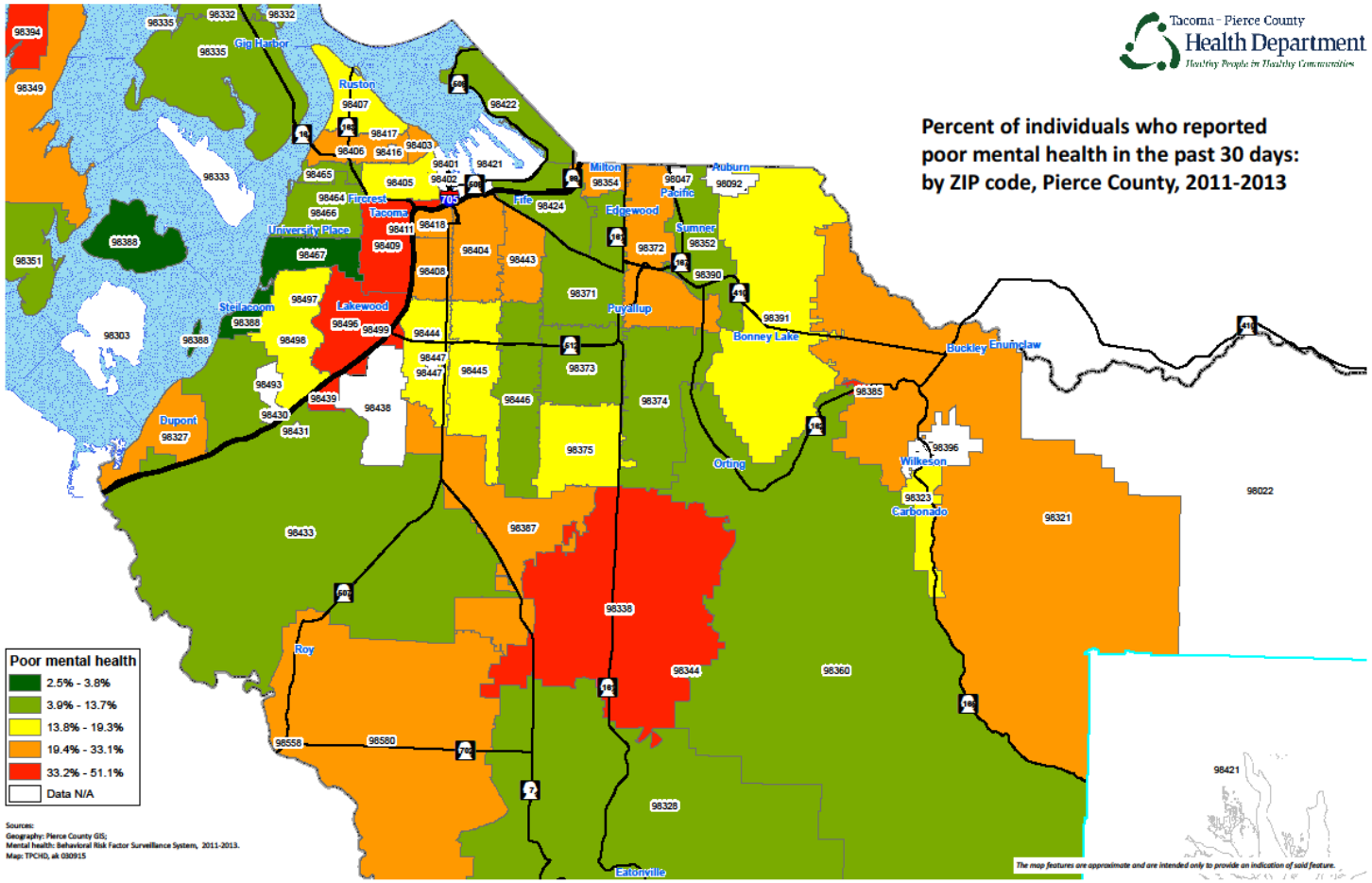
LGBTQ Populations

Although there are limited data regarding utilization of and need for behavioral health services by LGBTQ individuals in Pierce County, research shows that these populations are at elevated risk for behavioral health problems [91, 92]. In this study, key informants indicated that more outreach and engagement with the LGBTQ community is needed. One provider indicated that they have mental health providers that provide outreach to local LGBTQ centers for youth and adults one day per week. Transgender people are highly represented on the caseload. This provider indicated that it is important to bring services to the community and not expect them to come to the clinic for services. Services at the current level were described as "a drop in the bucket," and the provider indicated a need for more provider training and education to serve this population effectively. Another key informant noted that the LGBTQ population is often left behind in terms of cultural sensitivity and understanding, particularly around gender identity issues.

Rural Populations

A detailed investigation of geographic disparities is also outside the scope of this investigation. Like our findings on racial and ethnic variation, however, there appears to be geographic variation in regard to mental health outcomes within Pierce County. As noted in an earlier section, Pierce County residents, on average, report poor mental health with higher frequency than Washington state residents in general. Even within Pierce County, there is geographical variation in reports of poor mental health days (Figure 26), and areas with lower-than-average population density—such as Graham, Buckley, and Roy—have high proportions of the population reporting poor mental health, as do the County's two largest cities, Lakewood and Tacoma.

Figure 26. ***Percent of Pierce County Individuals Reporting Poor Mental Health in the Past 30 Days, by Zip Code, 2011-2013***



Source: Tacoma-Pierce County Health Department (TPCHD), Health Equity Maps, Mental Health[32]

[32] The TPCHD has created numerous maps like the one above, depicting geographic variation in many other health and behavioral health indicators of interest, including Adverse Childhood Events (ACEs) scores and rates of binge drinking. They can be accessed at http://www.tpchd.org/health-wellness-1/health-equity/health-equity-maps.

Key informants recognized and raised geographic disparities in access to quality behavioral health care as a barrier. Informants observed that, in general, rural areas of the County lack the array of resources available to residents in urban areas, particularly Tacoma. Key informants also noted that individuals with behavioral health issues in areas such as Bonney Lake, Wilkeson, Eatonville, and Carbonado face substantial transportation barriers that may result in restricted access and poorer health and behavioral health outcomes.

Meeting the Needs of Military Veterans and Service Members

The largest military installation on the West Coast, Joint Base Lewis-McChord, is located in Pierce County, and thousands of military veterans and their families reside on and around the base. An estimated 11% of Pierce County residents are veterans. Military veterans, particularly those with multiple deployments, are at higher risk for developing mental health and substance use problems, as are children and youth in military families [93]. Although there is no local data on the prevalence of traumatic brain injury (TBI) and Post-Traumatic Stress Disorder (PTSD)—among veterans or otherwise—in healthcare systems and emergency rooms, we know that nationally, between 19.5 and 22.8% of military members are returning from Iraq and Afghanistan with TBI, and approximately one in five with PTSD [94]. Since 2010, suicide has been the second-leading cause of death among active service members [95].

Key informants identified a number of service gaps for veterans. A common theme in key informant interviews with regard to veterans is challenges regarding communication between the military treatment providers, the Veterans Health Administration (VHA), and the civilian health and criminal justice systems in Pierce County. Key informants indicated that resources tend to be fragmented, communication with the VHA can be slow, and that it is difficult for off-base service providers to get services authorized. Key informants also noted a gap in the clinical competency of some off-base behavioral health treatment providers and a need for additional training so that providers can offer their services to veterans and military populations. The Veterans Training Support Center, located in Lynnwood, offers free continuing education for providers and other community members in PTSD, TBI, and other behavioral health issues, but it is unclear to what extent this resource is currently utilized.[33]

Key informants we spoke with suggested that available behavioral health resources for veterans may be underutilized. Give an Hour is a national organization that provides veterans with free, confidential mental health services regardless of payer type.[34] A key informant representing this organization indicated that in Washington state, there are 80 providers in the Give an Hour network, which is low considering the large military population in the state. Despite this, there are some providers in the network that aren't seeing clients, suggesting a need for additional outreach and education about this and other behavioral health resources. For veterans living in rural areas, Give an Hour has capacity to provide telehealth services, but these too are underutilized.

Give an Hour is coordinating a three-year initiative that began in May 2015. Funded by a grant from the United Health Foundation, the initiative is working to establish collaboration and coordination among mental health providers and other stakeholders in the city of Tacoma to identify existing mental health resources and develop action plans to reduce barriers and unmet needs for the military population. The project's goal is to increase education and collaboration between mental health organizations and the military so collaborations can be established and sustained after the

[33] http://veteranstrainingsupportcenter.org/

[34] https://www.giveanhour.org/

grant ends. In November 2016, Give an Hour will host a meeting to address issues related to communication barriers between on-base and off-base providers and the lack of knowledge among providers regarding how TriCare, the health care program of the U.S. Military, operates. Through this initiative, Give an Hour hopes to provide support for providers to navigate complicated military insurance systems to better provide support to service members and veterans.

Key informants from the criminal justice system indicated a number of veteran-specific programs. The Pierce County jail books over 200 individuals per month who identify as veterans. The Veterans Administration (VA) partners with the jail to provide veterans counseling. This program has been in place for one year, and key informants representing the jail indicated that it has been successful. Once released from jail, veterans are linked with the Pierce County Veterans Bureau. There is workforce training available to inmates, and support for finding jobs after release. At booking, the mental health professionals in the jail screen veterans for history of TBI and PTSD.

In June 2016, 12.5% of the Mental Health court participants are veterans.[35] There is also a specific veterans' track in the Felony Drug Court. Therapeutic court treatment providers work collaboratively with the VA for veterans who qualify for VA services. There is a Veterans Justice Coordinator at the VA who works with both the Mental Health and Felony Drug courts. Key informants from the courts indicated that there are some veterans who might benefit from therapeutic courts but are not currently eligible. For example, veterans with primary alcohol use issues and veterans with mental health issues who have been charged with domestic violence offenses or have had an ex parte restraining order filed against them are not eligible for therapeutic courts at this time.

Supporting Family Members of People with Behavioral Health Conditions

Several key informants indicated that there is a system-wide lack of support for families of people with behavioral health issues in Pierce County. One family member said that this lack of family support, "feels like a gaping hole" and that caregivers of people with serious mental health conditions feel very much on their own. Another family member said, "I have had to learn the hard way, the tricks of the system. What to expect and what not to expect…Often we feel like we are doing something wrong, but we are not getting the help we need…It's all just trial and error." Key informants said that families in Pierce County need more information about what services are out there, how the system works, and what they can do to support their family members with behavioral health needs.

One avenue for family support is mutual support groups, which bring families together to share knowledge and provide emotional support. A review of studies of the impact of mutual support groups for family members of individuals with serious mental health conditions found that such interventions have been associated with both family and patient psychosocial well-being, improving knowledge about mental health conditions, reducing burden and distress, and enhancing coping abilities and social supports [96]. NAMI Pierce operates one such group, the Family-to-Family program, which meets twice a month.[36] Two Family-to-Family courses graduated this summer, and there are plans to offer two more in the fall. NAMI also offers Homefront, which is a

[35] Source: Pierce County Mental Health Court

[36] http://namipierce.org/meetings-schedules/support-groups/

version of Family-to-Family developed specifically for the veteran community delivered by trained family members of service members and veterans with mental health conditions.[37]

Key informants felt these groups are in limited supply and variety (for example, few options outside of NAMI), and it is unclear whether those who might benefit are aware of them. One family member interviewed endorsed NAMI as an important and helpful resource, but indicated that NAMI is limited in terms of what it can offer and there are relatively few active members. This informant said that NAMI could likely be a resource for more people in the County if they knew about it. The PAR initiative, discussed previously, includes an effort to increase the use of family education programs, including Homefront.

Beyond mutual support groups, there may be a need to provide support to families regarding how to prevent crisis situations, and—critically—how to best respond to crises when they arise. One key informant suggested a virtual or real "warm room" for caregivers to use day or night to get support.

Family members interviewed for this study also described a need for improved communication with providers. One family member noted a need for shared decision-making related to psychiatric medications for families, and another family member key informant described difficulty communicating with his/her child's doctor, both in regard to diagnosis and day-to-day support. The person didn't feel that his/her voice was heard in the treatment encounter and felt misunderstood and judged by the clinician. S/he voiced a need for a "translator" between the family and the doctor to facilitate communication and advocate for the patient as well as a need for more feedback and communication from doctors, "not just blowing us off with statistics."

Shared Decision-Making and Service User Engagement and Education

As discussed in Appendix D, the most commonly cited reasons for unmet need for most services, according to case managers, was that the "person refused the service." In contrast, the most commonly cited reason among service users themselves was that they were not offered the service, and the second most common reason was "I refused because I didn't think I needed the service."

This finding—which is not unique to Pierce County[38]—suggests a need for increased education, communication, and shared decision-making between service users and providers. In a study of 174 service users in a community rehabilitative service setting in England, researchers found that of the 61 individuals who refused treatment (medication in this case), 85% reconsidered their refusal and engaged in treatment within one month [97]. The study found that community health professionals responsible for the coordination of care were most effective in reversing these refusals through explanation, education, and encouragement. The authors found that in their sample, only 6% of individuals were firm in their refusals. This study suggests that service user refusals are often the product of ambivalence and fluctuating attitudes toward mental health treatment. They emphasize the importance of the relationship between the provider and the service user in addressing the root cause of refusals through education and encouragement.

Increasing the use of shared decision-making approaches throughout the system may help reduce barriers related to service user refusals. Shared decision-making is a process of exploring the

[37] http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Homefront

[38] HSRI administered the SPES to case managers and service users in Milwaukee County, and findings there were similar to those in Pierce County.

service user's own goals and preferences for treatment. It occurs between a clinician and a client during the treatment encounter and assumes that both parties have relevant information to contribute to the process [98]. Shared decision-making has been widely used in the fields of physical as well as behavioral health, including mental health and substance use treatment [99, 100]. The approach recognizes that client and provider goals may not be congruent, and introduces a consensus-building process involving a systematic and ongoing co-exploration of treatment goals and expectations [101]. Research has shown behavioral health shared decision-making to be effective in terms of participant satisfaction, participation in treatment, and health status [102, 103].

Ensuring a Trauma-Informed System

As discussed in Section 3, we know that Adverse Childhood Events (ACEs) contribute to physical and behavioral health problems later in life. A high prevalence of histories of interpersonal trauma, such as from sexual and physical abuse and assault, has been well documented among adults served by mental health systems [104]. Therefore, it is universally understood that almost all individuals seeking behavioral health services have trauma histories. It has also been well-documented that there are many common procedures and experiences in service settings that serve to re-trigger trauma reactions in individuals and that are considered to be emotionally unsafe and disempowering for survivors of trauma [105, 106]. This includes the use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment instead of empowerment and choice [107]. Consequently, there has been a call for systems to promote trauma-informed care.[39]

Stakeholders in Pierce County made similar calls for trauma-informed care across the behavioral health system. Trauma-informed approaches are being implemented in some schools (though one key informant called for more training for public school teachers in trauma-informed principles), and several local behavioral health providers identify as "trauma-informed organizations." However, key informants indicated that these approaches are not being supported throughout the system. There may be opportunities to expand trauma-informed care within health system initiatives as part of the Accountable Communities of Health initiative, and the concept of trauma-informed care is closely linked with prevention activities informed by ACEs, as discussed in Section 3.

Balancing the Need for Inpatient vs. Community-Based Services

Multiple key informants and other stakeholders identified a system overreliance on crisis services. Key informants noted that experiencing the system through the crisis service pathway results in a "negative first touch" that could lead to reluctance to engage in treatment in the future. This dynamic may be particularly pronounced among young adults experiencing a first episode of psychosis and among members of certain racial and ethnic groups that are underrepresented in the current system such as Asian Americans.

Such an overreliance may be attributable in large part to inadequate or low-quality community-based services and outpatient treatment. Another common theme among key informants was a

[39] Trauma-informed care incorporates an appreciation for the high prevalence of traumatic experiences in persons who receive behavioral health services and a thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on individuals

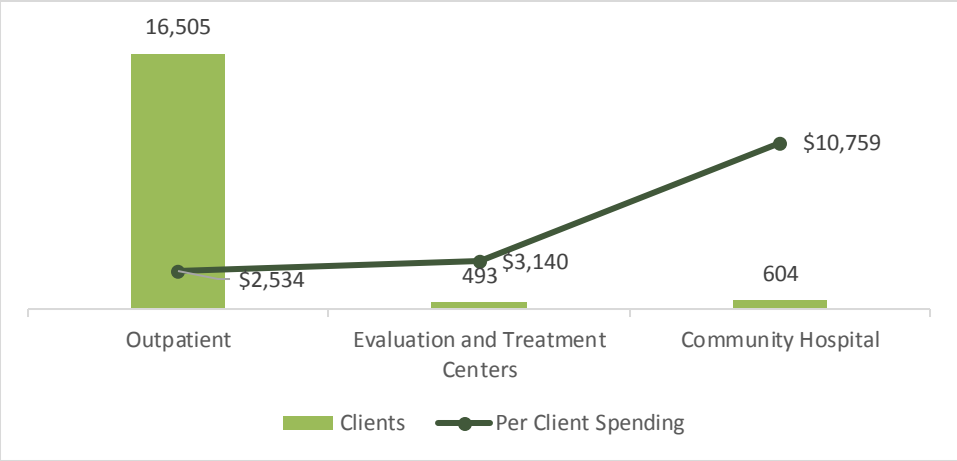
need for "in between" services for individuals who do not need (or do not believe they need) inpatient treatment. This lack of lower-intensity services results in a dynamic where individuals cannot access treatment until they reach a point of meeting the criteria for involuntary commitment. Key informants endorsed the value of psychotherapy and other outpatient services designed to help people remain in the community and prevent crisis before it occurs. One service user key informant noted, "Sometimes therapists can see something that you can't because you're in the middle of it."

In regard to some community members' call for more inpatient beds, one key informant asked, "Why can't people be in their own bed? That's the best bed to be in." Another key informant stated that the state's 49th-in-the-nation ranking for psychiatric inpatient capacity would not be a problem if there were appropriate community-based programs. Others said that the newly planned hospital is a welcome addition to the community but feared that if the hospital is not complemented with outpatient services, the benefits to the overall system will not occur. These concerns are warranted given the low rates of outpatient service utilization among individuals discharged from inpatient hospitals across the state and the particularly low rates of outpatient service utilization among those discharged from Western State Hospital (36.6% of WSH patients discharged receive publicly funded outpatient services within 30 days; see Figure 16 on page 43).

Nationwide, behavioral health systems are focused on reducing the need for inpatient and emergency services by ensuring a broader spectrum of community-based services, including services for individuals with acute behavioral health needs. The reasons for this focus are two-fold: First, inpatient hospitalizations are experienced as traumatizing due to high rates of physical and sexual violence as well as institutional practices such as seclusion and restraint, takedowns, and handcuffed transport [108, 109]. Therefore, for many service users, inpatient and emergency services are undesirable and avoidable when less coercive and disruptive community-based supports are available. Second, outpatient services are far less costly than inpatient services, enabling broader distribution of limited resources if preventable crises and hospitalizations can be avoided. According to the state DSHS, in FY2014 (the most recent year cost data are available), a total of 16,505 individuals in Pierce County received publicly funded outpatient services[40] costing an average of $2,534 per person. In contrast, only 493 individuals were admitted to E&Ts at a cost of $3,140 per person, and 604 were hospitalized at $10,759 per person. Not shown in Figure 27 are the 583 individuals who received treatment in state hospitals at an average yearly cost of $115,346 per person.

[40] Per the DSHS Client Data website, outpatient mental health services include "individual counseling and psychotherapy, medication management, crisis and stabilization, High Intensity Treatment and Program of Assertive Community Treatment, peer support, day treatment (day support), services to individuals transitioning from jails or correctional facilities, respite for caregivers, clubhouses, and supported employment as funding allow" (http://clientdata.rda.dshs.wa.gov/Glossary)

Figure 27. Utilization and Per Capita Cost for Outpatient and Inpatient Services Among the Medicaid Population in Pierce County, FY 2014



Source: DSHS Client Data

Why Service Allocation Is Challenging

Policy makers, understandably, often wish to know how to allocate scarce resources to ensure adequate coverage of both inpatient and community-based services. Unfortunately, the research literature provides no definitive answer about the right number of inpatient beds. In fact, over the half century since the advent of deinstitutionalization, the issue has been hotly debated on a number of fronts. The reason why an appropriate balance is so difficult to calculate is that, despite years of research dedicated to the subject, the extent to which outpatient services can serve as an alternative to inpatient has yet to be determined with any degree of certainty. There are a number of reasons why this calculation is so difficult, if not impossible, but there are five that are particularly relevant to this report.

First, and most important, research has demonstrated that a good and modern behavioral health system—one with an adequate supply and variety of outpatient services—will reduce the need for inpatient care [110]. Most people agree that all behavioral health systems must maintain some inpatient capacity, and the question is how many "avoidable admissions" can be prevented by an adequate supply of outpatient services. The problem is that the relationship between outpatient services and avoidable hospital admissions is so complex that it is, as of now, impossible to calculate precisely how the availability of outpatient services affects the ratio between avoidable and necessary admissions.

Second, most behavioral health systems offer a variety of services—psychotherapy, psychopharmacology, case management, peer support programs, etc.—all of which have a substantial evidence base demonstrating their effectiveness at reducing psychiatric inpatient hospitalizations[41]. The problem is that research has not yet shown the comparative effectiveness of these various services, especially for different service user sub-groups and in various types of systems. For example, Assertive Community Treatment has been shown to reduce hospitalization admissions, but mainly for patients with frequent admissions and in systems where admissions rates are relatively high. For another type of service user in another type of system, a different

[41] SAMHSA maintains a listing of such services in its National Registry of Evidence-Based Programs and Practices: http://www.samhsa.gov/nrepp

service such as supported employment may be more effective. In other words, the "right balance" issue arises not only with inpatient vs. outpatient care but also with various modalities of outpatient care. Depending on the particular mix of services, therefore, the specifics of a bed shortage in one location may differ from that in another. For example, community services may be ample for adults but limited for children, with the result that the bed shortage affects only children. As another example, there may be an adequate supply of long-stay hospital beds, for example in a state hospital, but a shortage of beds for patients requiring only a brief acute-care stay.

Third, in a mental health system that is increasingly privatized, whether with for-profit or non-profit hospitals, the supply and demand equation is affected by economic and policy factors, quite apart from clinical necessity. For example, the rapid expansion of private for-profit psychiatric hospitals in the 1980s in response to expanded insurance coverage and various policy changes was followed by an equally large contraction in the 1990s, primarily in response to cost-containment initiatives [111]. Economists call this dynamic "supplier induced demand," meaning that an increased availability of a service will result in greater utilization, independent of clinical need. This phenomenon has been well documented in the literature for many services including psychiatric hospitalization [112].

Fourth, changes in clinical practice and philosophy or—less frequent but more influential—the introduction of new treatment modalities, can rapidly alter the demand side of the hospital bed supply-and-demand equation. A dramatic example is the introduction of antipsychotic medications in the 1950s as a major facilitator of deinstitutionalization.

Fifth, every behavioral health system is different in many important respects. Most systems in the U.S. are, to varying degrees, county-based, and the county-level variation in numerous factors such as government structure and politics, illness prevalence, demographics, and social issues is even more extreme than state-level variation. It follows, therefore, that the variation in behavioral health systems, including the supply and demand of inpatient psychiatric care is equally great; therefore, no one formula can apply to every system.

Impact of Community-Based Services

To further add to the challenge of determining inpatient bed need, there is mounting evidence that a variety of hospital alternatives result in reduced need for costly inpatient services, though this literature tells a complex story. A systematic review of literature involving 10 randomized controlled studies comparing inpatient and day hospitals concluded that, "Caring for people in acute day hospitals is as effective as inpatient care in treating acutely ill psychiatric patients" [113]. Another recent review of 13 randomized controlled trials published in the *Journal of the American Medical Association* this summer compared four interventions hypothesized to prevent involuntary hospital admissions: community treatment orders (such as assisted outpatient treatment or AOT), compliance enhancement techniques, augmentation of standard care, and advance statements, including advance directives and joint crisis plans. The review indicated that only advanced directives served to reduce compulsory admissions, and this reduction was considerable, at 23% [114]. The review also concluded that the evidence base for Assisted Outpatient Treatment is lacking and called for more research into its impact.

In 2015, the Washington State Institute for Public Policy conducted a meta-analysis of community-based interventions that have been hypothesized to reduce psychiatric hospitalizations. In this review, three programs were identified as having a statistically significant effect on psychiatric hospitalization reduction: Assertive Community Treatment, Mobile Crisis Response, and Supported Housing for adults experiencing chronic homelessness. This same review found that Assisted

Outpatient Treatment was significantly associated with a small increase in psychiatric hospitalization [115]. A variety of services in addition to these, such as supported employment [116], residential crisis alternatives [117], and specialized programs for treating PTSD [118] have been shown by researchers to reduce hospital admissions.

In short, a variety of factors determine the need for inpatient beds. When there is a perceived shortage of inpatient beds in a community, it is therefore very important to determine on a local basis, in as fine-grained detail as available data allows, the particulars of that need. This includes identifying the characteristics of service users who are affected and determining whether the problem is in fact an inadequate supply of beds for that subgroup or a gap in the community service system that results in a demand for otherwise avoidable hospitalization. Numerous key informants in this report indicated severe shortages of community-based services, suggesting a need for careful review of those services before reaching a conclusion that a lack of inpatient services are at the root of Pierce County's behavioral health service needs.

5. Community Vision for a Behavioral Health Service System

In early June 2016, a community listening session was held to gather feedback for the project and take the public's input and views regarding the current and future behavioral system in Pierce County. Over 60 individuals attended the meeting, including users of behavioral health services, family members, advocates, providers, healthcare administrators, first responders, elected officials, and other concerned citizens from Lakewood, Puyallup, Tacoma, and elsewhere in the County.

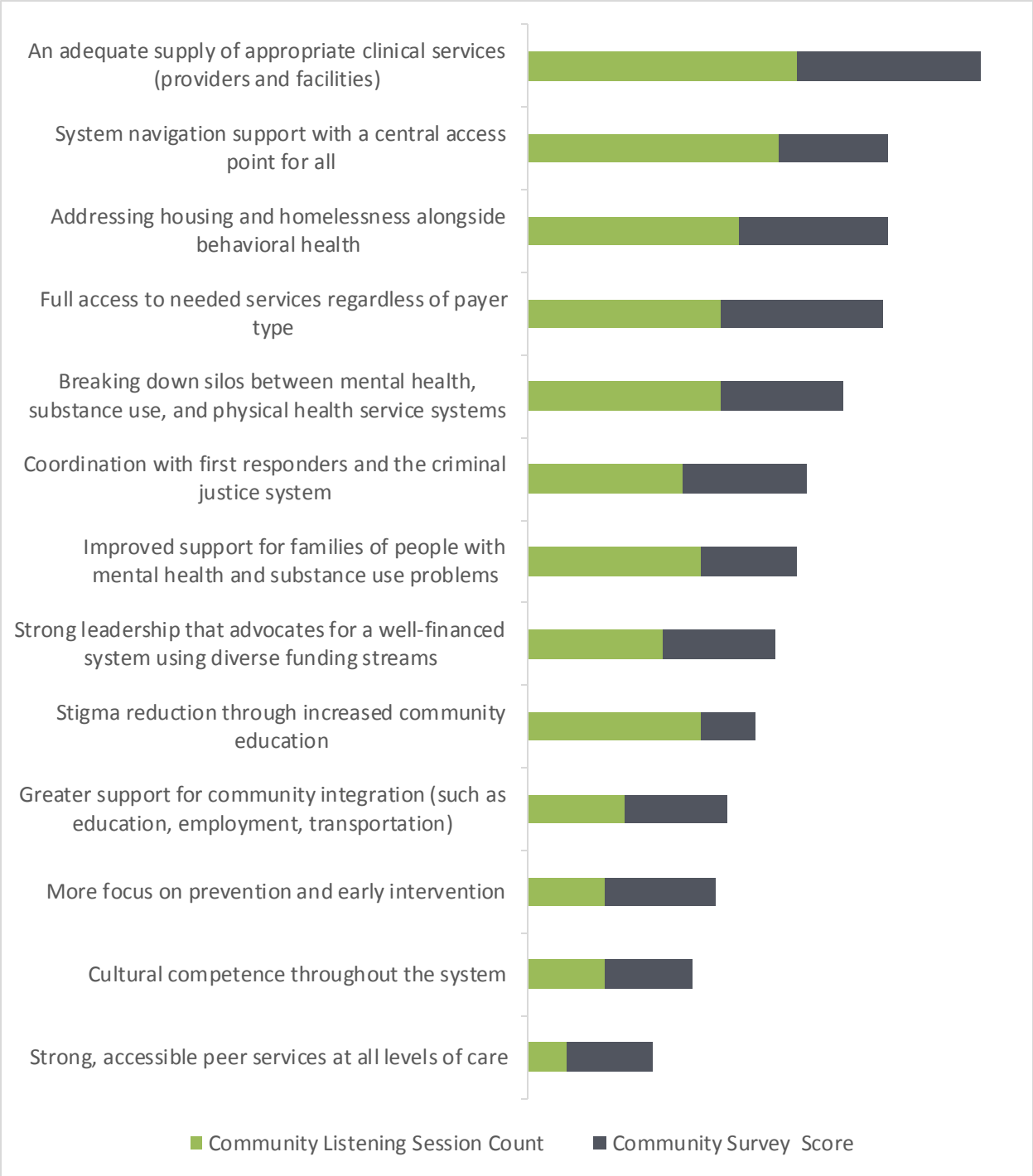
The meeting was facilitated using a *World Café* format, in which participants break into small discussion groups then bring back key observations to the group as a whole. Community listening session attendees were asked: *What is your vision for an improved behavioral health system five years from now?* and *What are the most pressing issues and challenges for people with behavioral health-related needs in Pierce County?* After the small group discussions, volunteers from each group reported what was discussed to the larger group, followed by a period of open discussion. Based on these discussions, the research team used qualitative research methods to distill the community's feedback into a set of "system priorities" and counts of the number of individuals who discussed each of these priorities (for a more detailed discussion of the methodology for analyzing the information garnered from the community listening session, refer to Appendix A).

In August 2016, members of the Pierce County community were invited to take a brief survey ranking the "system priorities" identified through the earlier community listening session in order of importance. Those who took the survey were also given the opportunity to submit additional open-ended comments regarding system priorities. These overall rankings were used to calculate a score ranging from least highly-ranked to most highly-ranked.

The system priorities and associated community listening session scores and survey rankings are depicted in Figure 28. The system priorities are further defined using community stakeholders' observations in the text that follows. A more detailed discussion of the methodology used to develop the information in the figure can be found in Appendix A.

In the comments portion of the survey, several respondents wrote that it was difficult to rank the denoted system priorities because they felt that all are very important. Respondents also emphasized that the system priorities are interrelated and should be addressed as such. *In interpreting Figure 28, please keep in mind that those items with fewer counts and lower rankings are nonetheless viewed by the community as critically important priorities.* A majority of the comments endorsed the priorities put forth in the survey.

Figure 28. System Priorities Identified by Pierce County Residents



- **An adequate supply of appropriate clinical services (providers and facilities).** According to community listening session participants and survey respondents, the behavioral health system in Pierce County has a shortage of qualified, licensed providers—including psychiatrists, psychiatric nurse practitioners, psychologists, social workers, and mental health and substance use counselors—as well as a lack of outpatient and inpatient facilities where people can receive services.

- **System navigation support with a central access point for all.** Stakeholders called for greater "no wrong door" access to the behavioral health system. Those with complex behavioral health needs may also need ongoing support to navigate the system. All too often, Pierce County residents fall through the cracks and do not receive the services and supports they need. A centralized system entry point needs to be developed so that anyone can receive the support they need to connect with appropriate services and supports in a timely manner.
- **Addressing housing and homelessness alongside behavioral health.** There is a significant lack of housing and housing options in Pierce County for those with behavioral health issues. Affordable and appropriate housing options should be developed and made available for people with behavioral health needs.
- **Full access to needed services regardless of payer type.** Not all Pierce County residents have health insurance, and some have limited health insurance coverage that does not provide for all types of behavioral health services. Without a system that provides access to the full continuum of behavioral health services for all residents, regardless of insurance coverage, these residents with behavioral health problems will be left out of the system.
- **Breaking down silos between mental health, substance use treatment, and physical health services.** All too often, mental health, substance use, and physical health systems do not "talk" to each other and, as a result, the person who is receiving services does not receive the highest quality of care that they could receive if all of their service providers worked together, as a team.
- **Coordination with first responders and the criminal justice system.** First responders need training in behavioral health crisis support and also need to be teamed with behavioral health providers who can support the person in crisis and connect them to services that are appropriate to their needs. Individuals involved in the criminal justice system with behavioral health needs must be supported before, during, and after criminal justice system involvement.
- **Improved support for families of people with behavioral health problems.** When a person is in crisis, the whole family is affected, and often family members are the front-line caregivers for people with behavioral health needs. There is a need in Pierce County for increased family trainings, support services, and increased family engagement in family members' services and supports.
- **Strong leadership of a well-financed system that uses diverse funding streams**. Pierce County needs to create an accountable organization that can ensure adequate funding of behavioral health services and supports where needed and oversee any changes and enhancements to the behavioral health system. This entity needs to have a mechanism for regularly engaging with the community to seek input regarding the adequacy of the system. Without such an organization in place, funding, resources and provision for behavioral health services and improvements will be fragmented, resulting in more limited access, poorer quality of care, and higher costs.
- **Stigma reduction through increased community education.** To be effective, systems change must include a wide range of public buy-in and involvement. Therefore, a community-wide anti-stigma campaign should be developed and implemented in order to educate the public about why these improvements in mental health services and supports are needed and the benefits to the community at large. Community members who frequently come into contact with people with acute behavioral health issues in settings such as libraries, places of worship, and businesses would also benefit from resources to build skills on how best to respond to these individuals.

- **Greater support for community integration (such as education, employment, transportation).** Recovery from mental health and substance use problems must include community integration in order to be successful. People with behavioral health diagnoses need access to transportation to attend appointments with providers and to effectively integrate into the community of their choice. Access to education and job training opportunities is essential to confidence-building and recovery, and access to wellness resources, including healthy meals and exercise, is also important to well-being.
- **More focus on prevention and early intervention.** Increased services for youth and their families—including targeted behavioral health education and trainings for students and staff in schools as well as early intervention for youth and young adults experiencing a first-episode of psychosis—are needed to effectively reach vulnerable young people and provide them with the support they need before crises occur.
- **Cultural competence throughout the system.** Behavioral health services and supports need to be accessible to people from all backgrounds, ethnicities, and cultures. Services and supports should be located within the communities that they serve, and providers should be representative of the diversity of the community as a whole.
- **Strong, accessible peer services at all levels of care.** Peer supports need to be available at all levels of services, and the peer work force must be supported to meet these needs.

The above descriptions are a synopsis of the community stakeholders' expressed viewpoints. Although we were not able to substantiate all of the claims with available data as part of this study, the priorities voiced by the community align with our findings in general and track with the recommendations laid out in the following section.

6. Service and Support and Infrastructure Recommendations

HSRI applauds the current significant contributions of Pierce County behavioral health stakeholders to prevent and treat behavioral health challenges. Our recommendations build on existing strengths and address gaps while being mindful of limited resources.

The first set of recommendations (**Service and Support Recommendations**) involve ways in which the behavioral health system might be strengthened through expanded access and service array adjustments. The second set of recommendations (**Infrastructure Recommendations**) involve a suggested course of action regarding the development of responsive, dynamic infrastructure that could build upon the County's current resources and set priorities, coordinate action, and carry out system improvement activities.

Our recommendations are based on information obtained from a wide range of sources including data, reports and key informants in Pierce County and Washington State, as well as best practices from other locales and the research literature. These recommendations generally reflect the principles identified in a widely disseminated 2011 brief produced by SAMHSA entitled *Description of a Modern Addictions and Mental Health Service System* [119]. The document presents a vision and describes the basic services required for a transformed and integrated system of care:

> *A modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective.*

While our recommendations are, for the most part, focused specifically on Pierce County behavioral health services and prevention activities, they are very much rooted in this SAMHSA vision of a comprehensive public health approach to mental health and substance use problems.

When applicable, we have included references to recommendations laid out in the 2015 Final Report of the Washington State Adult Behavioral Health System (ABHS) Task Force.[42] Aligning County and State priorities will likely be critical in ensuring the success of any system reform efforts, capitalizing on existing efforts and avoiding redundancies in initiatives.

Service and Support Recommendations

Per our contract with the County Council, we were asked to identify services and supports that could fill gaps between needs and current resources. Drawing from Pierce County's unique strengths and assets as well as the needs identified through this study, these recommendations are intended to serve as a roadmap for improvement efforts. We do not expect, nor do we suggest, that

[42] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

Pierce County will endeavor to implement all of these recommendations at once. Rather, our purpose is to present a range of possible options that Council Members and stakeholders—including legislators, other public officials, provider organizations and the public—may consider in addressing the challenges, filling the gaps, and improving the system of behavioral health care for Pierce County residents.

Service and Support Recommendation 1: Invest in Prevention

There are numerous opportunities to build on current prevention and early intervention efforts in Pierce County. Successful interventions should be tailored to specific communities and then scaled up so that all Pierce County residents can benefit from a prevention-focused system. By focusing on prevention, behavioral health problems can be addressed upstream. This proactive approach has the potential to prevent losses and suffering related to behavioral health crises that impact the population as a whole, not just individuals with behavioral health challenges.

States are increasingly using the SAMHSA block grant for prevention activities, and Pierce County should work with the state as they prepare the next block grant application to identify target areas for prevention resources to meet the proposed proactive approach. Public and private foundations such as the Robert Wood Johnson and Annie E. Casey Foundations are also good sources of funding for prevention and early intervention activities. Maintaining a roster of local foundations and their current initiatives may provide the county with additional funding opportunities (see Infrastructure Recommendation 1.3).

1.1: Sustain Comprehensive and Robust Community Education Efforts

As described in Section 3 of this report and laid out in detail in Appendix E (PAR Initiative description), numerous state and local community education and outreach initiatives are currently underway, from Mental Health First Aid trainings to early psychosis recognition and intervention. Key informants and community stakeholders voiced a need for more education of this kind, particularly campaigns that are aimed at promoting greater community acceptance and integration of people with behavioral health conditions; for example, there may be a need for outreach and education to potential employers regarding the provision of reasonable accommodations for people with psychiatric disabilities.

The PAR initiative may serve as an excellent starting point for building a robust and sustainable program of community education in Pierce County. A modest level of additional resources would be needed to build in substance use-specific community education activities, ensure successful activities are sustained beyond the three-year life of the grant, and conduct a continuous review of the program to ensure activities are relevant, impactful, and culturally responsive.

1.2: Adapt and Expand School-Based Prevention and Treatment

The Tacoma Whole Child Initiative is an innovative and evidence-based effort to school-based whole-health promotion that is taking place right here in Pierce County. Despite this and other initiatives described in Section 3, key informants voiced that there were unmet needs for behavioral health prevention activities, particularly outside of the Tacoma School District. Key informants noted that many schools do not have adequate resources to meet the behavioral health needs of their students and connect parents to behavioral health resources for their kids, particularly in rural communities.

While it would be inappropriate to export the initiative wholesale to other school districts without consideration of local context, the initiative does represent a significant resource for other parts of

the County. Thoughtful adaptation and expansion would result in children across Pierce County gaining access to critical, evidence-based behavioral health screening and social and emotional wellness promotion activities. Similarly, there may be opportunities to build upon and expand work of the coalitions established through the Community Prevention and Wellness Initiative in Franklin Pierce, Orting, and Lakewood to enhance substance use prevention within schools. These activities may benefit from an examination of national best practices for school-based substance use prevention.[43]

As with Service and Support Recommendation 1.1 above, the PAR initiative includes a number of school-based education activities, and a modest investment could serve to bolster these activities to encompass substance use prevention alongside mental health prevention and sustain them in an ongoing way.

1.3: Expand Mental Health and SUD Screening in Primary Care and Social Service Systems

Several initiatives in the County involve implementing mental health and SUD screenings in primary care and through other social services such as the WIC program. Each of these initiatives, described in Section 3, have various funding sources and populations of focus. Despite these initiatives, our key informants indicated that, in their view, given their experience with and knowledge of the County behavioral health system, there remains a need for more coordinated, cross-County efforts to systematically screen individuals for mental health and substance use issues. The proliferation of screening initiatives represents an opportunity for collaboration and learning across systems. For example, the Korean Women's Association is focusing its efforts on implementing screening and brief intervention with Asian American communities in primary care; lessons learned from this initiative may inform efforts to outreach to these communities in other social service settings where behavioral health screenings are taking place. Similarly, the Zero Suicide Initiative—designed as a system-wide approach—might be expanded beyond the CHI Franciscan system to incorporate other health and behavioral health systems in the County.

1.4: Add Evidence-Based Services for First-Episode Psychosis

The landmark Recovery After an Initial Schizophrenia Episode (RAISE) project, funded by the National Institute of Mental Health, has led to an increasing focus on identification and early intervention in first-episode psychosis.[44] The interventions tested in the RAISE project, Coordinated Specialty Care programs, involve multidisciplinary team-based treatment that includes psychosocial supports and family education. Coordinated Specialty Care has been found to reduce symptoms and improve quality of life for people experiencing early psychosis [120]. Such interventions alter the course of illness through outreach and engagement with individuals before years-long duration of untreated psychosis occurs [121] and through the early provision of comprehensive services. By providing low-dose medications and psychosocial and rehabilitative interventions, CSC programs can reduce impairment related to symptoms and increase skills and supports, enabling more effective functioning and a reduction of disability. Finally, by providing evidence-based practices such as supported employment and emerging practices such as supported education, CSC programs support individuals in pursuing desired roles such as student or worker that are interrupted by the emergence of psychosis during such a critical developmental time in individuals' lives, helping to maximize recovery.

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[43] Youth.gov features a searchable Program Directory detailing evidence-based prevention programs for young people: http://youth.gov/evidence-innovation/program-directory. SAMHSA's NREPP also includes numerous evidence-based and promising prevention programs: http://www.samhsa.gov/nrepp

[44] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml

In 2014, SAMHSA directed states to use 5% of their mental health block grant dollars to address early episodes of serious mental health conditions, and in 2016, SAMHSA increased that set-aside to 10% with an added requirement that efforts focus specifically on first-episode psychosis using evidence-based approaches such as those tested in the RAISE project [122]. Despite the evidence suggesting its importance, there are no service programs specifically geared toward early intervention for psychosis in Pierce County. To date, Washington's DSHS DBHR has undertaken two initiatives related to the mental health block grant set-aside; the first is a pilot treatment program in Yakima County, and the second is the "Get Help Early" educational campaign. Given the new requirements of the 10% mental health block grant set-aside, however, it is likely that first-episode psychosis programs will grow across the state—including in Pierce County—in coming years.

In fact, the BHO reported that it is in the beginning planning stages for such initiatives and is also interested in building first-episode-psychosis capacity outside of the block grant. We highly recommend coordination with the BHO and working with the state to ensure that all individuals experiencing early episodes of psychosis have access to these programs. Investing in evidence-based early intervention such as CSCs for this high-risk group will prevent and reduce the significant long-term impact of psychosis on individuals, their families, and the healthcare system.

Service and Support Recommendation 2: Extend and Expand the 2-1-1 Behavioral Health Specialist Services to Establish 2-1-1 as a Universal "Front Door"

A key theme that emerged from the community listening session and the key informant interviews was a need for a central access point to connect individuals with behavioral health needs with appropriate services. A truly effective "Front Door" for a behavioral health system must be accessible to all, not just individuals whose behavioral health needs have grown so acute to be in crisis. Further, an effective "Front Door" should provide an individual with a range of options to select the most appropriate course of action based on unique needs, circumstances, and preferences.

As noted above, the PAR initiative will create a Behavioral Health Specialist to work with 2-1-1 staff to acquire and maintain comprehensive knowledge of available resources in Pierce County and ensure that callers with mental health needs are connected to those resources. This position is designed to facilitate timely access to mental health resources, regardless of payer type and severity of need. The goal is to establish 2-1-1 as a central avenue to connect Pierce County residents to relevant mental health resources. If fully implemented, it is expected that this position would result in improving public knowledge of and utilization of mental health resources and services. If this time-limited program proves to be effective, it should be established within the 2-1-1 program and sustainably funded beyond the life of the PAR grant. Additionally, if effective, the Behavioral Health Specialist role should expand beyond mental health to include substance use disorder treatment and prevention resources. This relatively low-cost intervention would facilitate access and ensure that existing resources will be capitalized upon. The cost to reestablish the position after it ends in 2019 will likely be more than the cost to continue it.

Service and Support Recommendation 3: Increase Outpatient and Community-Based Service Capacity

Multiple key informants described a need for a crisis triage center (or centers) to serve as a central location for individuals in crisis to be brought to be evaluated and connected to treatment. However, in our experience, the effectiveness of such an access point hinges on there being an

adequate supply of services for individuals to gain access to. If there are inadequate services to connect individuals with, it is likely that such a crisis center would experience the same "bottlenecks" as emergency rooms and evaluation and treatment centers throughout the County. As discussed in Section 4, our study has found that while there may be need for additional inpatient capacity, there is a clear need to expand outpatient capacity, targeted to key gaps in the system. The following recommendations outline a plan for addressing those gaps.

3.1: Improve Provider Recruitment and Retention and Expand Access to Specialty Behavioral Health Care for Non-BHO Populations

Staffing shortages appear to be a core challenge in expanding the availability of outpatient behavioral health services in Pierce County, particularly specialty behavioral health care for those with private insurance or with public insurance who do not meet the state's Access to Care standards. We observed a need for an entity (see Infrastructure Recommendation 1 for more discussion of this entity) to foster partnerships among public and private providers and assist them to identify needed human resources and implement creative solutions to fill gaps in provider recruitment and retention. For example, outpatient service capacity issues may be mitigated by substituting currently used service providers and traditional treatments with innovative and creative options for outpatient care. Often, doctoral level psychologists and psychiatrists deliver many outpatient services, such as individual therapy and medication management. An increased use of Master's level clinicians (LMHCs, LICSWs, and MFTs) and nurse practitioners who can prescribe medications can expand capacity. Further, this entity may advocate to the state legislature to increase reimbursement rates to improve provider recruitment and retention and create and carry out an action plan for licensing, recruitment, and professional development to ensure a clinically competent workforce (for more information about recommended state activities to promote behavioral health workforce development, see ABHS Task Force recommendations 1 and 3).[45]

3.2: Support and Coordinate with Efforts to Enhance Availability of Behavioral Health Outpatient Services in Primary Care

By providing treatment earlier in the progression of mental health and substance use disorders, individuals may be less likely to require specialty behavioral health services like psychiatry and case management. In addition, individuals may perceive behavioral health care received from their primary care provider as being less stigmatizing than specialty behavioral health care. This is particularly important for older adults and for certain racial and ethnic groups whose cultural beliefs and preferences may be inconsistent with the traditional Western approaches to behavioral health treatment. Successful expansion of behavioral health capacity in primary care requires surmounting a number of significant challenges, including reorienting professional cultures, implementing evidence-based practices and practice guidelines, and changing funding structures. All of these have been historically difficult to accomplish [123]. Concerted efforts to address those issues by public and private stakeholders would likely help to alleviate the stress on emergency services and reduce the overutilization of unnecessary and costly first responder encounters and emergency department visits for behavioral health-related issues.

[45] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

Significant efforts to integrate behavioral and physical health care systems are already underway in Washington state (see Appendix C for a description of Integration 2020, Accountable Communities of Health). Ensuring that behavioral health is "at the table" at these initiatives will be a first step in capitalizing on opportunities to expand behavioral health outpatient services in primary care. To strengthen and align with other Washington State system integration efforts, we recommend the following:

- Align health home activities with emerging national models that build on integrated team-based approaches to care, health homes, Certified Community Behavioral Health Clinics and essential components of care coordination and outcomes-based care
- Expand health partners to include medical providers (primary care physicians, clinics, and hospitals) to create a cross-sector team care approach, improve care coordination and expand access to health services
- Prioritize and formalize essential care coordination functions and determine roles and responsibilities across state, health plan, county and community agency partners
- Standardize navigation protocols, including referral pathways, cross-sector provider communication, and follow-up practices to ensure greater consistency of model implementation across sites
- Ensure that the primary care workforce receives basic and ongoing trainings to ensure basic clinical competencies in working with populations with behavioral health needs and confront misperceptions regarding this population

3.3: Partner with Federally Qualified Health Centers and Similar Health Centers as Participants in the Delivery of Behavioral Health Outpatient Services

Outpatient service capacity is expanding outside of traditional behavioral health provider agencies. One of the primary benefits of expanding behavioral health service capacity in the Federally Qualified Health Centers (FQHCs) is the opportunity to integrate behavioral health care with comprehensive patient-centered medical homes for low-income individuals. The benefits of integrated care are well-established; individuals with behavioral health conditions experience high rates of serious health conditions such as diabetes, heart failure, and hypertension, but they often are unwilling or unable to access consistent primary care. In addition, a high percentage of individuals presenting at emergency departments with acute medical symptoms often are suffering with undiagnosed and/or untreated anxiety, depression, substance use, and other behavioral health disorders. FQHCs and similar health centers serve as medical homes, providing integrated medical, behavioral, dental, and vision care, as well as care coordination.

An additional benefit of FQHCs is that Washington, like many other states, reimburses Medicaid outpatient procedures at FQHCs using a prospective payment system. Under this system, health centers receive a fixed, per-visit payment for any visit by a patient with Medicaid, regardless of the length or intensity of the visit. Prospective payment reimbursement (PPS) differs from Medicaid fee-for-service (FFS) reimbursement in two important ways. First, the per-visit rate for the Medicaid PPS is specific to the individual health center location. Second, the per-visit rate is based on the previous year's rate, adjusted by the Medicare Economic Index (MEI) for primary care and *any change in the FQHC's scope of services.* Unlike the Medicaid FFS rates, which are set well below the amount needed to cover costs and are rarely increased, PPS rates allow FQHCs to cover their costs, which helps create a more sustainable workforce.

3.4: Join in Efforts to Ensure Behavioral and Physical Health Parity

An important contribution to the availability of behavioral services in primary care is the 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("Parity Act"). However, a number of barriers have prevented the legislation from fulfilling its promise. These barriers include insufficient state and federal enforcement, health plan noncompliance, including lack of disclosure of medical management information, and other implementation barriers to accessing mental health and substance use services on par with physical health services. The Helping Families in Mental Health Crisis Act (H.R. 2646), passed by the House of Representatives on a near unanimous vote (422-2), and the Mental Health Reform Act (S. 2680), unanimously approved by the Senate Health, Education, Labor and Pensions Committee (HELP), both include provisions for better enforcement of the Parity Act. These bicameral, bipartisan bills promote mental health and substance use parity by requiring better federal agency collaboration to enhance compliance through issuance of clarifying guidance, the reporting to Congress on federal parity investigations, and the development of an action plan to improve federal and state enforcement. If this legislation is coupled with state and federal implementation and oversight, including the randomized auditing process detailed in the Behavioral Health Transparency Act (H.R. 4276), the letter and spirit of the 2008 law will be realized and non-discriminatory access to treatment and recovery will ultimately become available. While this is primarily an issue for federal legislators and the state, counties may advocate for appropriate attention to this issue.

3.5: Develop and Expand Crisis Alternatives

Alternative crisis services such as crisis residential programs can provide resources to divert some individuals from acute inpatient and have been shown in many studies to reduce the need for inpatient care [124]. Crisis alternatives such as the Recovery Response Center currently exist in Pierce County, and this resource has proven to be effective in reducing inpatient admissions. Some key informants noted that the Recovery Response Center's location in Fife can be a barrier to access and expressed a need for more centrally located crisis alternative programs. Enhancing or expanding this service to other parts of the County might improve access and further reduce rates of involuntary interventions. There may also be opportunities to educate first responders to increase knowledge of the resource and correct any misperceptions about the appropriateness of the resource for individuals in crisis.

Other crisis alternative models, such as peer respites[46], are being adopted throughout the country and may serve as an additional resource for individuals in crisis [125]. Peer respites are voluntary, short-term residential programs for individuals experiencing or at risk of experiencing a psychiatric crisis. Peer respites typically have a non-clinical orientation, are staffed and managed by peer specialists, and have a governing or oversight body with a majority of members having lived experience of the behavioral health system. In peer respites, "guests" are engaged by peer support staff using trauma-informed principles that emphasize building healing, trusting relationships. One recent study found that peer respite guests were significantly less likely to use inpatient and emergency services compared with a similar group who did not use the peer respite [126]. These and other alternative approaches to supporting individuals in crisis, and for providing support to individuals before they reach a crisis state, could reduce the need for inpatient and emergency services for many. Crisis alternative services will never fully replace inpatient care, but they can be helpful in some situations to reduce utilization and recidivism.

[46] http://www.peerrespite.net/

3.6: Address Housing Needs Alongside Behavioral Health Needs

Access to safe, adequate, and affordable housing is a critical element in supporting individuals with behavioral health needs to live independently in their communities. Key informants described significant unmet housing needs among people with behavioral health conditions, and our analysis of quantitative data sources supports this claim; compared to other counties and the state, people with behavioral health needs are more likely to be homeless, and there are limited avenues to access affordable housing. Unmet housing needs are obstacles to recovery and reduce the effectiveness of behavioral health treatment. As depicted in Table 2, there are numerous housing resources available to some Pierce County residents with behavioral health needs, most notably the SAMHSA-funded PATH program and Permanent Supportive Housing. The peer-delivered Community Builders program is also aimed at supporting individuals to maintain housing; however, this program is available only for BHO populations. We highly recommend the County explore ways to expand these services, in terms of their capacity and their reach, so that all individuals with behavioral health needs who are homeless are identified, engaged, and supported in finding and maintaining housing.

Although Permanent Supportive is the "gold standard" and an evidence-based practice, it is designed for those with complicated behavioral health needs. An ideal housing support service array would provide a range of services that can be tailored based on individual needs. To ensure that the housing support services are available, the County could support state efforts to expand Medicaid funding for such services and ensure that such programs are delivered in adequate quantity and with high fidelity in Pierce County (see ABHS Task Force recommendation 18[47] and the description of the Medicaid Transformation Waiver in Appendix C). Some additional examples of how other states fund housing supports through Medicaid include:

- In Illinois, Louisiana, and Washington, DC, Medicaid reimburses Community Support Teams that provide ongoing housing supports to persons with serious mental health conditions.
- Massachusetts has an option for diversionary services for individuals at risk for homelessness. Medicaid covers a daily rate for each individual, enabling the service team to respond immediately to beneficiary needs.
- Illinois has incentive payments for housing stability to encourage health plans to invest in housing supports through a Medicaid bonus pool for persons with a mental health or substance use issue.

Importantly, Medicaid funds housing support services but will not fund room and board. Ensuring the availability of housing units should involve partnerships with the Washington State Housing Finance Commission and local housing authorities to put new Permanent Supportive Housing units into the development pipeline and explore other avenues to expand housing options to individuals with behavioral health needs.

3.7: Promote Employment Among Behavioral Health Service Users

Expanding the availability of work support programs is one of the more cost-effective investments of services for persons who would otherwise be non-taxpayers enrolled in the Social Security Disability Insurance (SSDI) program. It has also been shown to be associated with reduced hospital utilization. Therefore, we recommend that the County work with the state to ensure that a range of employment supports be established for people with behavioral health needs in Pierce County. These should include high-fidelity supported employment services such as Individualized Placement and Support, as well as other services such as job coaching and training and placement

[47] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

assistance. Washington's Medicaid Transformation Waiver (described in Appendix C) includes provisions to fund these services through Medicaid, so it will be important to support state efforts and ensure local capacity for such services so that Pierce County residents can benefit from this new resource.

It will also be important to work with local providers and explore public and private partnerships to enhance access to employment supports for individuals who may not be eligible for Medicaid-funded employment support services. There may be additional opportunities for collaboration with the State Division of Vocational Rehabilitation to promote employment among behavioral health service users. For example, the Workforce Innovation and Opportunity Act (WIOA), effective July 1, 2015, requires state-run Vocational Rehabilitation agencies to work with employers to assess their labor needs and coordinate the development of work-based learning opportunities such as apprenticeships, with government funding available to fund half of the first six months of individuals' salaries along with other supports.[48] The WIOA may be an opportunity for coordination between the behavioral health system, the Division of Vocational Rehabilitation, and local businesses to establish employer-based programs for people with behavioral health conditions.

3.8: Support State Efforts to Align Substance Use and Mental Health Services in the Medicaid State Plan

As described in Section 3 (section on Substance Use Disorder treatment), rates of substance use disorder treatment and completion are low throughout the state, and Pierce County is no exception. Key informants described staffing shortages and insufficient capacity across service types, and indicated that additional wraparound supports and peer services would be of benefit to people with substance use disorders. Key informants also expressed a high degree of uncertainty about what substance use disorder treatment in Washington State will look like once the transition to integrated mental health and substance use disorder treatment systems that began in April 2016 is complete.

In keeping with the current mental health and substance use disorder integration efforts, it will be critical that the County support state efforts to align substance use disorder treatment services with mental health services in the Medicaid State Plan, and also that the County encourage the state to maintain financial support for evidence-based, clinically appropriate substance use disorder services not currently covered by Medicaid (aligns with ABHS recommendation 4[49]). The Chemical Dependency Integration Work Group of the ABHS Task Force has recommended that case management, peer services, recovery supports, and medication monitoring and management be included as part of a comprehensive Medicaid service package for substance use disorder treatment.

3.9: Coordinate with the State Efforts on Medicaid Benefit Plan Options

In addition to the 1115 the state of Washington is pursuing for all Medicaid beneficiaries, there are numerous other waivers and state plan amendments (SPAs) that the state is eligible to submit to expand the behavioral health service array. The 1915(i) SPA has been the most common avenue for states to pursue the opportunities available via the Centers for Medicare and Medicaid Services (CMS).

Originally proposed in 2007, amended in 2010 and again in 2012, the 1915(i) offers states the option to include a wide range of home and community-based services as a State plan option. The

[48] For more information about the WIOA, see https://www.doleta.gov/wioa

[49] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

1915(i) is not a waiver like 1915(c)—it is an optional set of benefits that states can choose to add to their Medicaid State plan. The 1915(i) presents states with an opportunity to expand and enhance their community-based behavioral health service and support offerings. Eligible services include those already available through the 1915(c) waiver as well as new services particularly relevant to a behavioral health population, such as peer-provided services, supported employment, supported housing and peer respites. The 1915(i) state plan option also allows for the inclusion of self-direction[50] in state Medicaid plans.

In 2010, the Affordable Care Act (ACA) amended the 1915(i) in key ways, presenting new opportunities for using the state plan option to fund behavioral health services and supports: the range of covered services and supports was further expanded, eligibility was extended to include individuals with incomes up to 300% of the SSI Federal Benefit Rate, and states were permitted to have more than one 1915(i) benefit targeted to specific populations. If interested, the state can request free technical assistance from experts in using CMS authorities to expand behavioral health services.[51]

3.10: Expand the Scope of Peer Services, Particularly for Non-BHO Populations

Optum Pierce has invested significantly in developing the peer workforce in Pierce County; since 2009, Optum has trained approximately 500 individuals as Certified Peer Counselors, about 200 of whom are employed in the BHO system [127]. This newly trained workforce could be put to better use if there were capacity for peer specialist positions outside of the BHO network. This includes supporting state efforts to pursue Medicaid-reimbursement for peer-delivered SUD services (see 3.7, above). There may also be opportunities to partner with FQHCs and private health systems to develop more peer-delivered service capacity within their service networks. There may be opportunities to expand peer specialist services in primary care settings through the ACH/Integration 2020 activities.

Critically, peer services must still be delivered according to national practice standards in a manner that maintains the integrity of peer support. This will require significant support for the peer workforce as well as education for providers to promote culture change and challenge misperceptions about the role of peers in clinical treatment settings. Continuing to promote and expand the scope of peer services at all levels of care aligns with the ABHS Task Force recommendation 11.[52]

3.11: Target Resources Strategically to Reduce Inpatient Utilization

Targeting limited behavioral health system resources to the particular sub-group of individuals who are subject to psychiatric boarding and other forms of delayed treatment will reduce bottlenecks in the crisis and inpatient systems. Doing so may allow for more efficient investment in

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[50] In self-direction—also known as self-directed care—a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines.

[51] To apply for free technical assistance, fill out an application at http://www.hcbs-ta.org/. CMS has a website with the regulations and all published guidance to date found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

[52] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

targeted community-based resources that, in turn, may reduce the need for inpatient treatment. This is already taking place in BHO programs, but the high rates of emergency treatment suggest that more capacity is needed. This may involve expanding current evidence-based practices shown to reduce hospitalization, such as Assertive Community Treatment, as well as local initiatives with a proven track record for diverting individuals from hospitalization, such as Emergency Department Peer Support. Similarly, services that are targeted toward supporting community transitions should be emphasized; these services connect individuals with appropriate services once released from inpatient settings and can reduce re-hospitalizations. Again, such services are already in place in Pierce County and have demonstrated proven success, notably the Peer Bridger Program. Partnerships with the BHO should explore creative solutions to expand access among individuals with high levels of need who are not currently eligible for such programs. The PAR Initiative includes a strategy to expand Peer Bridger services for individuals discharged from St. Joseph Medical Center by establishing reliable, long-term funding and developing shared referral, reporting, and evaluation processes. PAR also includes a strategy related to supporting the Mental Health program at CHI Franciscan emergency departments. These efforts could serve as a starting point.

In addition, numerous key informants and stakeholders expressed concern regarding the timeliness of the Crisis Line and MOCT team, with some hypothesizing that long wait times for crisis response represent missed opportunities to divert individuals away from more intensive services like E&Ts and inpatient. Therefore, we also recommend working with the BHO to address these issues and enhance the responsiveness of the Crisis Line and MOCT.

Service and Support Recommendation 4: Expand the Use of Remote Health Interventions

Telemedicine is a nationally recognized approach to increasing access to care, including behavioral health care. A literature review was conducted, based on findings published from 60 scholarly sources within the past 12 years, to assess the use of telepsychiatry in the United States [128]. The review concluded that telepsychiatry was effective in treating individuals with a variety of mental health conditions. The review determined that treatment delivered using telemedicine was comparable to face-to-face service delivery and that most people who received the service were satisfied with their level of care.

Other remote health interventions, including social media platforms and smartphone applications designed to equip service users and providers with tools for engagement, coaching, and collaboration have proliferated in recent years.[53] As financing of behavioral health care shifts from fee-for-service to value-based payment models in coming years, there may be opportunities to incorporate such approaches into the provision of behavioral health care in Pierce County.

Consultation models where psychiatrists consult to primary care physicians about use of psychiatric medications for "routine" cases have also been used successfully in states and counties across the country; these models free up psychiatrists for patients with more complex medication regimes. Strategies such as arranging for eConsults, scheduling psychiatry "office hours" so psychiatrists can provide consultation to primary care physicians, and increasing training for primary care physicians on the use of psychiatric medications have been used to help augment the dearth of available psychiatrists in rural areas.

[53] For a discussion of recent trends and tools, see http://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment/index.shtml

Working to expand the use of evidence-based telemedicine and remote health practices may reduce barriers to care, particularly for those living in rural parts of the County. The ABHS Task Force includes recommendations to the state to adopt laws to regulate telemedicine providers and allow payment for telemedicine visits along with conducting education campaigns related to telemedicine in rural areas (ABHS Task Force recommendation 10)[54], which entities in the County could support.

Service and Support Recommendation 5: Enhance Service User Engagement, Activation, and Self-Management

In the SPES, we found that a high proportion of case managers attributed unmet needs to service user refusals, and that service users reported high rates of being unaware of services or refusing services because they didn't understand what the services were. These findings point to opportunities for better engaging service users as active participants in their care. Information and engagement is key to ensuring that service users are actively involved in their behavioral health care and active members of their own treatment teams. Involving service users in decisions about their care is essential in this process. We recommend three strategies for enhancing service user engagement, self-management, and activation. All three practices have been associated with increased engagement as well as positive service user-level outcomes and lower system costs.

5.1: Promote Shared Decision-Making

As noted previously, shared decision-making is a process through which service users and providers work with one another to understand a person's needs and preferences and ensure service users are active participants in their care. The SAMHSA-HRSA Center for Integrated Health Solutions maintains a website with links to resources to support shared decision-making, including freely available workshops and instructional videos and practical tools.[55] Shared decision-making could be promoted through connecting providers with free trainings and toolkits and measuring uptake of these shared decision-making practices throughout the behavioral health system. A number of web-based applications support shared decision-making in behavioral health care. CommonGround, developed by Dr. Pat Deegan, generates a one-page health report prior to an appointment to facilitate shared decision-making during the 15-minute treatment encounter.[56]

5.2: Track and Promote Patient Activation

Patient activation refers to the skills and confidence that service users have to engage in their health care. A 2013 study of over 33,000 patients in a large health system found that those with the lowest levels of patient activation had significantly higher service costs than those with the highest activation levels, even after controlling for commonly used "risk scores" used by health systems to predict future costs [129]. This study and others that indicate that interventions that build patient activation result in better outcomes and lower costs have led to an increasing focus on activation in health systems across the country [130]. The Patient Activation Measure used in the above studies has been adapted and validated for individuals with mental health conditions[57], and preliminary testing of the measure shows that those with higher levels of activation are more likely to have better mental and physical health and quality of life and higher rates of psychiatric medication adherence and satisfaction with treatment [131].

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[54] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

[55] http://www.integration.samhsa.gov/clinical-practice/shared-decision-making

[56] https://www.patdeegan.com/commonground

[57] The questions in the 13-item measure are at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3536445/figure/F1/

5.3: Encourage Establishment of Mental Health Advance Directives

Another strategy for ensuring that service users are active and engaged in their care involves promoting Mental Health Advance Directives (also known as Psychiatric Advance Directives). Mental Health Advance Directives are legal instruments an individual can use to specify instructions or preferences regarding future mental health treatment, including circumstances in which individuals lose capacity for informed consent during a mental health crisis[58]. Mental Health Advance Directives have been shown to reduce the need for costly involuntary treatment; a recent review synthesizing evidence from multiple interventions designed to reduce compulsory treatment found that advance directives were associated with the greatest reduction at 23% [132]. A Washington state statute[59] permits the execution of legally binding mental health advance directives. Although many states have such legislation, Mental Health Advance Directives are largely underutilized nationwide [133]. The state of Virginia has been lauded as pioneering policy innovations in this area, and a recent article in the journal *Psychiatric Services* describes these efforts [134].[60] The National Resource Center on Psychiatric Advance Directives[61] is also a useful resource for individuals, family members, and providers.

In Pierce County, the PAR initiative includes efforts to expand the use of Mental Health Advance Directives, so working with the PAR activities would represent a low-cost strategy to reduce the need for inpatient hospitalization while also promoting autonomy and empowerment and enhancing communication between patients, families, and their treatment team.

Service and Support Recommendation 6: Develop and Implement a Criminal Justice System Strategy Building on Existing Resources and Best Practice

Nationwide, stakeholders have described the criminal justice system as the "de facto behavioral health system" for those with serious behavioral health conditions, referring to the overrepresentation of people with serious mental health conditions in jails and prisons. The Sequential Intercept Model is used by many communities as a conceptual framework to understand and address behavioral health issues and the criminal justice system [135]. The version of the model in Figure 29, developed by the SAMHSA GAINS Center, may be a tool for organizing and evaluating initiatives in Pierce County.

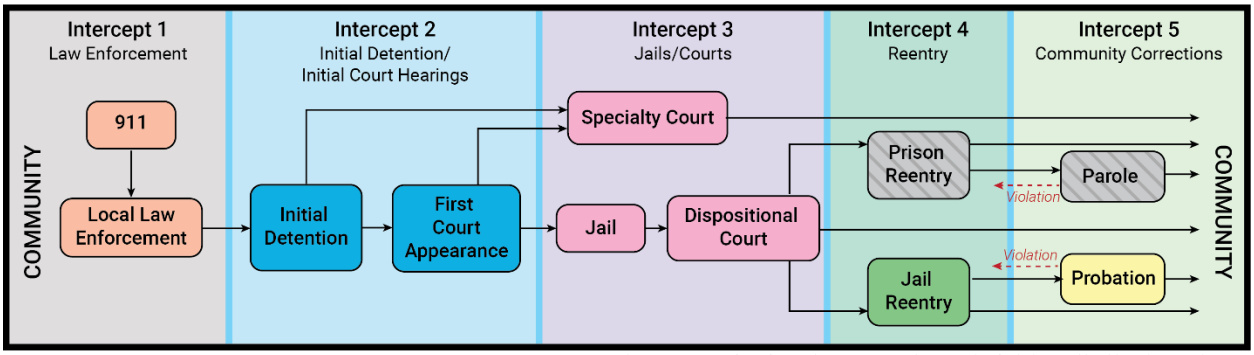
[58] http://www.nrc-pad.org/

[59] http://apps.leg.wa.gov/rcw/default.aspx?cite=71.32. Although there is no mandatory form, the statute provides a recommended form available here: http://www.nrc-pad.org/images/stories/PDFs/washingtonpadform.pdf

[60] http://www.ncbi.nlm.nih.gov/pubmed/25554231

[61] http://www.nrc-pad.org/

Figure 29. SAMHSA GAINS Center Central Intercept Model



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

In a robust system, interventions are targeted at each point of intercept between the behavioral health and criminal justice systems to prevent individuals from entering (Intercept 1) or penetrating deeper into the criminal justice system. Ideally, most people are intercepted in the earlier stages, with decreasing numbers at each intercept. Our recommendations are rooted in this framework, and we recommend that this framework be used as a tool in future efforts to coordinate and enhance these efforts.

6.1: Ensure Collaboration and Communication between Criminal Justice and Behavioral Health Service Systems

The effectiveness of interventions designed to meet the behavioral health needs of those involved in the criminal justice system will hinge on the quality of the collaboration between behavioral health and criminal justice system stakeholders. A recently published framework for mental health and criminal justice collaboration may serve as a useful resource for understanding best practices in collaboration [136].[62] The work of the District Court's Behavioral Health Unit in the Probation Department is a local model for specific activities and strategies for effective collaboration and communication; it could serve as a starting point for these discussions.

6.2: Promote Behavioral Health Training Among First Responders and Continue to Expand the Mental Health Co-Responder Program

Corresponding with Intercept 1 in the Central Intercept Framework, diverting individuals from the criminal justice system to treatment is the first opportunity to prevent criminal justice system involvement. Training police officers using Crisis Intervention Team (CIT) training is a first step in equipping the police force to better manage crisis situations encountered with individuals with behavioral health needs, and can help to assist individuals in accessing the treatment system [137]. These trainings are now required for all police officers and are available through the Washington State Criminal Justice Training Commission. The PAR initiative includes plans to facilitate mental health education for other first responders. By ensuring that these trainings are available on an ongoing basis, all first responders should be better-equipped in identifying and responding to behavioral health-related issues and engaging individuals in a voluntary decision to treatment or a safe alternative.

Key informants were universal in their endorsement of the Mental Health Co-Responder Programs in Tacoma and Lakewood, and data from the City of Tacoma suggest that the program has been

[62] http://www.ncbi.nlm.nih.gov/pubmed/27417893

successful in diverting people into treatment and away from jails and emergency rooms. Therefore, we recommend that the County partner with local police departments to identify financing sources and seek funding to sustain and expand this resource.

6.3: Build Upon Local Best Practices for Behavioral Health Criminal Justice Partnerships

As noted in Section 3, Pierce County is home to a number of successful initiatives to support individuals with behavioral health needs who have been involved in the criminal justice system. These include several therapeutic courts, the Community Re-Entry and Jail Transition Services Programs, and the District Court Behavioral Health Unit. These services address behavioral health needs along several points in the Central Intercept framework. Determining whether and how to expand or coordinate these efforts should be left to a local governing body and be part of a strategic planning process.

6.4: Support State Efforts to Expand Behavioral Health Services for Incarcerated Individuals

As noted throughout this report, individuals face numerous barriers to obtaining health insurance, even after the Medicaid expansion. For incarcerated individuals, it will be important to support and coordinate with the state's efforts to pursue an 1115 Medicaid Waiver to expand services to incarcerated individuals and work with the state to advocate for the suspension rather than termination of Medicaid benefits for incarcerated individuals (aligns with ABHS Task Force recommendation 6)[63]. These state-level efforts are consistent with the approach supported by CMS in a recent guidance letter to states.[64]

Service and Support Recommendation 7: Expand Support and Education for Families of People With Behavioral Health Conditions

The PAR initiative includes strategies to expand NAMI's offerings for family support, which are widely used throughout the country. These efforts may lead to an increase in NAMI's membership, which might foster the development of informal connections and groups alongside formal ones. Numerous other initiatives discussed in these recommendations, such as community education and outreach, school-based prevention activities, and the implementation of Mental Health Advance Directives, also involve increased information and support for families, as does the addition of a Behavioral Health Specialist in the 2-1-1 program. As we emphasize in Infrastructure Recommendation 1, establishing processes for meaningful input from family members and ensuring family member representation on bodies that oversee improvements of the behavioral health system will also be essential to ensure the voice of family members is represented in system change and ongoing quality improvement efforts.

Service and Support Recommendation 8: Foster Coalitions to Meet the Needs of Veterans and Service Members

As described in Section 4, an estimated one in ten Pierce County residents are veterans, and Pierce County is home to the largest military installation on the West Coast. Given the high prevalence of behavioral health needs among this population, any system reform effort should include a clear plan to ensure these needs are met. A number of strong coalitions and innovative programs are already in place that work to meet the needs of this population, and the Give an Hour initiative

[63] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

[64] The letter can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf

represents an excellent opportunity for stakeholders in Pierce County to come together and develop a comprehensive and sustainable plan to support veterans and service members. Ongoing efforts should be focused on sustaining and promoting current successful initiatives and creating a process for identifying and addressing gaps in an ongoing manner.

Infrastructure Recommendations

While the Service and Support Recommendations above provide a potential menu of activities that might improve the Pierce County behavioral health system, the Infrastructure Recommendations presented in this section provide a suggested course of action for carrying out those recommendations.

Infrastructure Recommendation 1: Establish a Central Coordinating Body

Gaps and limitations in behavioral health systems such as those we documented in this study are often due, in varying degrees, to fragmentation related to multiple funding sources and diverse organizations with differing missions and funding sources that provide only certain services to a specific subpopulation of persons needing behavioral health care. These circumstances are the consequence of numerous historical factors and are not easily rectified; however, there are examples in some locales of various models of coalitions, steering committees, task forces and the like that serve to enhance communication or coordination among the various parties involved in providing behavioral health care. Coalitions and related models may or may not have decision-making authority but can be effective at promoting consensus, limiting the negative consequences of competition, and advocating for addressing unmet needs. One local example of this is the Mental Health Substance Use Collaboration effort led by the City of Tacoma. There may also be opportunities to create such a coalition—or build upon current work—from the Accountable Communities of Health initiative.

We recommend that a central coordinating body be identified or established in order to promote the well-being of all Pierce County residents by supporting effective outreach and prevention and the delivery of comprehensive high-quality, accessible, effective behavioral health services and supports. Whether this body is newly formed or built upon the foundation of some existing structure, of which there are several possible candidates, ought to be a decision at the local level; therefore, we do not make any specific recommendation. Likewise, whether membership includes members of the public or service users is another decision to be made locally. We do recommend, however, that this decision take into consideration the fact that membership will influence the mission of the group. Regardless of how this entity is constituted, it should have the following functions and features:

- Include a funded position or consultant with a significant portion of time dedicated
- Create a strategic plan for system improvements with clearly articulated goals, objectives, action steps, and timelines for achieving the vision. The plan should lay out implementation steps and prioritize areas for short-, medium-, and long-term change
- Create or identify performance and outcome measures to incentivize and assess change with emphasis on accountability and key milestones
- Include the broadest possible representation of providers and policy makers involved in the Pierce County behavioral health system
- Engage community stakeholders in an ongoing, inclusive way to promote a shared vision for a healthy system

- Operate in concert with the many existing behavioral health initiatives and workgroups
- Work with Washington state to ensure alignment with relevant state initiatives and facilitate implementation of strategic plan
- Identify and pursue sustainable funding sources to enhance Pierce County's limited prevention and treatment system resources and support the envisioned change
- Identify and address potential concerns as they emerge, to prevent disruption in progress
- Develop strategies to ensure that system principles are included (e.g., trauma-informed care) and that data elements required for system accountability are adopted

1.1: Ensure Full and Active Inclusion of Service Users in All Planning and Oversight Activities

Because the ultimate goal of system improvement efforts is to create a behavioral health system that best meets the needs of the community and promotes recovery at all levels, it is critical that service users and their family members are fully involved in all aspects of the process. As noted, whether these parties are represented by means of the entity proposed in Infrastructure Recommendation 1 or is a separate group is again a decision that should be made locally. In either case, our experience has shown that in order to reduce the effect of tokenism and promote full and active involvement, it is necessary to have more than one user of behavioral health services as well as family members represented on every committee as well as each sub-committee or working group. Because service users are themselves a diverse group, care should be taken to involve individuals who are reflective of Pierce County's diversity.

1.2: Capitalize and Build on Current Initiatives

Current initiatives in the broader health care system, particularly Integration 2020 and the development of Accountable Communities of Health, offer an opportunity to harness these forces of change for improvements in the behavioral health sector. Furthermore, it is important to ensure that behavioral health has a place in these initiatives. We therefore recommend that Pierce County behavioral health stakeholders embrace the ACH concept and ensure that behavioral health is "at the table" for all efforts to integrate behavioral health and physical health systems and ensure the success of Integration 2020. We also recommend that Pierce County behavioral health stakeholders work in concert with the state's strategic behavioral health planning efforts whenever possible (the state's ABHS recommendations are referenced throughout our recommendations).

1.3: Develop an Organized System for Identifying and Responding to Funding Opportunities

This is a period of tremendous change for health and behavioral health systems, for Washington state and for the country as a whole. Having a designated person to keep a finger on the pulse of system changes and opportunities will be critical for ensuring that Pierce County receives an adequate and ongoing supply of funding for system improvement efforts. The behavioral health initiatives discussed throughout this document are funded by an array of sources, including private and public grants and local, state, and federal programs. While we discuss some potential financing opportunities, they are by no means a comprehensive account of all possible funding streams. By establishing an entity charged with monitoring possible funding sources and identifying and responding to opportunities, the County may capitalize on diverse funding streams and ensure a more sustainable system.

Infrastructure Recommendation 2: Support Current Efforts to Enhance and Integrate Provider Data Systems

In today's health care environment, comprehensive, integrated data systems are considered essential to effective planning, service coordination, and delivery. The use of electronic health records has been vastly accelerated since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, which authorized incentive payments to increase physician adoption [138]. The Washington State Health Care Authority is currently developing a clinical data repository that will allow health care providers to access a person's health care information across practice settings in real-time,[65] which will present an excellent opportunity to begin to integrate clinical data. According to the AHBS Task Force, there are federal confidentiality laws that may restrict the sharing of substance use disorder treatment data among providers, which will complicate data sharing in the newly integrated system [139], so it will be important to work with the state to reduce these barriers.

In the behavioral health field, although progress varies widely, a number of state mental health agencies have initiated efforts to link patient-level data with other agencies such as criminal justice, health, employment, child welfare, juvenile justice, and education [140]. We recommend that Pierce County leadership work in concert with state efforts to develop data sharing standards and common understandings of privacy laws, and advocate to the federal government to amend privacy laws as appropriate to reflect today's integrated health care environment (corresponds with ABHS recommendation 2)[66]. This effort should include working with state agencies and within the County to align data monitoring systems and encourage them to adopt shared data conventions that will prepare the County for Integration 2020 (described in Appendix C), including shared measures, data elements, and data dictionaries. This enhanced system should also allow for monitoring of racial and ethnic disparities to track whether the County is meeting the needs of all Pierce County residents and enable a quick response to correct disparities in access, quality, and outcomes.

The state, health plans, and counties play an important role in facilitating a shift from data reporting for "compliance" to "accountability" for population health management and outcome and value-based care. The following should accompany the rollout of any new data system:

- Training for behavioral health providers to routinely collect and use data to inform clinical decision-making and demonstrate improved individual-level outcomes
- Sufficient capacity across all providers to collect data in formats that allow for assessment of the core functions that are essential to integrated or coordinated care (e.g., referral tracking, follow-up, care planning, and cross provider/system communication)
- Efforts to ensure that the goal of required data collection and reporting moves beyond documenting the number and type of services delivered to tracking whether the services are making a difference in the lives of individuals and improving overall population health (i.e., moving from volume-based care to value-based care)

[65] http://www.hca.wa.gov/assets/program/Clinical-Data-Repository-Information-Sheet.pdf; http://hca.wa.gov/about-hca/health-information-technology

[66] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

Infrastructure Recommendation 3: Develop System Metrics to Track Progress on Key Goals

Data system efforts may also include selecting a set of performance and outcome indicators based on specific system goals. The City of Tacoma has put in place a number of performance monitoring strategies through the program that administers the Mental Health and Chemical Dependency Tax, and these strategies may serve as a model or starting point for County-wide activities. Service users, families, providers, advocates, and other key stakeholders should be involved in the identification and selection of the performance and outcome indicators for the system. It is important that both process and short-term and long-term outcome measures are included. Process measures capture how services and treatments are provided and allow system stakeholders to compare the quality of services across the County and to identify trends and exceptions to trends.

Some examples of metrics other communities have used as part of routine reporting and dashboard systems include the following:

- Provider collaboration measures around referrals and data sharing
- Number of inpatient bed days utilized by payer source and demographics
- Number of behavioral health emergency room encounters
- Number of new persons entering the system (could be defined as those completely new to the system or those who have not received a service for a specified amount of time)
- Number of persons entering the system via police or other criminal justice entry point
- When new services are added, tracking the number of people utilizing the service by month
- Number receiving employment support services
- Number receiving housing support services
- Number of service users in competitive employment
- Number of service users who attain and maintain stable, integrated housing
- Number receiving housing vouchers
- Number of peer specialists employed
- Service user activation (Patient Activation Measure-Mental Health) and health and mental health-related functioning
- Substance use disorder treatment, retention and engagement

Infrastructure Recommendation 4: Conduct Further Data-Driven Assessments of Need and Access

The analyses in this report, based on utilization data and key informant interviews, provide a partial picture of existing and needed outpatient services and suggest a need for outpatient and community-based service enhancements that may provide a better return on investment than inpatient services. However, continued monitoring of outpatient need and capacity will be essential to ensuring a high-quality behavioral health system in the long term. An important element that requires monitoring is access to network providers. It may be worthwhile to employ a method recommended by the U.S. Department of Health & Human Services (DHHS) known as simulated patient (or "secret shopper" [141, 142]) and employed in a variety of studies for that purpose [143], [144]. Under this approach, investigators represent themselves as individuals seeking outpatient behavioral health treatment to confirm whether new clients were being accepted, whether providers accepted various insurance sources (including Medicaid), and the length of wait time to the first appointment.

In recent reports and in key informant interviews, some advocates cited figures of inpatient bed capacity in Pierce County being far lower than the national and state averages. These figures have been cited as evidence of unmet mental health treatment needs. However, as discussed in an earlier section, such arguments may rest on the assumption that inpatient psychiatric care is the solution to the myriad problems facing Pierce County residents with behavioral health needs, which may not be the case. For reasons outlined above, any assessment of bed need first requires a detailed assessment of outpatient services. Determining inpatient bed need in Pierce County requires a more detailed analysis than was feasible given the scope of this study. Such an assessment may be more informative in conjunction with enhancement of outpatient services. Further, the fact that inpatient bed capacity is likely to increase dramatically in the County in the coming years with the opening of the planned CHI Franciscan/Multicare hospital suggests that a focus on outpatient capacity may be a more productive option in the near term.

Infrastructure Recommendation 5: Ensure a Culturally Competent and Trauma-Informed System

In our key informant interviews, we learned that many organizations in Pierce County have a strong commitment to cultural competency and trauma-informed approaches. These important principles should be at the heart of any efforts to coordinate and improve behavioral health services system-wide. Therefore, we recommend that the efforts of a central coordinating body include strategies to ensure cultural competence and trauma-informed care.

Nationally, disparities in behavioral health care for racial and ethnic minorities have been described in many landmark documents [145, 146]. In 2011, the U.S. DHHS developed an *Action Plan to Reduce Racial and Ethnic Health Disparities* that includes action steps related to behavioral health.[67] These disparities include less access to services, lower likelihood of receiving needed services, and greater likelihood of receiving poorer quality care. The authors of these reports and others in the field have identified the provision of culturally competent care as an important means of eliminating disparities in behavioral health care. This is an issue that is not particular to Pierce County; it is widespread and affects many behavioral health systems.

There are many definitions of cultural competency, but the classic and most commonly used was developed by Cross, Bazron, Dennis and Isaacs [147]. These researchers defined it as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. While the focus of the cultural competency literature is primarily on individuals from racial and ethnic minority backgrounds and with limited English proficiency, these principles also apply to work with other cultural groups, such as individuals who are deaf and hard of hearing, individuals with physical disabilities, individuals that are members of the LGBTQ community, etc.

A commitment to cultural competency could take the form of having a dedicated budget for cultural competency activities; developing a written cultural competency plan that outlines clear goals and objectives, strategies, and implementation timetables; and developing policies on cultural and linguistic competency for the entire system or as they relate to specific services (crisis, inpatient, community-based services). The DHHS Office on Minority Health developed National Standards for Culturally and Linguistically Appropriate Standards in Health and Health Care (The National CLAS Standards) that can provide a framework for developing a cultural competence plan. The CLAS

[67] http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

website[68] includes numerous resources for systems and providers, including a "Tracking CLAS" page that offers a state-by-state compendium of National CLAS Standards Implementation activities. In Washington state, the Governor's Interagency Council on Health Disparities maintains a CLAS Standards training website that features e-learning modules as well as in-person training materials that can be adapted to fit specific organizational needs.

In terms of trauma-informed care, the SAMHSA National Center for Trauma-Informed Care (NCTIC[69]) defines it as a framework that is focused on healing and recovery, under which the premise for organizing services shifts from looking at "what is wrong with you?" to "what happened to you?" This requires an organizational shift from a traditional "top-down" environment to one that is based on collaboration between service users and providers. A trauma-informed approach rests on the following key assumptions: "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**."

NCTIC offers a variety of resources, including training and technical assistance, to assist behavioral health systems in ensuring a trauma-informed approach. The project team recommends that leadership in Pierce County follow the actions that NCTIC identified in its *Guidance for a Trauma-Informed Approach*[70] to ensure a system-wide orientation to trauma-informed care.

[68] https://www.thinkculturalhealth.hhs.gov/
[69] http://www.samhsa.gov/nctic/trauma-interventions
[70] http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

7. Conclusion

Our analysis of extant data, key informant interviews, and the Service Planning and Evaluation Survey responses all highlight the variety of challenges faced by the Pierce County community as it seeks to ensure adequate access to behavioral health services and support the recovery and well-being of Pierce County residents. There are challenges that many other county-based behavioral health systems in the country face: issues of fragmentation, disparities in access, a rapidly changing policy environment, multiple levels of government, and limited resources.

Our analysis also indicates that stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied on as the sole basis for remedial action. This is not to say that these sources are not reliable, but rather it recognizes that the complexity of the behavioral health needs, services, and prevention activities limits the capacity to understand the full nature and scope of any feature when viewed from a single perspective. There is no single "cause" of the myriad problems faced by Pierce County residents with behavioral health needs, and accordingly, there is no single solution to "fix" the system. Our various data sources indicate a range of factors that need to be addressed and complex, interconnected unmet needs that collectively place a burden on many systems and sub-systems with an ultimate result of poorer behavioral health across the County.

The bottom-line conclusion generated from this analysis is that there is no single entity ensuring a seamless and effective behavioral health system for ALL Pierce County residents. There is, however, a proliferation of promising initiatives and coalitions of talented individuals committed to improving this system. A single entity with a defined mission and legal authority is in the best position to define the vision and the goals for this effort, with the diverse array of other stakeholders in the community contributing as partners.

Moreover, it is critical that the current fragmentation and discontinuity of behavioral health services be addressed by establishing comprehensive and well-integrated data systems that will provide for overall monitoring of system performance and identify opportunities for improvement. Several of our recommendations focus on the potential benefits of increased data sharing and health information technology in general.

This study and this report is only one step in Pierce County's assessment and analysis efforts. No single report can tell the entire story of a county's populations in need, and the services required or the barriers that exist to meeting those needs. Furthermore, no single report can be as detailed as stakeholders might like for issues of interest. However, we hope that the information in this report and the process by which the information was developed can provide the basis for future planning efforts to create an improved behavioral health system throughout Pierce County.

Appendix A: Data Sources and Methods

The behavioral health study involved four types of data: existing prevalence, service utilization, and outcome data; the Service Planning and Evaluation Surveys (SPES); key informant interviews with stakeholders; and community feedback. Data were analyzed using a mix of qualitative and quantitative research methods.

Existing Prevalence, Service Utilization, and Outcome Data

A team at HSRI located, compiled, and synthesized existing quantitative and qualitative data from a wide variety of sources for this report. These included publicly available data as well as data provided by key informant interviews. Data sources, referenced throughout the report, included service utilization and outcome data reported through the Washington State DBHR, CHARS hospital data, and reports and articles from a variety of published and unpublished sources. To place the local Pierce County issues in the context of the national health and behavioral healthcare environment, peer-reviewed research articles and national literature have also been drawn on as part of this project and are referenced throughout the final report.

Data sources most commonly used for this report include:

- **Behavioral Risk Factor Surveillance System (BRFSS).**[71] The BRFSS is a national telephone survey administered to more than 400,000 U.S. residents in all 50 states and the District of Columbia each year. The core survey measures assess health-related risk behaviors, chronic health conditions, and use of preventative services.
- **Healthy Youth Survey (HYS).**[72] The HYS is a survey administered to youth who are students in Washington State. The survey assesses a number of health behaviors including: alcohol, marijuana, tobacco and other drug use; dietary behaviors and physical activity; mental health; school climate; quality of life; and risk and protective factors. The survey results are available as an analytic dataset for public use.
- **Robert Wood Johnson Foundation, County Health Rankings.**[73] The County Health Rankings program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. This county-level ranking system follows a model of population health which highlights "health factors" and "health outcomes" that influence the overall well-being of communities across the nation. County-level measures from an array of national and state data sources (e.g., BRFSS) were standardized then combined using rigorous, scientifically informed procedures. Counties are ranked within states based on these measures.
- **System for Communicating Outcomes, Performance & Evaluation (SCOPE–WA).**[74] SCOPE-WA is a reporting and query application created by the Washington State Division of Behavioral Health & Recovery (DBHR). Data on patient characteristics and treatment received is available from the DBHR TARGET (Treatment and Assessment Report Generation Tool) system and was updated monthly before April 1, 2016. Additional

[71] http://www.cdc.gov/brfss/
[72] www.askhys.net
[73] http://www.countyhealthrankings.org/
[74] www.scopewa.net

treatment outcome data is derived from administrative data sources such as Medicaid, employment, and state-level arrest databases.

- **National Survey on Drug Use and Health (NSDUH).**[75] NSDUH is a federally conducted face-to-face interview administered to persons 12 and older who are residents of households, non-institutional group quarters, and military bases. Data are collected on mental disorders, co-occurring substance use and mental disorders, and treatment for substance use and mental health issues. For this report, small area estimates (SAE) were used from data combined from the 2012-2014 NSDUH to determine estimated prevalence.
- **United States Census Bureau.**[76] The Census Bureau's Population Estimates Program (PEP) produces estimates of the population among U.S. states, counties, cities and towns, and the Commonwealth of Puerto Rico and its municipalities. New estimates are released annually, at which point, the entire series of estimates is revised for all years to the last census. PEP state and county data are available by age, sex, race, and ethnicity.
- **Youth Risk Behavior Surveillance System (YRBSS).**[77] The YRBSS is a collection of ongoing national, state, territorial, tribal, and local school-based surveys that are completed biennially. It also includes one-time national surveys and special-population surveys. Data are collected from students in public and private schools ranging from 9th through 12th grade. Survey questions target health risk behaviors which contribute to leading causes of death among youth and adults in the U.S.
- **Comprehensive Hospital Abstract Reporting System (CHARS).**[78] Administered by the Washington State Department of Health, the CHARS contains hospital inpatient discharge information derived from hospital billing systems along with demographics, diagnostic and procedure codes, and costs.
- **WA DSHS Client Data Reports.**[79] The WA DSHS publishes aggregated, anonymous data for individuals who receive DSHS services, including mental health and substance use disorder treatment services. The Client Data Reports include unduplicated counts of individuals served, use rates, and direct service costs. The most recent Client Data Reports available for this study were from fiscal year 2014.

Service Planning and Evaluation Survey

The Service Planning and Evaluation Survey (SPES) was designed to provide information on services needed, services received, and reasons for not receiving those services from the perspective of case managers and service users. The SPES is significant in that it provides an in-depth view of service gaps for a population of individuals with significant behavioral health needs that would otherwise be unavailable through the other data-gathering strategies in the study. For the purposes of this project, the target population for the SPES was adult users of publicly funded mental health services in Pierce County who are living in the community (not residing in inpatient settings). Although this group does not represent all users of behavioral health services in the county, it represents adults in the community with high levels of behavioral health service needs.

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[75] https://nsduhweb.rti.org/respweb/homepage.cfm

[76] https://www.census.gov/

[77] http://www.cdc.gov/healthyyouth/data/yrbs/index.htm

[78] http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS

[79] https://www.dshs.wa.gov/sesa/research-and-data-analysis/client-data

HSRI has used versions of the SPES in past projects but tailored the survey to meet the specific needs of this study. After working with stakeholders in the County to articulate a set of service categories that case managers and service users would be familiar with, HSRI created two versions of the SPES for use in Pierce County: the SPES-CM for case managers and the SPES-SU for service users. The SPES-CM was an online survey, while the SPES-SU was a paper survey, and both surveys are confidential, meaning that they do not collect information that could be used to identify an individual. Draft versions of the surveys were reviewed by case managers and BHO staff and further revised to incorporate their feedback.

In June, case managers from Greater Lakes Mental Health, Comprehensive Life Services, and Multicare Good Samaritan participated in a training, developed and led by HSRI, describing the SPES, its use, and how to complete the SPES-CM. They also reviewed procedures for distributing the SPES-SU to their clients, including detailed procedures to gather informed consent and ensure confidentiality. The SPES data collection protocol and all instruments associated with the study were reviewed and approved by HSRI's Institutional Review Board to ensure compliance with federal and organizational standards for research ethics and the protection of human subjects.

Case managers completed the online SPES-CM for all eligible clients on their caseloads; to be eligible, individuals needed to be residing in the community and not residing in an institutional setting, such as an inpatient hospital, in the month of June. This eligibility criterion was designed based on best practices in research ethics to ensure that individuals were able to make an informed decision about whether to participate in a research study. Eligible service users received a study introduction from their case manager. If interested in participating, the service user reviewed and provided informed consent, completed the paper version of the SPES-SU independently, and returned the completed survey in a sealed envelope to the case manager. Upon returning the completed SPES-SU, service users received a $5 gift card from their case manager.

After collecting the confidential completed SPES-SU surveys, case managers mailed them back to HSRI, where they were entered into a database. Databases containing SPES-CM and SPES-SU responses were then inspected to ensure data quality. HSRI researchers then created descriptive summaries of the information from each of the surveys, including services needed, services received, and reasons for unmet need. Results of these analyses are included in Appendix D.

Key Informant Interviews

HSRI conducted in-person and telephone interviews with over 50 individuals over the course of this brief study. Key informants were chosen as having a particular perspective about behavioral health issues in Pierce County and included service users, family members, and representatives from mental health and substance use disorder service providers, county departments, local towns, the BHO, and the criminal justice system. Potential key informants were identified by County Council staff and other key informants. Interviews were conducted individually and in small groups. Represented service and support organizations are listed in Appendix B. Key informants also included service users and their families.

Interviews were conducted using a semi-structured style using a set of interview questions that were developed by the study team and reviewed by County Council staff. With consent from the key informants, interviews were audiotaped. All key informants were informed about the purpose of the study and processes in place to ensure research ethics. Special precautions were put in place to ensure informed consent and anonymity of service user and family member key informants. The

interview guide, interview protocol, and informed consent materials were reviewed and approved by HSRI's IRB.

Three HSRI researchers listened to audio recordings of the interviews and created interview summaries consisting of salient themes and quotations. Interview content was categorized into the following themes: Brief biography of key informant; background/overview of key informant's organization and/or relationship to the Pierce County behavioral health system; identified challenges, barriers, and problems within the current behavioral health system; identified beneficial resources, services, and supports within the current system; and recommendations for improving the Pierce County behavioral health system in the future.

In addition to these interviews, several stakeholders provided direct email feedback, and this information was also incorporated into the report as appropriate.

Community Listening Session and Community Survey

After obtaining verbal consent from participants, the HSRI researcher who facilitated the June Community Listening Session audiotaped the discussion. The HSRI meeting facilitator also collected notes generated by participants. These materials were then analyzed by a three-person team to generate a set of 13 "system priorities" using a grounded theory approach [148].[80] As a first step, two HSRI researchers separately listened to the audio recording of the Community Listening Session and noted down recurrent themes related to challenges in Pierce County's current behavioral health system and visions for an improved behavioral health system. The two researchers' notes were then shared, compared, and discussed by the two researchers and the project's lead researcher. This discussion and analysis resulted in a second merged list of themes that all three researchers felt appropriately summarized the comments of the Community Listening Session participants. The two researchers then separately listened to the audio recording a second time and categorized the comments made by participants into these 13 themes to generate counts of the number of times each theme was discussed throughout the meeting. During a final meeting of the research team, the group compared the two sets of categorizations and counts, revisited areas in which there were discrepancies, and further refined the 13 themes until agreement between all three researchers was reached. This meeting resulted in a final list of themes or "system priorities" and counts of the number of times each theme was mentioned by a community member participant.

In an effort to provide one additional opportunity for stakeholders in the community to provide feedback regarding what they felt were the most important issues facing the Pierce County behavioral health system, HSRI developed a brief online survey inviting community members to rank each of the system priorities identified through the community listening session in order of importance. Survey respondents were also invited to submit additional open-ended comments. In August, the County Council sent the survey link to a list of over 440 community stakeholders, including service users, family members, advocates, providers, healthcare administrators, County staff, and other interested parties. Email recipients were also invited to forward the link to any others who may not have received it. In total, 55 individuals completed the survey. Survey respondents assigned a ranking to each of the 13 system priorities, with 1 being the highest priority. HSRI researchers calculated a final score by subtracting the average ranking from the number of priorities. These scores were then incorporated into the counts generated through analysis of the community listening session data to construct Figure 28.

[80] Grounded theory is an approach to qualitative research that involves systematically discovering concepts and themes that emerge from the data rather than from pre-conceived theory.

Appendix B: Key Informants

Representatives from the following organizations served as key informants and/or provided support and consultation for this study:

CHI Franciscan

Kim Dodds, Former Program Coordinator, City of Tacoma

Edgewood Police Department

Give an Hour

HopeSparks

Korean Women's Association

City of Lakewood

Multicare

Optum Pierce

Parkland Community Change

Pierce County Community Connections

Pierce County Department of Assigned Council

Pierce County District Court

Pierce County Superior Court

Pierce County Jail

Recovery Innovations

Seamar

Town of Steilacoom

Tacoma Area Coalition of Individuals with Disabilities (TACID)

Tacoma-Pierce County Health Department

Tacoma School District

We also conducted in-depth interviews with several service users and family members, including individuals who identified as both service users and family members.

HSRI worked with partners at the Technical Assistance Collaborative, DMA Health Strategies, and Wellesley Partners to review final drafts of the report and provide feedback on the accuracy and completeness of its recommendations.

Appendix C: Pierce County Context

A number of local and state initiatives serve as important context to this study and its recommendations. They are briefly reviewed here.

State Initiatives

At the state level, recent legislative changes and planned administrative initiatives are anticipated to have a major impact on how physical and behavioral healthcare are delivered.

Washington State Adult Behavioral Health System Task Force

Established by state law in 2013, the Adult Behavioral Health System Task Force is tasked with making recommendations for reforming the state's behavioral health service purchasing and delivery systems [149]. The Task Force was composed of 11 members representing lawmakers, state agency administrators, county commissioners, and a tribal member. The Task Force met eleven times in 2014 and 2015 and heard testimony from 100 stakeholders. The meetings culminated in a final report that includes a set of final recommendations for behavioral health system reform.[81] The Task Force's recommendations are referenced in the recommendations section of this report.

Mental Health and Substance Use Treatment Integration and Integration 2020

In March 2014, the Washington State legislature passed ESSB 6312, "An Act Relating to state purchasing of mental health and chemical dependency services."[82] The bill was signed into law by the governor in April 2014. The Act called for the integrated purchasing of Medicaid mental health and substance use treatment services through managed care by April 1, 2016 and full integration of Medicaid behavioral health into physical health care by January 1, 2020.

On April 1, 2016, Behavioral Health Organizations (BHOs) replaced Regional Support Networks (RSNs) and County substance use treatment coordinators, previously administered through Pierce County Community Connections. In Pierce County, Optum Pierce—formerly the RSN—assumed the role of the BHO. Under this new integrated arrangement, all Medicaid behavioral health services are purchased through managed care contracts, with the BHO receiving a single capitated payment for Medicaid-eligible individuals and assuming full financial risk for behavioral health services. This arrangement was in place for mental health services prior to the integration effort but presented a significant change in the way substance use treatment services are financed in Pierce County. The integration effort moved substance use treatment services from a fee-for-service model to a managed care model.

In Pierce County, all but one of the fourteen agencies that had been providing SUD treatment in the County signed on to contract with the BHO. Key informants from the BHO noted that they are working to ensure a broad spectrum of SUD treatment services for eligible Medicaid enrollees (those who meet state Access to Care standards that have been expanded to include people with substance use disorders). As of the time of the key informant interviews, the transition was still taking place, and key informants noted that providers are still learning the new billing procedures

[81] http://leg.wa.gov/JointCommittees/Archive/ABHS/Pages/default.aspx

[82] http://lawfilesext.leg.wa.gov/biennium/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf

and the BHO is also on a "learning curve," being cautious about what services they will cover and adhering closely to the contractual requirements for services.

On January 1, 2020, responsibility for managing behavioral health services will be transferred from BHOs to Managed Care Organizations (MCOs), which will assume full responsibility for all physical and behavioral health services for Medicaid eligible adults in each region. Some key informants expressed concern about what this transition will look like and how it will align with other initiatives in the County.

Washington State Medicaid Transformation Waiver

The Centers for Medicare and Medicaid Services (CMS) authorize waivers to allow states flexibility in operating their Medicaid programs. One type of Waiver, the 1115 Research and Demonstration Waiver, allows states to test new approaches to financing and delivering Medicaid services. Using an 1115 Waiver from CMS, the Washington State Health Care Authority has proposed a five-year demonstration to transform its Medicaid health system—including the behavioral health system. The proposal, which involves a $3 billion federal investment, includes plans to fund nontraditional services with goals of bending the Medicaid cost curve, reducing hospitalization (including psychiatric hospitalization), and improving population health. The Waiver will cover all Medicaid enrollees but also includes plans for a new, limited benefit package for individuals with long-term service and support needs who do not currently meet Medicaid financial eligibility criteria but are "at risk" for future Medicaid enrollment [150]. The Transformation Waiver Activities includes plans to add services that support housing and employment as part of the Medicaid benefit [151].

Per the Washington State Health Care Authority website, as of August 16, 2016, the HCA is currently in negotiations with CMS and aims to have a final agreement in place this fall. Accountable Communities of Health will coordinate the Medicaid Transformation Waiver projects [152].

Local Initiatives

As many key informants noted, there have been numerous initiatives in Pierce County aimed at assessing community needs for health and behavioral health and improving the social service systems. Selected initiatives are briefly described here. One additional effort, the PAR Initiative, was described in greater detail in Appendix E.

Accountable Communities of Health

Part of the Healthier Washington Initiative and aligned with Integration 2020, the Accountable Communities of Health (ACH) project is currently in development and is anticipated to be complete in 2020. It involves nine regionally governed entities that will be responsible for coordinating healthcare initiatives and services, developing new health care payment models, identifying ways to enhance prevention activities, and advocating for underserved people and communities [153]. The primary purpose of the ACH is to provide whole person care. In Pierce County, the Tacoma-Pierce County Health Department is leading the ACH initiative, serving as the "interim backbone organization" to facilitate decision-making and guide ACH development [154]. The TPCHD hosts a physical and behavioral health integration workgroup that meets regularly, and many key informants interviewed for this project participated in that workgroup.

Key informants indicated that the initiative is not without challenges. Social service sectors and health care sectors have not collaborated before and have not yet found a way to do so. Although there appears to be common interest in implementing the ACH, key informants expressed

uncertainty about what the ACH and Integration 2020 will look like and noted that there isn't yet an understanding of how to make it happen; as one informant put it, there is a "gap between theory and execution." One key informant said that this gap is particularly large in behavioral health, with no current collaborations between physical and behavioral health providers in anticipation of 2020.

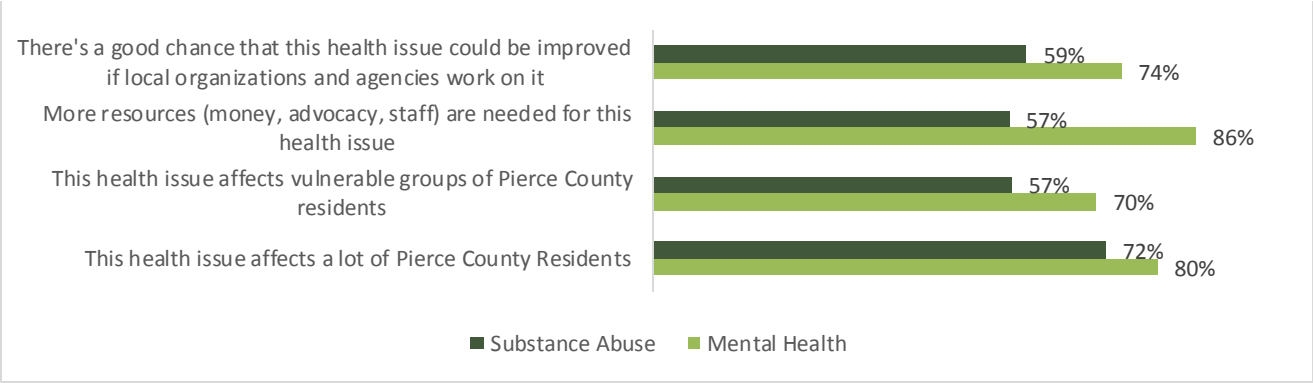
Community Connections Integrated Community Behavioral Health Plan

In the summer of 2016, the Pierce County Community Connections Department convened an advisory group of stakeholders in the behavioral health system to form a "short-term ad hoc Behavioral Health Committee." This group, which met three times during the summer, produced an *Integrated Community Behavioral Health Plan Framework.*[83] The draft vision, purpose, and goals of the document are in line with the findings and recommendations of this report.

Pierce County Community Health Improvement Plan

In 2012 and 2013, the Tacoma-Pierce County Health Department facilitated the Pierce County Community Health Assessment, which brought together stakeholders throughout the County and identified five key areas of need for community health, two of which were mental health and substance abuse. Through a comprehensive prioritization process involving over 150 community partners, mental health was ranked as the top health issue in Pierce County (substance abuse was ranked as fourth-highest, tied with access to quality care and services). After an additional web-based survey of 250 community residents that was translated into Spanish and Korean, mental health remained at the top of the list of health priorities, and substance abuse was ranked number five [155]. Survey responses relative to mental health and substance use are listed in Figure 30. The Community Health Improvement Plan includes a series of goals and objectives related to enhancing behavioral and emotional well-being of Pierce County residents.

Figure 30. Statements Endorsed by Pierce County Community Members Related to Behavioral Health Priorities



Source: 2014 Pierce County Community Health Improvement Plan

City of Tacoma Mental Health and Chemical Dependency Sales Tax

In 2011, Pierce County decided not to adopt the 0.1% Mental Health and Chemical Dependency sales tax, and in April 2012, the City of Tacoma did adopt the tax.[84] Annual funding in Tacoma is

[83] Available at http://www.co.pierce.wa.us/DocumentCenter/View/42886

[84] The tax is authorized by RCW 82.14.360.

approximately $4.5 million. All funded services are required to be part of a coordinated system of care and are available to individuals physically located within the City of Tacoma regardless of payer type. The City created a Program Coordinator position to develop and administer the tax-funded program. The Program Coordinator created a coordinated system of care designed to be comprehensive and holistic, ranging from housing supports to treatment. According to the former Program Coordinator, a key informant for this study, the tax is unique in that it is a highly flexible source of funding for mental health and substance use disorder services. Funded services are required to be part of a coordinated system of care, but there are no specific eligibility requirements attached to them. Funds can be used to close gaps for people who do not have Medicaid and people with undiagnosed problems who need treatment.

In Tacoma the funds were awarded through a competitive grant process, and private and public organizations were invited to apply. Agencies funded by the tax were required to establish a Memorandum of Understanding with one another to foster a spirit of collaboration and integration. The City also created a database that tracked all services provided as well as client information (demographics, disability status, etc.); using the system, the City can track rates of inter-agency collaboration to meet complex needs of individuals. According to the former Program Coordinator, funded agencies were held accountable to provide evidence of this collaboration as part of their service provider contracts. The system was also designed to flag undesirable system outcomes, for example placing individuals with behavioral health needs in jails rather than in treatment.

The Program Coordinator also established a collaborative of agencies across the County that meets once a month. Over 50 providers regularly attend these meetings to work together to address challenges. Each meeting involves shared learnings with time left at the end for networking. Providers share presentations, and sometimes outside experts are brought in to speak.[85]

Numerous key informants held up the program put together by the City of Tacoma to administer and monitor the programs funded by the Mental Health and Chemical Dependency Tax as a good example of a data-driven, coordinated, comprehensive system. However, some key informants also noted some challenges with the program that could be informative for similar efforts in the future. Initially, some providers said they experienced the funding process as a high level of commitment, with complicated reporting and data sharing requirements that provoked concerns about confidentiality. One key informant noted that larger agencies saw the tax as a way to diversify and expand revenue, and another noted a "spirit of entitlement" among some of the larger agencies that led to an expectation that funding would be received. Key informants said that smaller agencies may not have been equipped to competitively pursue the funding given the extensive requirements, which is a concern because smaller agencies may be best-equipped to meet the needs of more diverse populations and may offer creative solutions to community challenges that larger agencies may overlook. Another challenge is ensuring that all agencies involved in the initiative have a recovery orientation and a whole-health perspective consonant with the program requirements; for example, ensuring that agencies were committed to person-centered approaches to service delivery where service users are fully-informed and active members of the treatment team as opposed to more traditional, provider-directed approaches where service users are given fewer options and not consulted regarding treatment decisions.

[85] https://www.cityoftacoma.org/government/city_departments/neighborhood_and_community_services/human_services_division/mental_health_and_substance_use_disorders/Collaboration

Appendix D: Service Planning and Evaluation Survey (SPES) Findings

The results from the Service Planning Evaluation Survey for Case Managers (SPES-CM) and Service Users (SPES-SU), administered in July 2016, are reported here.

Study Population Characteristics

In total, 9 case managers from three provider agencies participated in the SPES-CM, completing surveys for 272 of their adult case management clients. Over 75% of the SPES-CM responses came from Greater Lakes Mental Healthcare; the remaining 24% came from Multicare Good Samaritan Outreach Services and Comprehensive Life Resources. Of the 272 SPES-CMs that were completed, 71% (n=194) of individuals received case management services for the month of June and were included in the survey results. The most common reasons for not receiving services in the month of June were that the person didn't require case management services (38.8%, n=31), the person had no contact with the case manager (30.0%, n=24), and the person was newly enrolled in case management in the month of June (22.5%, n=18).

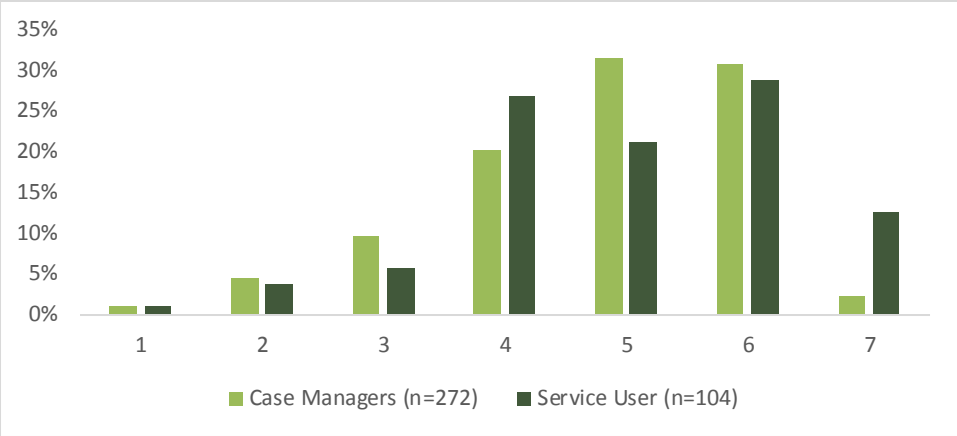
Case managers at each of the provider agencies distributed the SPES-SU to each of their eligible clients (individuals residing in the community who were not residing in institutional settings in the month of June). In total, 111 service users agreed to participate in the study and completed the SPES-SU. In total, 46.8% of respondents (n=52) received case management through Greater Lakes Mental Health, 36.0% (n=40) from Multicare Good Samaritan, and the remaining 17.1% (n=19) from Comprehensive Life Resources. SPES-SU respondents were asked a series of optional demographic questions. Characteristics of the SPES-SU respondents are reported in Table 6.

Table 6. SPES-SU Respondent Characteristics

Characteristic	Valid n	% or mean
Female	107	57.0%
Age (mean)	94	45.2
White Non-Hispanic	100	83.0%
African American	111	15.3%
Married	107	8.4%
Completed High School	107	82.2%
Employed Part- or Full-Time	104	10.6%

Case managers and service user respondents were asked to rank level of mental health-related functioning during the past month using the Resource Associated Functional Level Scale (RAFLS), a measure designed by HSRI to capture an individual's functional level as it relates to the types of behavioral resources they may need. The scale ranges from 1 (requiring the most intensive level of support) to 7 (does not need any support). Case manager and service user-rated RAFLS scores are depicted in Figure 31.

Figure 31. Proportions of Case Manager and Service User-Rated RAFLS Scores



Average RAFLS ratings were very similar between case managers (mean=5.0) and service users (mean=4.8), though a higher proportion of service users rated themselves as system-independent, meaning not requiring any mental health services or supports.

SPES-Identified Service Needs

Figure 32 depicts the number of service users who indicated a need for each service, whether they received the service or not, organized by service type. Figure 33 depicts the number of individuals for whom case managers identified a need. Although service categories overlap for the most part, the list of SPES-SU services was slightly more condensed than the services listed in the SPES-CM.

Figure 32. Numbers of Service Users Who Indicated a Service Need (n=111)

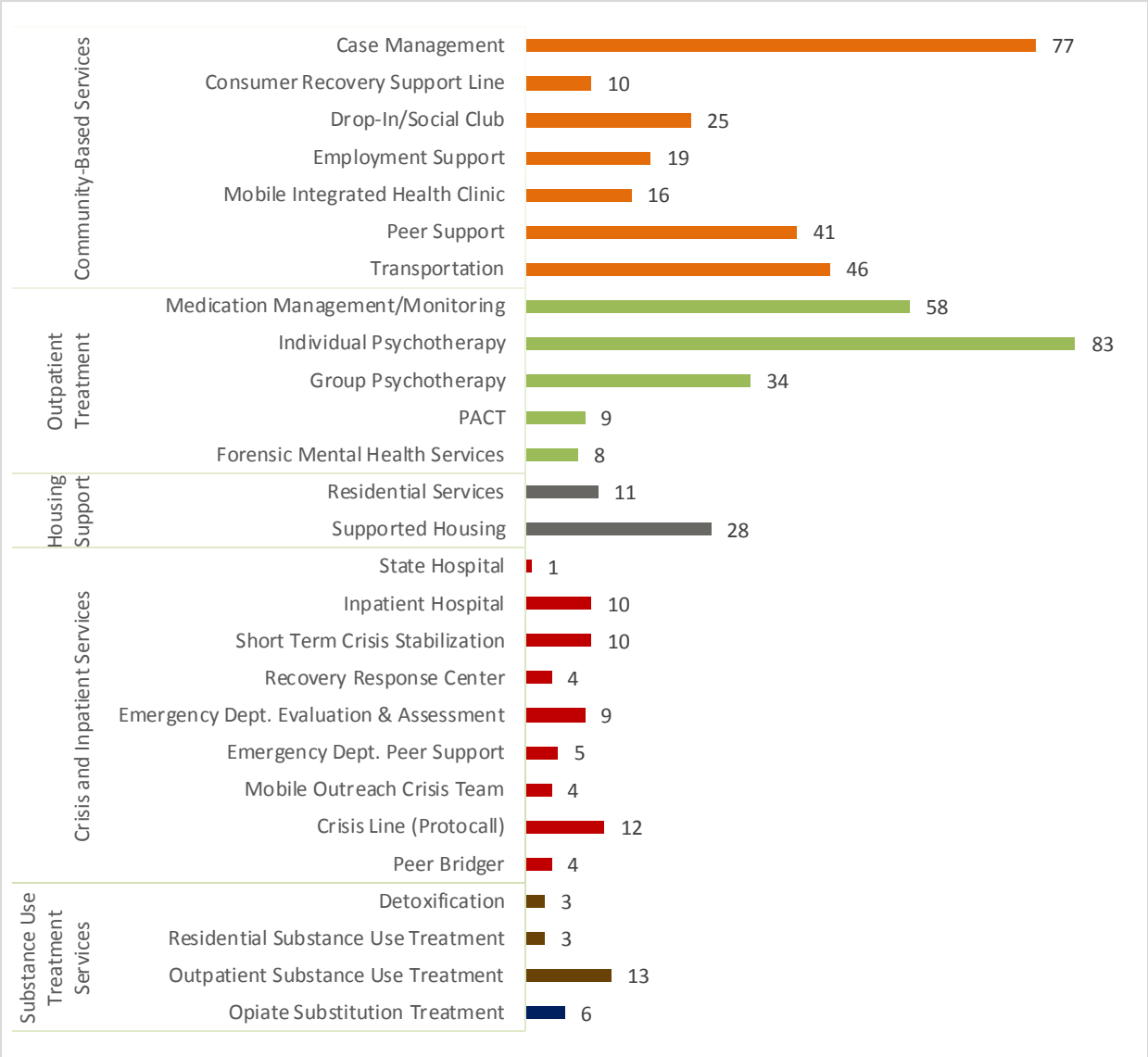
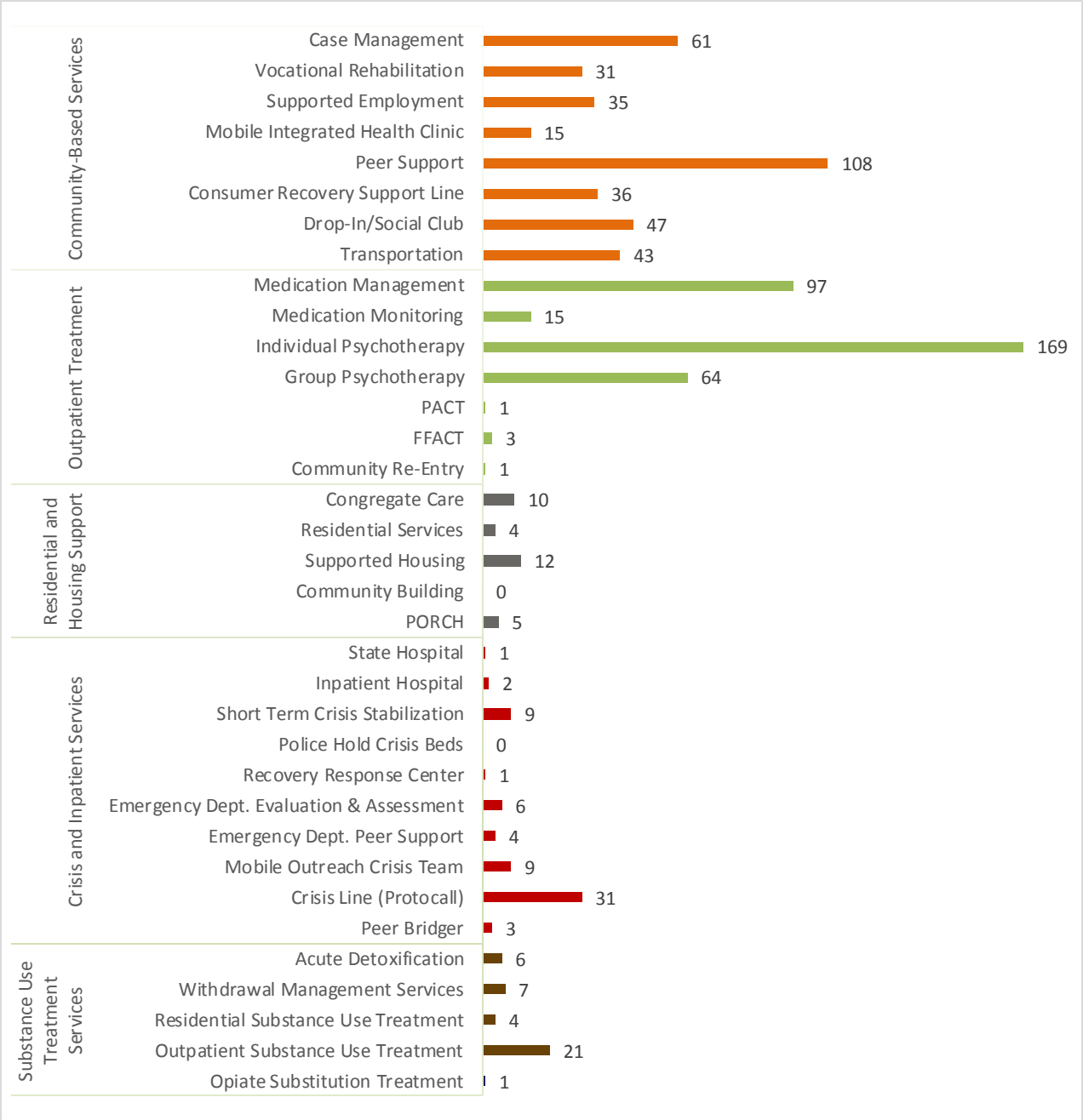
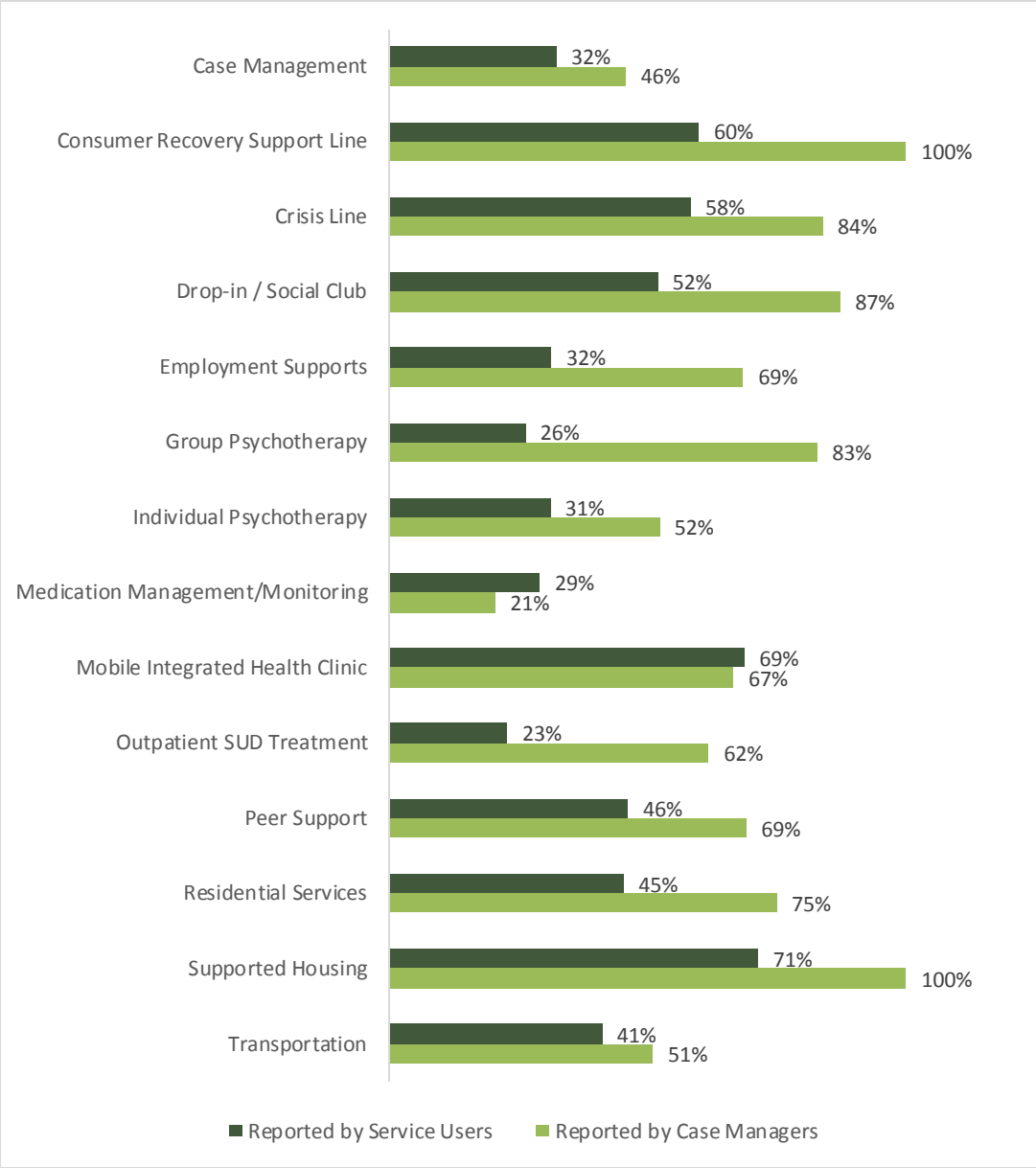


Figure 33. Numbers of Service Users for Whom Case Managers Indicated a Service Need (n=272)



In addition to asking about needed services, the SPES asks about services actually received. The percentage of case managers and service users who identified unmet service needs for key services are presented in Figure 34; the figure includes all services for which more than 10 individuals had a need.

Figure 34. Proportion of Service Needs That Were Unmet According to Service Users and Case Managers



Note: Medication Management and Medication Monitoring were collapsed into one category in the SPES-SU, as were Supported Employment and Vocational Rehabilitation.

With the exception of the Mobile Integrated Health Clinic, case managers perceived higher levels of unmet need than did service users themselves. However, for several services, unmet need was indicated among more than half of service users and case managers: Supported Housing, Mobile Integrated Health Clinic, Drop-in/Social Club, Crisis Line, and the Consumer Recovery Support Line.

Case manager respondents were asked to report units of services needed and received, enabling the research team to calculate the magnitude of unmet need using the SPES-CM data. These figures are

displayed in Table 7. The proportion of unmet need is calculated as the difference between units needed and received divided by the units needed.

Table 7. Magnitude of Unmet Need Among Those With Unmet Service Needs, According to Case Managers

Service (Units)	Individuals with Unmet Needs	Total Units Needed	Total Units Received	Difference	Proportion of Unmet Need
Case Management (Hours)	28	80	18	62	78%
Vocational Rehabilitation (Hours)	21	129	1	128	99%
Supported Employment (Hours)	24	164	2	162	99%
Mobile Integrated Health Clinic (Hours)	10	11	0	11	100%
Peer Support (Hours)	74	191	16	175	92%
Consumer Recovery Support Line (Calls)	36	112	5	107	96%
Drop-In / Social Club (Hours)	41	135	15	120	89%
Transportation (Trips)	22	178	11	167	94%
Medication Management (15 min)	20	20	0	20	100%
Individual Psychotherapy (Hours)	88	277	108	169	61%
Group Psychotherapy (Hours)	53	208	52	156	75%
Supported Housing (Hours)	12	75	7	68	91%
Crisis Line (Calls)	26	82	4	78	95%
Outpatient Substance Use Treatment (Hours)	13	246	79	167	68%

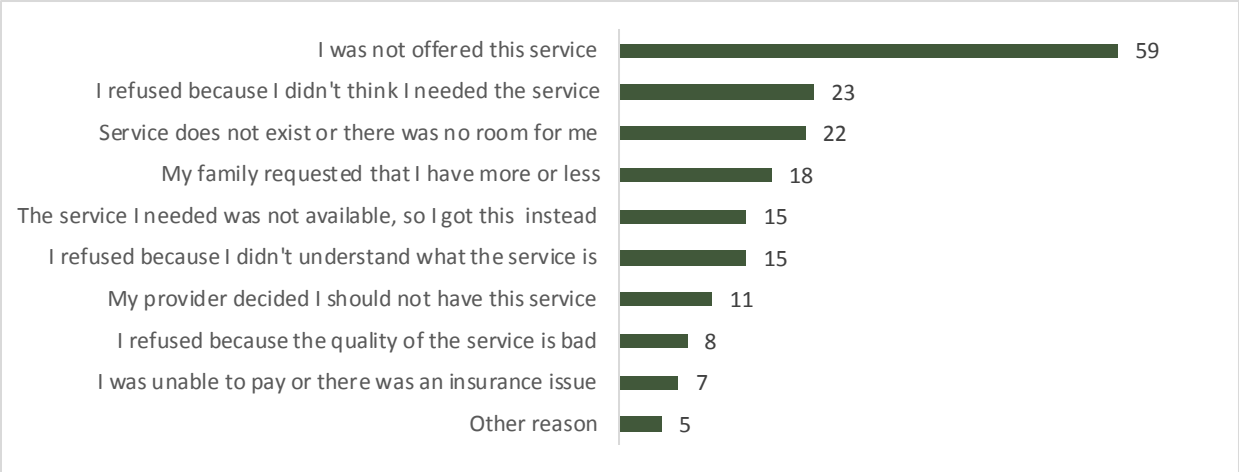
Note: Responses of '30 or more' units were counted as 30

Two services—Medication Management and Mobile Integrated Health Clinic—had the highest proportion of unmet need. All 20 of the individuals with unmet medication management needs did not receive any of this service, and all 10 of those with unmet Mobile Integrated Health Clinic needs did not receive the service. Proportion of unmet need was over 90% for Vocational Rehabilitation, Supported Employment, Supported Housing, Peer Support, Consumer Recovery Support Line, Crisis Line, and Transportation. Outpatient services—including individual and group psychotherapy and outpatient substance use treatment—and case management had smaller proportions of unmet need, but all were over 50%.

Reasons for Unmet Need

Service users and case managers were asked to indicate reasons for unmet service needs. Service users were provided a list of potential unmet needs and asked to "check all that apply." Counts of reasons for unmet need identified by service users are depicted in Figure 35.

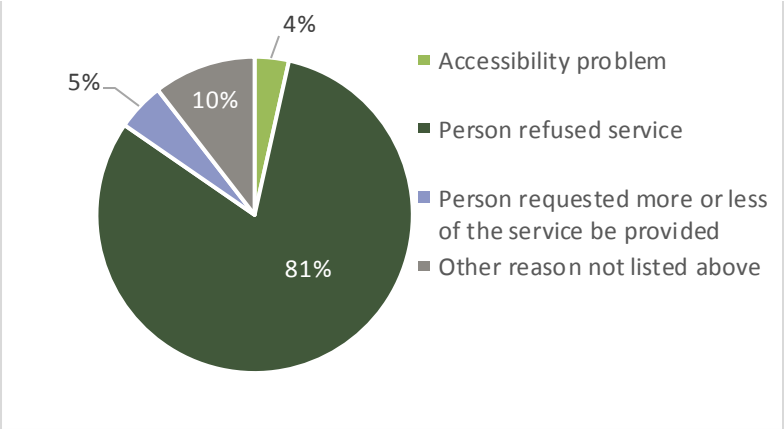
Figure 35. Reasons for Unmet Need Identified by Service Users



The most commonly identified reason from service users was that they were not offered the service. Service users also didn't receive services because they refused or their family members requested that they have less of the service. In 22 instances, service users attributed a lack of capacity as being the reason for unmet need.

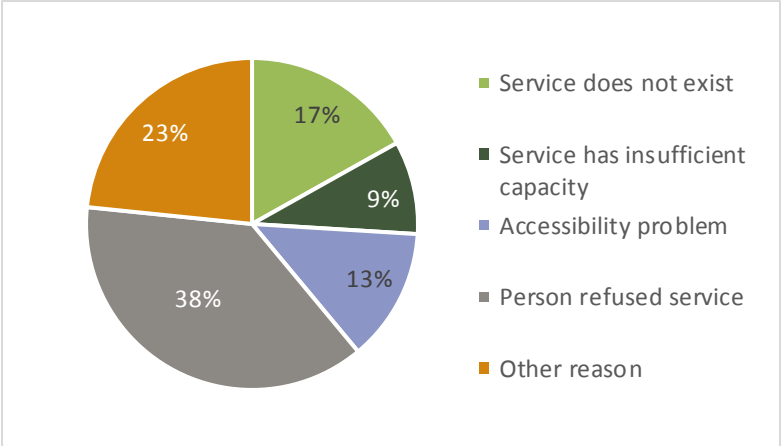
The most commonly identified reason for unmet service need for many services among case managers was service user refusals. In regard to peer-delivered services such as Peer Support, Drop-in/Social Club, and the Consumer Recovery Support Line, 81% of unmet needs were attributed to service user refusals (Figure 36).

Figure 36. Reasons for Unmet Need for Peer Support, Drop-In/Social Club, and Consumer Recovery Support Line, According to Case Managers



Case manager-reported reasons for support services related to housing, employment, and transportation were more variable, as depicted in Figure 37. Although service user refusals were still the most commonly cited reason, they only accounted for 38% of the total reasons, with issues related to capacity and accessibility accounting for another 39% of all reasons.

Figure 37. Reasons for Unmet Need for Supported Housing, Supported Employment, Vocational Rehabilitation, and Transportation, According to Case Managers



Conclusions

The SPES is one tool for examining service needs and access within behavioral health systems. In this study, the SPES was used to understand the service needs of adult case management clients. It represents a deeper examination of service needs than would be possible through examining service utilization data alone. Some limitations are important to keep in mind when interpreting these results. Most importantly, the SPES population is likely not representative of all Pierce County residents with behavioral health service needs. Because the population was adult case management clients, these individuals probably have more intensive service needs than the general population. Further, as depicted in Table 6, SPES-SU Respondent Characteristics, the SPES-SU population is not representative of the racial and ethnic diversity of Pierce County residents. In particular, very few survey respondents identified as Hispanic or Asian. When the survey population is different from the population of focus in regard to these key characteristics, this limits the generalizability of the findings.

Ultimately, this survey is an initial examination of needed and received services and reasons for unmet need among one subset of Pierce County behavioral health service users. Further research is needed before policy action is taken based solely on these results. However, the results do suggest high levels of outpatient and community-based service need among Pierce County behavioral health service users. Reasons for unmet need are varied, but include services being unavailable and service users refusing to access those services. This suggests a need for a) expanded outpatient and community-based service array, b) increased service user outreach and education to ensure individuals understand the range of service and support options available to them, and/or c) using techniques such as shared decision-making to ensure individuals are connected with services based on their own individual needs and preferences.

Appendix E: PAR Initiative Summary

Prevent-Avert-Respond (PAR) Mental Health Initiative

The Prevent-Avert-Respond (PAR) Initiative aims to reduce mental health crises in Pierce County, through a full population approach that benefits residents with all types of mental conditions, socioeconomic background, age, cultural needs, and insurance. The initiative's overall goals are to:

- Prevent mental health crises through early detection of emotional distress and mental illness, and supportive resources for people with high crisis risk.
- Avert emerging mental health crises through evidence-based recognition, referral, and intervention skills.
- Respond effectively to community members in serious mental distress to facilitate the best possible outcomes.

Built within the nationally utilized *Spectrum of Prevention* framework, the PAR Initiative's collaborative strategies were developed through over 200 stakeholder meetings, and designed to significantly and sustainably impact mental health in Pierce County. These strategies will build capacity among individuals, families, professionals, and organizations to recognize and manage mental health problems before they reach crisis stage; encourage and expedite help-seeking; and facilitate excellent assistance to persons in crisis. Broadly integrated throughout our community, this increased capacity will help reduce suicides, self-harm, violence, and other avoidable and traumatic consequences of mental health crises. It will also decrease our reliance on financially and emotionally high cost interventions like hospitalization, jail, police and EMS response, and emergency department use. The long-term vision of the PAR Initiative is to cultivate transformation in our collective capability and beliefs about mental disorders, and our responsibilities as citizens and as a community.

The PAR Initiative is funded by grants from the CHI Mission & Ministry Fund and the Franciscan Foundation, through June 2019. The contact person is Monet Craton, PAR Initiative Director, at (253) 539-6786 or monetcraton@chifranciscan.org.

STRENGTHEN INDIVIDUAL KNOWLEDGE & SKILLS

Strategy 1: Increase the availability of NAMI Pierce's Family-to-Family, Homefront, and Basics programs

NAMI Family-to-Family is an evidence-based, 12-session education program for family, partners, friends and significant others of adults living with mental illness. The program is designed to help family members understand and support their loved one living with mental illness and maintain their own well-being, and includes information on schizophrenia, bipolar disorder, major depression and other mental conditions. Thousands of families have described the program as life-changing. The program's trained teachers are family members who know what it's like to have a loved one living with mental illness.

NAMI Homefront is a six-session adaptation of the Family-to-Family Program that is focused on the unique needs of the families of military service members and veterans who are living with mental illness, and who often face post-deployment or post-discharge challenges. The program helps family members understand and support their loved one while maintaining their own well-being. The trained teachers of this course have experience with military culture and having a family member with symptoms of a mental health condition.

NAMI Basics is a 6-week education program for parents and family caregivers of children and teens who are experiencing symptoms of a mental illness, or whom have already been diagnosed. This program is also adapted from Family-to-Family. The group setting provides mutual support so participants receive compassion and reinforcement from people who understand, and can help others benefit from their own experiences. In 2014, 99% of participants said they would recommend the program to other parents. The course is taught by a trained team with lived experience who understand what families are going through. NAMI Basics covers:

- Managing crises, solving problems and communicating effectively
- How to take care of yourself and handle stress
- Developing the confidence and stamina to support your child with compassion
- Advocating for your child's rights at school and in health care settings
- Current treatments, including evidence-based therapies, medications and side effects
- Gaining an overview of the public mental health care, school, and juvenile justice systems

(See www.nami.org/Find-Support/NAMI-Programs for more program information.)

- Strategy 2: Expand access to Wellness Recovery Action Plan ® (WRAP) facilitation classes

The Wellness Recovery Action Plan ® (WRAP) is a personalized wellness and recovery system that helps people: 1) decrease and prevent intrusive or troubling feelings and behaviors; 2) increase personal empowerment; 3) improve quality of life; and 4) achieve their own life goals and dreams. A WRAP also includes plans for responses from others when an individual cannot make decisions, take care of him/herself, or keep safe. WRAP has been studied extensively in rigorous research projects and is listed in SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). Individuals learn to use a WRAP through a peer-led and peer-engaged group process, via lectures, discussions, and individual and group exercises. Groups are led by two trained co-facilitators who use WRAP for their own recovery. WRAP concepts and values are illustrated through examples from the lives of the co-facilitators and participants. *(For more information, see www.copelandcenter.com/wellness-recovery-action-plan-wrap.)*

A key part of expanding WRAP use in Pierce County will be engaging local mental health, social services, and possibly health care organizations to begin offering WRAP classes to their clients or patients. We will facilitate their ability to provide WRAP classes by training their staff as WRAP Facilitators. We will also recruit from our strong local community of Certified Peer Specialists. Our primary partner in this work is Optum BHO, whose Peer Support Specialist is a certified WRAP Facilitator Trainer.

- Strategy 3: Promote use of Mental Health Advance Directives

A Mental Health Advance Directive (MHAD), or psychiatric advance directive, is a written document that expresses one's wishes in advance about what types of treatments, services, and other assistance the person wants during a mental health crisis. A MHAD can also grant legal decision-making authority to another person to be an advocate and agent until the crisis is over. Benefits of using a MHAD can include: 1) promote autonomy and empowerment; 2) enhance communications between self, doctor, treatment team, and family; 3) protect from ineffective, unwanted, or possibly harmful treatment or actions; and 4) help prevent crisis situations and reduce the use of involuntary treatment or safety interventions, such as restraint or seclusion.

PROMOTE COMMUNITY EDUCATION

Strategy 1: Partner with 2-1-1 to increase community knowledge of and connection to needed mental health resources and services

The new 2-1-1 Mental Health Resources Navigation Program has been developed in response to widespread lack of knowledge among Pierce County residents and professionals about how to access mental health services and resources. We determined that a mental health resources directory was impractical because there are too many services to fully list and keep updated, and there's no sustainable way to get a resource guide to everyone who might possibly need it. Instead, we are building on 2-1-1's strong call center infrastructure and expertise and existing community resources database. The 2-1-1 Mental Health Resources Navigation Program is a feasible and effective way to make it easy for community members to connect to mental health services and resources. Planned for launch in Fall 2016, core program elements include:

Promote 2-1-1 to Pierce County as the place to call to learn about and get help connecting to mental health resources and services. We're developing print and online promotional materials designed for broad and sustainable distribution throughout Pierce County. Materials will use simple, focused language that's appropriate for residents with low literacy and future translation.

Maximize 2-1-1's ability to provide excellent mental health resources navigation. We are currently hiring a Mental Health Resources Specialist at 2-1-1, who will:

- Acquire and maintain comprehensive knowledge of changing mental health resources and services
- Provide ongoing training to 2-1-1 phone answerers on mental health resources and services. (We have also arranged initial 2-1-1 staff training - Pierce County Mental Health Crisis training, and a specialized "Bringing Hope to Every Interaction" training designed for non-clinical staff.)
- Provide back-up for 2-1-1 phone answerers when callers have challenging mental health resource needs
- Keep the mental health resources section of 2-1-1's online database up-to-date and user friendly

Improve overall county knowledge of and utilization of all mental health resources and services. The Mental Health Resources Specialist will also:

- Serve as a knowledge resource to local social workers, case managers, therapists etc. when their clients or patients have unusual or challenging mental health resource needs
- Participate in Pierce County mental health planning meetings to share specialized knowledge of public and private mental health resources

Build coordination between local and state phone assistance lines (e.g.2-1-1, Pierce County Crisis Line, Pierce County Recovery Support Line ("Warm Line"), WA Recovery Help Line, and Teen Link)

- Strategy 2: Support suicide prevention efforts by building awareness of suicide as a public health issue that everyone can help address

We have three main partners in this strategy, to date: American Foundation for Suicide Prevention (AFSP) – WA Chapter, LivingWorks, and the WA Department of Health (DOH). The majority of suicide prevention community education work will begin in year 2 of the PAR Initiative, including:

1) Widespread, local delivery of AFSP's new "Talk Saves Lives" lunch-and-learn presentations to community groups, by a cadre of AFSP-trained community volunteers.

2) Launch LivingWork's esuicideTALK, a 1-2 hour online, interactive learning experience that helps participants explore issues surrounding suicide, using adult learning principles. An organizational license provides access to an unlimited number of community members for one year, along with a custom home page. We will prepare for maximum community participation by securing commitments from many organizations to promote the course and make it readily available to their clients/employees/customers (e.g. libraries, unemployment office, coffee shops with free Wi-Fi, nonprofits, businesses, etc.). *(See www.esuicidetalk.net for more information.)*

3) The WA DOH released the WA State Suicide Prevention Plan in early 2016, identifying statewide community awareness and education strategies. The PAR Initiative will collaborate with DOH and Pierce County stakeholders to deploy outreach activities in our community, including through participation in the recently formed WA Mental Health Promotion Workgroup. This group's initial focus will be developing strategies for rolling out the State Plan. *(See the State Plan at www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePreventionPlan)*

Strategy 3: Promote mental health literacy and decrease stigma via educational/promotional materials and awareness campaigns

A county team to which the PAR Initiative belongs has been meeting to develop a Pierce County mental health anti-stigma campaign, which the PAR Initiative will help support. The PAR Initiative will also facilitate local use of the multitude of free and low-cost print and online materials currently available from national and state organizations to improve our community's mental health literacy, acceptance of mental illness, and belief in the importance of seeking help. One example is the "Campaign to Change Direction," which is endorsed by many national mental health

advocacy leaders. We will use these materials to reach specific groups with targeted information, enhance other PAR Initiative strategies, and support partners' mental health awareness and stigma reduction efforts.

Strategy 4: Educate high school students in recognizing signs of mental health problems and the importance of getting help for self or others

The PAR Initiative is working with Project AWARE at WA OSPI (Office of the Superintendent of Public Instruction) and the Jordan Binion Project to implement an evidence-based, 10-12 hour Mental Health & High School Curriculum. Developed by Dalhousie University / IWK Health Centre in Canada, the Curriculum has been broadly adopted in Canada and five other countries with documented increase in mental health literacy and decreased stigma – in both students and teachers. The Curriculum Guide (with teacher assessment, lesson plans, class activities, etc.) is free online, and has been downloaded or purchased in hard copy in the U.S. However, the Curriculum has not yet been formally implemented in the U.S, which involves training teachers to deliver the Curriculum and other technical assistance from Dalhousie University / IWK Health Centre. *(See www.teenmentalhealth.org/curriculum/ to view the Curriculum Guide and research articles.)*

WA OSPI revised WA's K-12 Learning Standards in early 2016, and excitingly, mental health education is now a high school Learning Standard for the very first time. Project AWARE is promoting and supporting the Curriculum in Washington so high schools can effectively meet the new mental health Learning Standard. The Jordan Binion Project separately identified the Mental Health & High School Curriculum as an outstanding resource; we then connected with Project AWARE and developed a collaborative approach to amplify implementation in Washington and Pierce County.

The Curriculum will be piloted in high schools throughout Washington in the 2016-2017 school year, with a formal evaluation conducted in partnership with Dalhousie University / IWK Health Centre. We expect the evaluation results to qualify the Mental Health & High School Curriculum for inclusion in the NREPP. A Train-the-Teacher Trainer event in July 2016 prepared 37 mental health and education professionals to train teachers to deliver the Curriculum. These individuals are now training teachers at 45 schools across the state to deliver the Mental Health & High School Curriculum, including 7 in Pierce County. We anticipate helping many additional schools implement the Curriculum over the next several years, including as many as possible of Pierce County's 30+ high schools.

Strategy 5: Educate college students in recognizing signs of mental health problems and the importance of getting help for self or others

We will work with The JED Foundation, a national leader in suicide prevention and emotional health on college campuses *(see www.jedfoundation.org)* to pilot the new JED Gatekeeper Program for Higher Education at Pierce County colleges and universities. The program includes Gatekeeper Training for college staff and student leaders, How to Help a Friend Training for students, plus toolkits, booster programs, and community building activities to sustain learning and awareness. The How to Help a Friend Training, booster programs and community building activities will expose students to mental health information, convey the importance of offering help to others in distress, and teach them how to offer help effectively.

EDUCATE PROVIDERS

- Strategy 1: Increase locally accessible and sustainable Mental Health First Aid (MHFA), Youth MHFA, and Military MHFA training
-

Provided in the U.S. by the National Council for Behavioral Health, Mental Health First Aid (MHFA) is an international program proven to be effective, with peer-reviewed studies showing that individuals trained in the program:

- Increase their knowledge of signs, symptoms and risk factors of mental illnesses and addictions
- Can identify multiple types of professional & self-help resources for people with mental illness or addiction
- Increase their confidence in and likelihood to help an individual in distress
- Show increased mental wellness themselves

- Studies also show the program reduces the social distance created by negative attitudes and perceptions of individuals with mental illnesses. MHFA is included in the NREPP. *(See www.mentalhealthfirstaid.org/cs/about/ to learn more.)*

The PAR Initiative will substantially increase MHFA training in Pierce County by bringing the National Council here in October 2016 to provide MHFA Instructor Training to 30 individuals with professional or personal knowledge of mental health and substance use issues, and experience teaching/facilitating groups of adults. Priority for Instructor Training will be Pierce County organizations and individuals with long-term commitment to providing free/low cost MHFA trainings in our community. The PAR Initiative will have "Coordinator Level Access" with the National Council to track Instructors, classes held, and evaluation results. We will support and promote 3 types of MHFA training – adult, military/veterans, and youth. MHFA training participation will be maximized via proactive community promotion, training costs support, and maintaining a broadly publicized community training calendar (to include other mental health trainings) and active interest list.

Strategy 2: Provide suicide prevention and management education through ASIST and safeTALK programs

ASIST (Applied Suicide Intervention Skills Training) is an evidence-based, two-day interactive workshop that trains people to help prevent the immediate risk of suicide *(see www.livingworks.net/programs/asist/)*. The first ASIST program is scheduled for January 2017, promoted in partnership with Optum BHO. SafeTALK is a half-day workshop that increases awareness about suicide risk, prepares participants to identify persons with thoughts of suicide, and shows how to connect them to help and resources. It is listed in the Suicide Prevention Resource Center's Best Practices Registry- USA *(see www.livingworks.net/programs/safetalk/)*. AFSP–WA Chapter has local certified trainers for these programs and has agreed to provide four free SafeTALK trainings annually in Pierce County for the next three years. They will also provide two ASIST trainings annually, free in year one and covering half the costs in year 2 and 3. In alignment with AFSP's long-term goals, we will facilitate strong local connections for AFSP (such as Optum collaboration for the first ASIST training) and establish a plan for ongoing suicide prevention trainings in Pierce County after the PAR Initiative ends.

Strategy 3: Facilitate mental health education for EMS personnel

We have developed a mental health education plan with Pierce County EMS leaders and local organizations who will assist with training. The top two mental health training priorities EMS identified are: 1) Education about mental health crisis and treatment services for adults and children/youth in Pierce County, and effective coordination with and referral to these services; and 2) De-escalation training to improve outcomes when working with adults and children/youth experiencing a mental health crisis. Other mental health training interests include education about mental health diagnoses/symptoms, training specific to working with people who are suicidal, and advanced de-escalation training to equip EMS personnel for dangerous and high intensity mental health crisis situations. Training in the first two priority areas will be developed by small teams of EMS leaders and local experts. With over 1,000 EMS personnel in our county, and their personnel time and logistics challenges for training, it was decided these trainings will be delivered by the local experts to 1-2 live EMS audiences and filmed for later viewing by all EMS personnel.

Strategy 4: Build awareness and knowledge about the importance of early psychosis recognition and intervention

This is an emerging partnership with the WA Division of Behavioral Health and Recovery (DBHR), which developed its Early Psychosis Initiative in late 2015 per SAMHSA's mandated use of mental health block grant funds. The initiative is designed to "enhance the recognition of early signs and symptoms of psychosis so that effective treatment can be started promptly." *(For more information, see www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/signs-early-psychosis)*. We are developing specific collaborative activities with DBHR to help disseminate their information in Pierce County. We started by introducing the Early Psychosis Initiative to community leaders and stakeholders at two April 2016 events: 1) presentation to the City of Tacoma's Mental Health/Substance Use Disorder Collaboration, 2) presentation to 100+ community leaders, co-hosted with the Tacoma-Pierce County Health

Department. These events helped generate interest in creating an early psychosis treatment program in Pierce County, with initial planning underway.

Strategy 5: Support NEAR/ACES education in Pierce County

In Summer 2015, the Foundation for Healthy Generations began a statewide, long-term initiative to disseminate NEAR education and support trauma-informed services (NEAR stands for Neuroscience, Epigenetics, ACEs, and Resiliency). The PAR Initiative has convened a planning group including the Foundation for Healthy Generations, two local Master NEAR Trainers they have trained, and the Tacoma-Pierce County Health Department, to explore best options for NEAR/ACEs education and other ACEs work in Pierce County. *(To learn more about NEAR and Washington State, see the 2014-2015 report at: http://www.healthygen.org/sites/default/files/Online%20Version_2014-2015%20Statewide_4-21-15.pdf)*

Strategy 6: Partner with Tacoma-Pierce County Health Department and UW in Triple P Intervention Training for mental health providers

Launched in 2015, the Triple P Urban Initiative is a partnership between the Tacoma-Pierce County Health Department (TPCHD) and the University of Washington (UW), funded by WA DBHR. Triple P is an evidence-based, public health approach to promoting positive parenting that includes five intervention levels - from universal prevention, to indicated prevention, to intervention levels 4 and 5 *(see www.triplep.net/glo-en/home/)*. The Triple P Urban Initiative is training three groups of pediatric primary care providers in Pierce County in Triple P level 2 interventions. Once trained and accredited, the providers can access a streamlined referral process to connect their highest-need families to TPCHD's Family Support Centers, which provide comprehensive services and home visits.

In partnership with the PAR Initiative, the Triple P Urban Initiative is also training a cohort of children/youth mental health providers in Triple P Level 4 intervention. This is a 10-session intervention that includes thorough assessment of parent-child interaction, applying parenting skills to a broad range of target behaviors, and using generalization enhancement strategies to promote parental autonomy. In addition to gaining advanced, best practice skills to help parents, these mental health providers will also be able to directly access Family Support Center services for the families they work with.

Strategy 7: Increase mental health knowledge among high school and college staff

High school teachers will learn how to deliver the previously described Mental Health & High School Curriculum through a 1-day Teacher Training and a self-study guide. Research has demonstrated this training increases teachers' mental health literacy and decreases self-reported stigma. College staff will increase their mental health knowledge and intervention skills through the previously described JED Gatekeeper Program training, which is designed to: 1) Inspire Gatekeepers to see their important role for campus safety and student well-being; 2) Educate different groups of Gatekeepers (faculty, staff, student leaders) about the specific warning signs they can cue to - including behavioral, emotional, and problematic thinking; and 3) Equip Gatekeepers with specific skills to ensure they feel confident to intervene. We will work with local colleges and universities to implement The JED Foundation's new Gatekeeper Program on their campuses. The JED Foundation will come to Pierce County in 2017 and 2018 to provide Gatekeeper Program Instructor training to local college staff. These Instructors will then be qualified to provide Gatekeeper Training to other college staff, How to Help a Friend Training to students, and can also train other college staff and student leaders to provide How to Help a Friend Training.

FOSTER COALITIONS & NETWORKS

Strategy: Support current & forming behavioral health coalitions & groups

The PAR Initiative and/or CHI Franciscan Health actively participates in the following coalitions and groups: City of Tacoma Mental Health/Substance Use Disorder Collaboration; Community Health Improvement Plan - Mental Health Work Group; Physical and Behavioral Health Integration Committee (under the Accountable Community of Health Group; Community Mental Health Oversight Committee (focused on ED/crisis services improvement); WA DBHR's Mental Health Promotion Work Group (statewide); and a new group convened by the PAR Initiative – local

organizations serving family members of loved ones with mental health challenges. There is some interest in creating a Pierce County behavioral health prevention coalition or group; the PAR Initiative would play an active role in such a coalition when and if this develops.

CHANGE ORGANIZATIONAL PRACTICES

- Strategy 1: Implement the Zero Suicide Initiative at CHI Franciscan Health

Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention, and a project of the Suicide Prevention Resource Center. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge. For health care systems, this approach represents a commitment to: 1) Patient safety, the most fundamental responsibility of health care; and 2) The safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients. The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. The challenge and implementation of a Zero Suicide approach cannot be borne solely by the practitioners providing clinical care; Zero Suicide requires a system approach to improve outcomes and close gaps *(from: www.zerosuicide.sprc.org)*.

CHI Franciscan Health was accepted to the May 2015 Zero Suicide Academy, after completing a comprehensive Organizational Self Study. We launched our Zero Suicide Initiative pilot in September 2015, with Phase 1 including regional emergency departments, the inpatient mental health unit, outpatient behavioral health therapists, and the inpatient Psychiatric Assessment Team.

Strategy 2: Expand Peer Bridger services for patients leaving the St. Joseph Medical Center Mental Health Unit

Administered by Recovery International via a contract with Optum BHO, the Peer Bridger Program is a short-term, community-based program that bridges the gap between inpatient care and community services through transition services and support provided by a Certified Peer Specialist. People who have just been discharged from psychiatric hospitalization, or evaluation and treatment centers are very vulnerable to decompensation, risk of harming themselves or others, and re-hospitalization. Currently, program services are limited to patients in the public mental health system (e.g. have Medicaid and/or hospitalized via Crisis Services), and we want these valuable services to expand to discharging mental health unit patients with private insurance, Medicare, and no insurance. There are two major areas of work to accomplish this goal:

1) establish reliable, long-term funding, and 2) develop shared referral, tracking/reporting, and evaluation processes.

Strategy 3: Support the ED Mental Health Team Program at CHI Franciscan Health emergency departments

The ED Mental Health Team Program involves a Certified Peer Specialist and a Therapist working onsite in the emergency department to provide supportive counseling, community resource assistance, and follow-up calls to patients presenting with mental health concerns. The goal is to help ED patients get the services they need to stabilize and keep safe, instead of being hospitalized. The program has now been implemented in the emergency departments at St. Joseph Medical Center and St. Clare Hospital, and served 515 patients at the two facilities from January-July 2016. Greater Lakes Mental Healthcare provides the program via a contract with Optum BHO.

Strategy 4: Help improve coordination between EMS, mental health crisis services, law enforcement, and emergency departments

The PAR Initiative and CHI Franciscan Health are collaborating in several efforts and groups to improve coordination among mental health crisis response and service-providing organizations, such as the Community Mental Health Oversight Committee. The mental health education we are facilitating for EMS personnel will also help improve coordination.

Strategy 5: Implement depression and anxiety screening at CHI Franciscan Health WIC clinics

CHI Franciscan Health has two WIC clinics in Pierce County that currently serve a combined population of about 7,000 low-income women who are pregnant, new mothers, or who have young children qualified for WIC. This is a very large population of women at risk of developing mental disorders, especially perinatal depression and anxiety (from 2004-2008, 10% of new mothers in Pierce County developed post-partum depression – *PRAMS*). This socioeconomic group also typically has low mental health literacy and fewer social supports and resources to help them deal with mental disorders. In August 2016, the U.S. Preventive Services Task Force (USPSTF) issued a new recommendation regarding depression screening for adults: "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." Screening and referring WIC clients for depression and anxiety is sanctioned by the federal WIC program and has been implemented by other WIC programs in the U.S.

WIC leaders and the PAR Initiative are developing processes for WIC staff to screen their clients for depression and anxiety using the Edinburgh Depression Scale, a validated tool commonly used for perinatal depression and anxiety screening (including by WIC's co-located partner organization, Step-by-Step, which provides Maternity Support Services). A score of 10 or higher on the Edinburgh Scale will result in: 1) referral for counseling to Step-by-Step (and/or other community mental health providers); 2) guidance for the client to tell their primary care provider about their screening results; and 3) follow-up on referrals to check that the client connected.

We have also arranged mental health training for WIC staff to help them be well-prepared for mental health crises and problems their clients may experience, including Pierce County Mental Health Crisis Training in August 2016 and Perinatal Depression and Anxiety training in December 2016 that will also reinforce the new screening and referral processes.

OBJECTIVE 6: INFLUENCE POLICY & LEGISLATION

Strategy: Coordinate with local and state organizations to advocate for policy changes and legislation aligned with PAR goals

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