Continuum of Care Needs Summary

1. Screening, Case Management & Referral

Mental Health and Substance Abuse

- General understanding about how to access services
- Defined follow-up services post detox, respite, and/or inpatient stay to assure that individuals become engaged or re-engaged in ongoing outpatient services
- Comprehensive, current directory of resources and education about the 211 information and referral system to dispel misperceptions and erroneous information about what services are available and about the best way to refer clients or patients to receive services.

Mental Health

- True continuum of care for all children, both lower level as well as high intensity and crisis services
- Public Knowledge/Community and Partner Education
    - Implement an initial public education campaign regarding crisis telephone services, 211, and, for Medicaid enrollees, NSMHA access line and other aspects of NSMHA services.
    - For primary care practitioners (PCPs), seek informal inclusion of the NSMHA region in the Partnership Access Line and provide PCPs with information about how to obtain child psychiatry consultation through this system.

Substance Abuse

- Screening, Brief Intervention, and Referral to treatment in hospital emergency departments, primary care offices for at-risk substance abusers before more severe consequences occur.

2. Prevention/Early Intervention

Mental Health and Substance Abuse

- Evaluation of "upstream" services that might prevent the progression to crisis (e.g. integration of behavioral health with primary care, supported housing and employment models, focused recruiting of non physician providers such as Psychiatric Advanced Registered Nurse Practitioners)
- Prevention type services which target children and youth who need support and instruction.
- Teach middle and high school aged youth intervention skills to enable them to better help their peers with drug or alcohol use, aggressive behavior, depression, etc.
- Improved capacity of skilled, school based interventions for individual youth experimenting with or using drugs or alcohol

Substance Abuse

- Increase the culturally relevant and bilingual capacity of intervention services
- Provide 24 hour access to intervention professionals for law enforcement and EDs

3. **Recovery/Relapse Prevention**

Mental Health and Substance Abuse

- Adequate, clean and sober, supported housing, to ensure recovery for individuals living with mental illness and chemical dependency disorders.
- Increased housing stock; identify partners to support the treatment services and case management necessary to help individuals succeed.
- Ongoing community education groups for family members adjusting to recovery

Mental Health

- Additional support groups facilitated by treatment professionals

Substance Abuse

- Additional drug and alcohol free community social, cultural, and recreational activities for people in recovery
- Additional continuing care groups in high schools for students who have completed treatment

4. **Inpatient**

Mental Health and Substance Abuse

- Retention and expansion of community inpatient capacity
- More secure, involuntary settings for people who are in serious crisis and need longer term support and stabilization
- Regional residential treatment programs (28 days or more) for youth in the county
- Additional treatment alternatives to jail or detention (youth) for those lower risk offenders whose criminal behavior is linked to their addiction or mental illness (programs like juvenile drug court, mental health court, etc.)
- Regional residential programs for youth or adults who have co occurring substance abuse and mental illness
- Culturally relevant, bilingual treatment choices for Skagit County residents

Mental Health

- Maintain inpatient capacity at Western State Hospital. Washington has 19 psychiatric beds per 100,000 residents while the national recommendation is 50 beds per 100,000.

- Additional psychiatric inpatient bed capacity; individuals spend time "boarding" in EDs because there are not beds available anywhere in the state.
- Forensic inpatient capacity. The most practical way to meet this need is through treatment beds at Western State Hospital.
- Increased agency choices for all people seeking treatment

5. Outpatient/ Intensive Outpatient Services

Mental Health and Substance Abuse

- Comprehensive case management and treatment services for families and individuals struggling with mental illness and chemical dependency. In 2009 study, almost half of inpatient mental health admissions were for patients who had received no outpatient mental health services before admission and 83 – 96% of these patients did not receive outpatient treatment following discharge.
- There is a fairly complex, multi-factorial eligibility criterion that includes income, clinical diagnosis, functional status, crisis state, and treatment modality. Only when all criteria are met can a patient be offered services, then services are limited to a particular number of visits based on a combination of the patient's clinical acuity and the number of services available under current budget constraints. Sometimes clients can only be seen once a month.
- Perception of extremely long wait times for outpatient services at mental health providers. There is also a perception that if a client does get seen, they will likely only be seen once, then will be discharged to self management.
- Ability to expand employment to clients through thrift store creation and the like
- Funding mechanism for prescription medications for client who receive state-only funding
- Treatment services in outlying areas of the county: east of Sedro Woolley, Anacortes
- Additional treatment services for: Youth in school; Individuals with co-occurring disorders; Adults and families involved with Child Protective Services; Low income adults without insurance

Mental Health

- Adequate Spanish language mental health services. Skagit County been identified as a mental health professional shortage area and the public mental health system employs only 2 or 3 Spanish speaking therapists.
- Services for those who have insurance but can't afford co-pay or who are in the country illegally or those who don't meet access to care standards
- Walk in mental health clinic (store front)

- Funding mechanism to serve "families" and serve children without having to push into adult diagnostic patterns.
- Coordinated care planning among all child-serving systems, including crisis planning, include family/adolescent so information is shared across systems with their consent
- School-based therapeutic day program with ESD as partner
- Mechanism for older adults to access the MH system
- Expanded ECS program (which can serve dementia patients) in partnership with ADSA and in coordination with older adult programs funded by Federal Block Grant
- Psychiatric services, particularly Child Psychiatrists; telepsychiatry
- Therapists specifically trained in CBT, DBT, FFT, trauma-based CBT

Substance Abuse

- Educational opportunities to assist staff in developing expertise.
- Transportation to treatment appointments and 12 step meetings
- Need to provide mental health service to provide counseling on site.
- Funding for medically assisted treatment, i.e. suboxone for opiods, vivitrol for alcohol dependence.

6. Crisis System

Mental Health and Substance Abuse

- Ability to provide prescriptions at the Skagit County Crisis Center in order to reduce the costly and avoidable utilization of Skagit County emergency departments.
- Enhanced ability of local communities to provide integrated services to individuals with mental illness and/or chemical dependency by integrating funding for crisis respite, detoxification, case management, and other crisis interventions.
- Crisis Stabilization Unit to provide a secure, medically staffed triage capacity for law enforcement and other first responders.
- Community planning for high utilizing clients that present in the ER rooms consistently.
- Ability for clients with extensive mental illness to access inpatient CD treatment.
- Address medication seeking individuals who go to ED and provision of case management for medication seekers
- Focused crisis role for serving older adults, given the mix of medical, dementia, and MH/SA issues; medically-supported detox for elderly, medically involved
- Focused use of local inpatient capacity to reduce transport to out-of-region beds
- Emergency shelter (72 hours) for youth in crisis due to substance abuse or mental illness

- Integrated intervention and detoxification programs
- 24 hour access to intervention professionals for law enforcement, hospital emergency departments, emergency medical services
- Community planning for high utilizing clients that present in the ER rooms consistently and each provider of the client is working from a different plan. Shifts at the hospitals prevent implementation of consistent planning and follow through. On the CD side, clients with extensive mental illness are rarely able to access inpatient CD treatment which is very problematic.

Mental Health

- Crisis services/options for children
- Consistent protocols between VOA and all 911 dispatch units (with training to accompany)
- VOA protocols and scripts that assure consistent responses while balancing the need for responsiveness and flexibility.
- More VOA phone time for those needing support
- Mobile Outreach Crisis Teams that go to homes and other community settings; Use peer/parent partners on teams
- Regional Geriatric Assessment Team to provide non-24/7 outreach and assessment for older adults in the community, in private homes and in facilities. In addition to outreach and assessment, services would include targeted training and consultation for: Hospitals/EDs; Dementia facilities; Skilled nursing facilities (SNFs); Adult family homes (AFHs); Mobile outreach staff
- Consistent protocols (e.g., assessment, planning, ongoing communication)for clients shared with Adult Protective Services (APS)
- Formal training and consultation capacity to support mobile outreach services to children, youth and families
- DCR function within the staffed operations of the CSUs (e.g., as employees)
- CSUs as new point of entry to the crisis system (rather than EDs).
- Respite for Children/Youth that is less facility-based; goal of keeping in child/youth in out-of-home care for no more than 72 hours; not accessed through Children's Administration
- Respite for Older Adults that is less facility based; goal of keeping person in out-of home care for no more than 72 hours
- Develop appropriate inpatient care for persons with dementia and services for children and youth through collaboration with existing inpatient units
- Improvements in operations of IP/E&Ts including:
    - Peer staffing in E&Ts
    - Reductions in seclusion and restraint
    - Family involvement

Substance Abuse

- Training to community groups on how to intervene to help family members, friends, etc., who may be struggling with drug or alcohol use
- Develop additional detoxification services for youth and adults
- Increase culturally relevant, bilingual capacity of crisis intervention services.
- Develop a secure detox facility with medical staff available on site, with additional long term treatment beds and follow-up case management.

7. **Ancillary Systems**

Mental Health and Substance Abuse

- Revisit expedited procedures to improve prioritization of lost Medicaid prior to jail discharge (CSOs have cut staffing and slowed the process down considerably)
- Crisis Intervention Training (CIT) to all first responders and seek more training on MH/SA issues at the academy level.
- Develop standardized data tracking across LE agencies to quantify the volume of activity and track the impact of implementing new crisis system components

Mental Health

- Develop consistent protocols between jails, counties, NSMHA and providers:
- Establish consistent protocols for when first responders request assist and for when mobile crisis outreach teams (or DCR) needs assist (protocols should address children/youth, adults and older adults, as response approaches will vary)
- Create more partnerships for joint outreach—DCRs with first responders
- Develop consistent protocols with EDs regarding communication with LE regarding patients who eventually are not admitted (NSMHA might play a convening role with EDs and LE agencies)
- Develop consistent protocols between juvenile detention, counties, NSMHA and providers per above
- Develop additional capacity in local community colleges to provide certified peer counselor training that is also recognized by the state
- Develop a module to train parents and caregivers as family partners prepared to serve families, children, and youth receiving MH services

Substance Abuse

- Community awareness projects
- Employment opportunities
- Training for "Recovery coaches"