Skagit County Community Services
Mental Health and Chemical Dependency Services Needs Identification

A. **November 20, 2008 Community Forum:** 70 people attended a Skagit community forum to review priorities and endorse an action plan. Attendees included:

- Hospital administrators
- Emergency department social workers and physicians
- Representatives from mental health and chemical dependency treatment programs
- National Alliance for Mental Illness (NAMI)
- Skagit County agencies (Public Health, Human Services, and Youth and Family Services)
- North Sound Mental Health Administration
- Members of the two Skagit County Citizen Advisory Boards (Mental Health and Substance Abuse)
- Residents of Skagit County
- Representatives from Department of Social and Health Services CSO

The following treatment priorities were identified (issues are not listed in any particular order):

Issue One: Housing

1. Need for adequate, clean and sober, supported housing, to ensure recovery for individuals living with mental illness and chemical dependency disorders.
2. Need for increased housing stock; we can identify partners to support the treatment services and case management necessary to help individuals succeed should housing become available.

Issue Two: Inpatient Services

1. Need to 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.* Western State Hospital beds are essential to the health and safety of individuals and our communities. Wards must not be closed.
2. Need for forensic inpatient capacity. The most practical way to meet this need is through treatment beds at Western State Hospital.
3. Need to support the retention and expansion of community inpatient capacity:

Issue Three: Crisis and Acute Services

1. Need to station a medical professional with prescriptive authority at the Skagit County Crisis Center in order to reduce the costly and avoidable utilization of Skagit County emergency departments.
2. Need to enhance the 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.
3. Need to support the development of a Crisis Stabilization Unit to provide a secure, medically staffed triage capacity for law enforcement and other first responders.

Issue Four: Outpatient Services

1. Need to develop more comprehensive case management and treatment services for families and individuals struggling with mental illness and chemical dependency.

2. Need to develop and support 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 two Spanish speaking therapists.

B. From Skagit County Alliance for Healthcare Access, Community Assessment Report, April 2010

All of Skagit County qualifies as a Mental Health Professional Shortage Area, generally defined as a population greater than 6,000 per core-mental-health-professionals and a population greater than 20,000 per psychiatrist.

p. 6

"There were also concerns expressed about the quality of services available at some behavioral health providers. Emergency Departments, especially at Skagit Valley Hospital see many patients with mental health crises that have very long lengths of stay while waiting for placement in an appropriate level of care, with some being discharged without appropriate placement. Finally, while public (Medicaid and county) funding does exist for some crisis and high level services, there is almost no availability of routine behavioral health services such as counseling and ongoing medication management for low income individuals."

pp. 25-27

Behavioral Health/Chemical Dependency Services

There are a number of behavioral health and chemical dependency programs serving Skagit County. These programs have very complex and confusing eligibility requirements, referral methodologies, and limitations on services offered. Additionally, state budget cuts in recent years have resulted in the elimination, reduction, or modification of services that has left many clinicians and referral sources uncertain about what is available and how to access it for their patients. In a low income community needs assessment conducted in 2009, respondents cited a lack of general understanding about how to access services.[1] In another study completed in 2009 by the North Sound Mental Health Administration, in the five county region including Skagit County, 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. [2]

For people who qualify for Medicaid, there is a prepaid behavioral health plan that is separate from the medical coverage for this population. These services are offered through the North Sound Mental Health Administration who subcontracts with various providers. 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.

In a very unique program, Skagit County has funds from a 1/10 of 1% sales tax that are dedicated to supplementing the state funded mental health programs targeting those who do not meet eligibility requirements for state programs. The Community Wellness Program offers counseling to Skagit County residents up to 350% of FPL who do not meet eligibility criteria for

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[1] North Sound MHA Acute Care/Crisis Planning Data Book NEW, Adults Ages 18+, FY2009 (July 2008- June 2009)

[2] North Sound MHA Acute Care/Crisis Planning Data Book NEW, Adults Ages 18+, FY2009 (July 2008- June 2009)

Medicaid, and it can provide up to twelve counseling sessions. The current case load is 120-140 clients.

Other services that are supported with funds from this sales tax include:

- School Based Mental Health Program through Catholic Community Services
- Jail Treatment Program through Compass Health
- Mental Health Court
- Wrap Around Children's Services through North Sound Mental Health Administration
- Skagit County Behavioral and Crisis Center (Chemical Dependency) through Compass Health
- Family Treatment Court through Phoenix Recovery Services
- Adult Treatment Court through Skagit Recovery Center
- Housing Stipends for Chemical Dependency clients
- Chemical Dependency Case Management Services through the Crisis Center
- Mental Health Treatment for Chemical Dependency clients at Phoenix Recovery Services

Chemical Dependency services are funded by the state in yet another separate program that subcontracts with local providers.

Available Mental Health and Chemical Dependency Services include:

Outpatient Mental Health Services

- Crisis Line and Access Line – two separate phone lines offering triage and referral and dispatch of Designated Crisis Responder if necessary
- Skagit County Behavioral and Crisis Center – pre-treatment and stabilization beds
- Mental Health Court - judicial supervision during mandatory mental health treatment for non-violent offenders
- Jail Treatment Program – mental health services as needed while in jail
- Jail Transition program – mental health services for 90 days after release from jail
- Catholic Community Services
- Sea Mar Community Health Clinic
- Sunrise Mental Health Services
- Compass Health
- Community Wellness Program
- Veteran's Administration
- Upper Skagit Tribe
- Swinomish Tribe
- Skagit Treatment and Engagement Program (STEP) – hard to engage/homeless population
- A few private providers who typically do not see Medicaid or uninsured clients

Inpatient Mental Health Services

- Skagit Valley Hospital – 15 inpatient beds for adults only (no children, adolescents, or geriatrics)
- North Sound Evaluation and Treatment Center – 16 beds for involuntary detention

School Based Mental Health Services

- Catholic Community Services – School-based counseling
- At Risk Intervention Services (ARIS) – case management for high risk youth
- Skagit Discovery – problem solving, decision making, and social skills for children with emotional, social and behavioral difficulty
- Parent Child Assistance Program (PCAP)

Other Services

- Peer Connections Center – a drop in center providing peer support, organized activities and education, and linkage to other services
- Secret Harbor and Foster Care Resources – residential placement and mental health treatment for children

Outpatient Chemical Dependency/Detox Services

- Phoenix Recovery Services
- Skagit Recovery Center
- Skagit County Behavioral Crisis Center – respite beds for sub-acute detox
- Family Treatment Court
- Adult Treatment Court

A secure detox facility located in Sedro Woolley was recently closed due to budget cuts.

Inpatient/Residential Chemical Dependency Services

- Pioneer Center North – 140 beds (Skagit County residents represent only about 10% of the patients treated here. Others are from throughout the region.)

Observation: *In spite of what would appear to be a wide array of services, interviewees almost unanimously cite mental heath services as the biggest gap and the biggest concern in terms of access to healthcare for the poor and vulnerable in the county*. Everyone is very aware of recent losses in state funding for services and the elimination of several programs. This awareness seems to have translated into a belief that "there is simply nothing available". Interviewees indicate that the few staff left to serve patients have such heavy case loads that they are unable to provide any truly meaningful help to patients. They also report that there is high turnover in counseling staff due to low wages. It is concerning that several interviewees who would normally be referral sources for these services seemed discouraged enough that it appears that they may no longer even be trying to access services for some patients because they believe the effort would be fruitless. Many interviewees do report positive impressions of the services at the Crisis Center (for both mental health and chemical dependency patients) and believe that more beds of this type would be useful.

Many interviewees report a perception that there are extremely long wait times for outpatient services at Compass, Catholic Community Services, and other 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. Many interviewees seemed unaware of behavioral health services at Sea Mar. There seems to be little or no access to behavioral health services for uninsured individuals and little or no access to services that are non-emergent or non-urgent except for the Community Wellness Program.

The North Sound Mental Health organization is currently engaged in an evaluation of the crisis response system. Designated Crisis Responders report that they believe they are only able to procure the appropriate and needed services for about 10% of the patients they are called to see. Not surprisingly, this corresponds to a high number of complaints about the existing crisis response system to the Mental Health Ombuds.

There does not appear to be any entity or group that is seriously evaluating the "upstream" services that might prevent the progression to crisis for these patients (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 [ARNP's], etc.) The planned residency program at Skagit Valley Hospital in partnership with the Pacific Northwest University of Health Sciences has the potential to positively impact this situation if a Psychiatric residency is offered and new model of practice are explored.

Improving access to behavioral health and chemical dependency services for the vulnerable populations in Skagit County will be one of the most important, most complex, and most difficult undertakings that must be considered by the Skagit Alliance for Healthcare Access.

pp. 33(recommendation)

Form a special task force (perhaps an extension of the existing crisis response system) to clarify existing mental health/chemical dependency services, eligibility criteria, and how to effectively access them, then move on to identifying options for expansion of ambulatory non-crisis behavioral health services. Explore models that integrate behavioral health with primary care, perhaps building on both Sea Mar and the RHC's.

C. From NSMHA Crisis Review Report, 3-30-10:

Public Knowledge/Community and Partner Education

1. Implement an initial public education campaign regarding crisis telephone services, 211, and, for Medicaid enrollees, NSMHA access line and other aspects of NSMHA services. Once mobile outreach crisis teams and crisis stabilization units (CSUs) are in place, initiate a major public education/social marketing campaign.
2. 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.
3. For Law Enforcement (LE), expand Crisis Intervention Training (CIT) to all first responders in the five counties (and investigate the possibility of a briefer, consolidated curriculum) and seek more training on MH/SA issues at the academy level.
4. Establish closer collaboration between the counties and NSMHA in system planning (e.g., for NSMHA funding and the counties' plans for 0.1% sales tax funding).

Crisis Telephone

5. Develop *consistent protocols* between VOA and all 911 dispatch units (with training to accompany) that address these and other questions:
6. Establish VOA *protocols and scripts* that assure consistent responses while balancing the need for responsiveness and flexibility, addressing:
7. Develop *new protocols* to support system as CSUs are developed
8. Provide more time on the phone for those needing support

Law Enforcement

9. Develop standardized data tracking across LE agencies to quantify the volume of activity and track the impact of implementing new crisis system components
10. Work to bridge different cultures and languages
11. 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)
12. Create more partnerships for joint outreach—DCRs with first responders
13. 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)
14. When CSUs are in place, develop *new protocols* for when LE takes into custody and brings to CSU (per SSB 5533 and would need to coordinate with prosecuting attorneys to develop consistent approaches across the region) versus taking to jail or ED

Crisis Transportation

15. Budget flex funds for individual community solutions

Mobile Outreach Crisis Team

16. Create Mobile Outreach Crisis Teams that go to homes and other community Settings
17. Develop *consistent protocols* for:
o Lower level of criteria for outreach with safety assessment
o Addressing violence (e.g., PACT/intensive outpatient examples)
o Timing in the reading of rights (use statewide protocols)
18. Develop mechanisms to bill insurance for mobile outreach services—as healthcare reform is implemented, there will be more coverage of the population and the costs of these services should not be borne solely by Medicaid and state funding
19. Develop mechanisms and *consistent protocols* for communication among providers based on HB2025, passed in the 2009 legislative session:
20. Use peer/parent partners on teams and bring their strengths to the process, including making follow-up calls to individuals that have received crisis services— currently there are parent partners serving on child and family wraparound teams

Specialized Crisis Consultation

21. Implement a 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:
o Hospitals/EDs
o Dementia facilities
o Skilled nursing facilities (SNFs)
o Adult family homes (AFHs)
o Mobile outreach staff
22. For older adults living alone and isolated, not voluntarily seeking services, work to support their current living setting rather than removing them
23. Collaborate with Adult Protective Services (APS) to develop *consistent protocols* for shared clients (e.g., assessment, planning, ongoing communication)
24. Ensure that mobile outreach capacity includes child specialists across the region
25. Establish formal training and consultation capacity to support mobile outreach in their services to children, youth and families

Designated Mental Health Professional/Crisis Responder

26. Establish the DCR function within the staffed operations of the CSUs (e.g., as employees)
27. Develop *consistent protocols* for:
o Reading of rights (use statewide protocols)
o Interpretation of what meets ITA criteria
o Dispatch criteria for DCR outreach (e.g., EDs, jails, DCR with LE)

Crisis Stabilization Unit
Established pursuant to SSB 5533, a CSU:
□ Operates 24/7
□ Is essentially an E&T level of licensure (residential treatment)
□ Can be a portion of a facility licensed as E&T or hospital, so it would be feasible to co-locate a CSU and E&T
According to the legislation, law enforcement can bring a person directly to the CSU when:
□ The individual committed a non-felony crime that is not a serious offence [based on standards agreed upon with the prosecuting attorney] and is known to suffer from a mental disorder
□ There is cause to believe that the person is suffering from mental disorder and presents imminent likelihood of serious harm or is in imminent danger because of being gravely disabled
The person must be seen by a mental health professional within 3 hours of arrival and, within 12 hours, a DMHP/DCR must determine if the individual meets detention criteria.

Recommended actions Include:
28. Establish CSUs in Whatcom, Skagit, and Snohomish counties (which if sited properly, might also serve Island and San Juan counties). Use the CSUs as regional resources, to maximize crisis supports within the five county NSMHA region.
29. Make the CSUs the new point of entry to the crisis system (rather than EDs) welcoming families and consumer walk-ins, voluntary and involuntary individuals.
30. Develop the following capacities:
o Centralized shared information (among CSUs/DCRs, VOA, mobile outreach crisis teams)
o Admission criteria (no cherry picking)
o Immediate access to medications
o Substance abuse service capacity/detox, co-occurring disorders
o Deal with violent individuals, safely able to use restraint and seclusion, security that doesn't count on calling LE
o Properly staffed/trained with ability to manage in crisis mode, with force as the last option
o Staff to initiate treatment and engage people with ongoing treatment, housing supports and other aftercare services (manage the revolving door)
o Alerts to current providers to engage in follow up planning
o Address medication seeking (see EDs)
31. Build *consistent protocols* regarding:
o Referral from community agencies
o Criteria and process for LE drop off and follow up communication
o Dealing with prior criminal history
32. Co-locate the Snohomish, Skagit, and Whatcom mobile outreach teams with the CSUs, to build a consistent systemic approach to crisis services and community partnerships.
33. Develop mechanisms to bill insurance for CSU services—as healthcare reform is implemented, there will be more coverage of the population and the costs of these services should not be borne solely by Medicaid and state funding

Respite
In addition to the CSU capacity there is a continued need for respite capacity, both facility and non-facility-based services. Current respite capacity includes:

□ Skagit
o 11 beds integrated w/ subacute detox
o MH side has access criteria (perceptions of difficulty in getting people in), admission issues are related to having double rooms, not mixing MH and SA or M and F, which leaves second beds frequently blocked
o Staffed with entry level staff
Recommended actions include:
34. Retain current facility capacity and develop additional non-facility-based and smaller or mobile respite resources. Use the facilities as regional resources, to maximize crisis supports within the five county NSMHA region
38. For Children/Youth and Families
o Age range from 3-18
o Need different environments, less facility-based, goal of keeping in child/youth in out-of-home care for no more than 72 hours
o Need respite that is not accessed through Children's Administration
39. For Older Adults
o Need different environments, less facility based, goal of keeping person in out-of home care for no more than 72 hours
40. Establish *consistent protocols*
o Admission criteria and rule outs (no cherry picking, accept challenging behaviors)
o Medical clearance rules and processes
o For some populations to "step over" to respite (without going to ED or CSU) via mobile outreach or current service provider
o Work with housing agencies to hold housing while person is stabilized so they have a place to come back to after discharge

Emergency Departments
41. Change the culture of coming first to the ED for MH/SA conditions. Educate the community and key partner agencies. There are relationships that consumers have with EDs and ED staff, and this would need to be addressed
42. Establish a continued ED role to address medication seeking and provision of case management for medication seekers
43. Consider a focused crisis role for serving older adults, given the mix of medical, dementia, and MH/SA issues; detox is needed for elderly, medically involved people, but should be medically backed up
44. When CSUs are in place, develop *new protocols* for transfers from the ED to the CSU and communication between the CSUs and EDs.

Community Inpatient/Evaluation & Treatment
According to a 2008 Washington State Hospital Association Report, the state has insufficient psychiatric inpatient bed capacity.

> *In 2000, 28 community hospitals provided 799 community hospital inpatient mental health beds. Because of financial losses and other challenges between 2000 and 2006, Washington State experienced an 18 percent reduction in community inpatient hospital mental health bed capacity, dropping from 799 to 657 total psychiatric beds. As of today, 637 inpatient mental health beds are available in 23 community hospitals to serve our state's mental health population, slightly lower than in 2006, while the population and demand for services have continued to grow. Of these available beds, only 361 (57 percent) are in hospitals certified by the Washington State Division of Mental Health for involuntary treatment admissions.*

In the 2010 legislative session, SSHB3076 was passed to amend RCW 71.05, the Involuntary Treatment Act, broadening the criteria for detention (see Attachment I for a summary). Testimony regarding the bill pointed out that there are currently insufficient inpatient beds. The

fiscal note observes that an accurate estimate of the increase resulting from the legislation is not possible and reported that RSNs estimated two to five percent increased detentions, which has been taken into account in the budget forecasts accompanying this report.
Individuals spend time "boarding" in EDs because there are not beds available anywhere in the state. There is a concern that people are diverted into the criminal justice system because of lack of access to acute care. What is not known is what the demand for IP service would be if there were other alternatives available in the crisis/acute care system.
Financing of new crisis services could come from reductions in IP utilization (Attachment H summarizes Multnomah County's experience with such a paradigm shift). The goal should be to work with hospitals in the five-county region to address IP needs whenever possible within the region.

Recommended actions include:
45. Reduce transport to out-of-region beds through focused use of local capacity (currently all children/youth, and a portion of adults/older adults are hospitalized out of region)
46. Collaborate with existing inpatient units to develop appropriate inpatient care for persons with dementia (E&Ts are not designed for their care), and services for children and youth
47. Ensure bi-lingual and bi-cultural capacity
49. Develop improvements in operations of IP/E&Ts including:
o Peer staffing in E&Ts
o Reductions in seclusion and restraint
o Family involvement
50. Housing options need to be developed for post crisis/inpatient care (transitional and permanent)

Connection to Ongoing Mental Health and Substance Abuse Services
51. Provide defined follow-up services post CSU, respite, and/or inpatient stay to assure that individuals become engaged or re-engaged in ongoing outpatient services
52. Develop *consistent protocols* for contacts between case managers/clinicians and CSU/E&T/IP and priority for follow up care
53. For enrolled clients, PACT and intensive outpatient teams are accountable to manage crisis 24/7 and do outreach to current clients
54. For other enrolled clients, provider must make contact within 3 business days of notification of IP admission
55. Use the rehabilitation case management code and federal block grant to fund work with new, unenrolled clients needing better links from IP to OP
56. Consider possible use of 0.1% sales tax funding for post crisis/IP follow-up MH case management for unenrollable clients
57. Weave SA into the crisis response system and create capacity for immediate SA follow up appointments—use 0.1% sales tax funding to expand SA access and case manager follow up after crisis as Skagit has done
58. Expand SA treatment options

Specific Recommendations for Ongoing Care for Children/Youth and Families
59. Coordinate care planning among all child-serving systems, including crisis planning, include family/adolescent so information is shared across systems with their consent
60. Improve advance crisis planning and a single on-line source for all crisis plans
61. Develop *consistent protocols* across all child-serving systems regarding crisis response accountabilities
62. Use flex funds to support expansion of treatment aides, looking at how this might be combined with expanded staffing of mobile outreach, respite and CSUs
63. Develop school-based therapeutic day program with ESD as partner
64. Expand NAMI Basics program for families of children/youth into all five counties

Specific Recommendations for Ongoing Care for Older Adults

65. In addition to dementia, there are depression, PTSD, and SA conditions to be addressed. Older adults are not currently accessing the MH system; developing primary care based MH/SA services could help address this need
66. Expand the ECS program (which can serve dementia patients) in all five counties, with hospital diversion and jails as referral sources, in partnership with ADSA and in coordination with older adult programs funded by Federal Block Grant in three counties

Specific Recommendations for Ongoing Partnership with Criminal Justice

67. Develop *consistent protocols* between jails, counties, NSMHA and providers:
68. Revisit *expedited procedures* to improve prioritization of lost Medicaid prior to jail discharge (CSOs have cut staffing and slowed the process down considerably)
69. Develop *consistent protocols* between juvenile detention, counties, NSMHA and providers per above

Workforce Development

70. Partner with providers and educators in the region to develop a more formal set of initiatives that will grow future staff capacity for the NSMHA system
Related to this potential initiative is the development of certified peer counselors to work in CSUs, mobile outreach, respite and in the delivery of ongoing outpatient services.
71. Develop additional capacity in local community colleges to provide certified peer counselor training that is also recognized by the state
72. Develop a module to train parents and caregivers as family partners prepared to serve families, children, and youth receiving MH services
73. Address other barriers related to increasing the number of certified peer counselors

D. Additional needs identified:

- Psychiatric services, particularly Child Psychiatrists; telepsychiatry
- Telepsychiat
- Therapists specifically trained in CBT, DBT, FFT, trauma-based CBT
- Treatment services in outlying areas of the county: east of Sedro Woolley, Anacortes

E. From Skagit County's Strategic Plan for Chemical Dependency Services 2007-2013

Efforts undertaken in the the development of Strategic Chemical Dependency Treatment Goals for Skagit County for 2007-2013 included:

- Individual meetings with Skagit County chemical dependency treatment providers contracting for public funds, including:
    - Skagit Recovery Services
    - Phoenix Recovery Services
    - Sea Mar Behavioral Health Program
- Meetings with emergency department and social work staffs of Island Hospital (Anacortes) and Skagit Valley Hospital (Mount Vernon)
- Meetings with the North Sound Mental Health Administration, regional Designated Crisis Responders, and the Volunteers of America, specifically to problem solve Skagit County's crisis response capacities
- On going meetings with the Skagit County Substance Abuse Advisory Board and quarterly meetings jointly with the Skagit County Mental Health Advisory Board and the Substance Abuse Advisory Board
- Survey of the Developmental Disabilities Advisory Board of Skagit County

- Special meeting with DSHS financial workers to discuss access to publicly funded treatment, including ADATSA
- Reviewing TARGET and Treatment Analyzer data
- Tabulating 98 surveys, including 11 in Spanish, from members of the community addressing Crisis Intervention, Intervention, Treatment, Aftercare, and Violence Prevention
- Facilitating a strategic planning needs discussion involving the criminal justice community, including representatives from:
    - The Anacortes Police Department
    - The Skagit County Sheriff's Department
    - Skagit County Human Services
    - Skagit County Youth and Family Services
    - Skagit County District Probation
    - Skagit County District Court
    - Skagit County Mediation Services
    - The Washington State Department of Corrections
    - Skagit County Information Technology Services
    - The Skagit County Public Defender
    - The Skagit County Prosecuting Attorney
    - Skagit County Superior Court
    - The Mount Vernon Police Department
    - The Skagit County Jail
    - Skagit Recovery Center Adult Felony Drug Court Treatment Staff

Summary of Results from Meetings, Conversations, and Surveys from the Skagit County Community (87 Surveys)

I. Priorities for Crisis Intervention Services

A. Improve crisis services for substance abusing youth

B. Provide follow up case management or counseling for people recovering from a crisis episode

C. Continue to develop crisis triage programs which offer 1 safe door for people in crisis to enter, whether it be for mental illness or substance abuse

D. Increase community knowledge about how to access the crisis intervention system

E. Provide emergency shelter (72 hours) for youth in crisis due to substance abuse or mental illness

F. Improve crisis services for substance abusing adults

G. Improve access to crisis services for emergency rooms, emergency medical services, and law enforcement

H. Increase culturally relevant, bilingual capacity of crisis intervention services

I. Provide more secure, involuntary settings for people who are in serious crisis and need longer term support and stabilization

II. Priorities for Intervention Services

A. Improve the capacity for skilled, school based interventions for individual youth experimenting with or using drugs or alcohol

B. Create intervention and detoxification programs which integrate services for individuals struggling with co-occurring substance abuse and mental illness

C. 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.

D. Provide 24 hour access to intervention professionals for law enforcement, hospital emergency departments, emergency medical services

E. Provide training to community groups on how to intervene to help family members, friends, etc., who may be struggling with drug or alcohol use

F. Develop additional detoxification services for youth

G. Increase the culturally relevant and bilingual capacity of intervention services

H. Develop additional detoxification programs for adults

III. Priorities for Treatment Services

A. Develop regional residential treatment programs (28 days or more) for youth in the county

B. Provide more 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.)

C. Develop regional residential programs for youth or adults who have co occurring substance abuse and mental illness

D. Develop regional residential programs (28 days or more) for adults in the county

E. Increase culturally relevant, bilingual treatment choices for Skagit County residents / Increase the agency choices for all people seeking treatment

Note: These specific populations were identified on surveys to be in need of additional treatment services:

1. Youth in school
2. Individuals with co-occurring disorders
3. Adults and families involved with Child Protective Services
4. Low income adults without insurance

IV. Priorities for Continuing Care or Aftercare Services

A. Develop additional drug and alcohol free community social, cultural, and recreational activities for people in recovery / Develop additional continuing care groups in high schools for students who have completed treatment

B. Provide on going community education groups for family members adjusting to recovery

C. Provide additional support groups facilitated by treatment professionals

F. Mental Health Provider Survey Results:

- "Gap" is probably those who have insurance but can't afford copay, people in the country illegally (except through County program) or those who don't meet the requirements mentioned.

- Need more bilingual therapists, need crisis services/options for children, need crisis centers, CLIP facilities in region, need overall more funding so caseloads lower.
- Would like to see true continuum of care for all children, have both lower level as well as high intensity and crisis services; easier, quicker access (which means more capacity) spread throughout the County, funding mechanism to serve "families" and serve children without having to push into adult diagnostic patterns.
- 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.
- More housing is needed for co-occurring disordered clients who are trying to get clean
- Shelters/respites/etc. will not take clients who are mentally ill and have behavioral problems or CD issues and it is hard to get 2nd chances once a bridge is burned for them. A walk in mental health clinic (store front) would be very helpful along with a safer place to bed down at night when shelters will not accept them or are full
- On-site housing referral component, medical services, and more expansive CD program to Compass's existing program as well as the ability to expand employment to clients through thrift store creation and the like
- People under GA-U (Disability Lifeline) have always been a gap and we seriously doubt that the new approach to the program will be effective, especially if they terminate services to the program after 24 months.
- We have cases where a client receives services under state-only funding but cannot afford the meds that are prescribed. Sometimes the client gets on medical coupons fairly quickly and flex funds can be used until then. Occasionally free meds are obtained for a while.
- There is no comprehensive, current directory of resources although several organizations (including the Community Action Agency where we work) produce a resource guide. There is little awareness of the 211 information and referral system. Many misperceptions and much erroneous information exist about what services are available and about the best way to refer clients or patients to receive services.
- Prevention type services which would target children and youth who are in family situations which provide them with limited support and instruction.

G. Chemical Dependency Treatment Providers Survey Results
Needs and Gaps:

- Lack of a secure detox facility with medical staff available on site. Additional long term treatment beds. Follow-up case management.
- Additional services to assist the elderly population.
- A variety of housing options to assist those in recovery and those who are not, but still need a safe place to live. This housing would be supported by case management services to assist with basic needs and motivation to change.
- Educational opportunities to assist staff in developing expertise.
- Community awareness projects.
- Crisis stabilization unit for individuals to be assessed and triaged to appropriate services without having to go to the ED.
- Affordable suboxone treatment.

- Recovery housing.
- Transportation is a barrier for many people that do not have Medicaid coverage or adequate private transportation.
- Need funds to contract with MHPs who could provide counseling on-site. We have limited funding for mental health services for our Drug Court patients and it has increased our recovery rate without a lot of extra costs.
- Lack of employment.
- Inpatient treatment for co-occurring clients.
- Psychiatric medication for co-occurring clients.
- Lack of case management/engagement services in some programs cause clients to be too easily closed without services.
- Funding for medically assisted treatment.
- More services to Hispanic community.
- Treatment in outlying areas of the county.