Pierce County Behavioral Health System Study

Addendum: Revised Recommendations

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This document was prepared for the Pierce County Council as part of the Pierce County Behavioral Health System Study contract. The work was overseen by Tom Swanson and Michael Transue.

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.

1. Executive Summary

In 2016, the Human Services Research Institute (HSRI) conducted a study of the behavioral health system in Pierce County for the Pierce County Council. The final *Pierce County Behavioral Health System Study* report identified significant behavioral health-related needs in the County. And though HSRI identified many unique strengths and promising initiatives, there were also gaps between community need and available resources.

Over one year since the HSRI report, the County has made significant improvements in its behavioral health system, and a sweeping initiative to integrate physical and behavioral health care through Medicaid is on the horizon. Yet some gaps remain unfilled, and some challenges have persisted.

In the winter of 2017-2018, HSRI reengaged Pierce County stakeholders for further consultation on facilitators and barriers to progress toward the 2016 recommendations. HSRI identified four common themes from the stakeholder interviews:

- *Entities in Pierce County have made significant positive changes, but demand for behavioral health services far exceeds current supply.*
- *Behavioral health workforce shortages and a lack of affordable housing for people with behavioral health issues continue to pose significant challenges.*
- *Stakeholders are concerned about ensuring the complex needs of people with significant behavioral health conditions are met as integration takes place.*
- *Now more than ever, there's a need for a central coordinating body*.

Based on stakeholder conversations and our assessment of the current environment in Pierce County, HSRI offers the following revised recommendations:

Primary Recommendation
1. Establish a central coordinating body
1.1. Establish a charter and membership
1.2. Ensure a process of community engagement that includes full and active inclusion of service users and their families
1.3. Adopt a process for prioritization, implementation, and continuous monitoring, review, and refinement of behavioral health system changes
1.4. Ensure alignment of all activities with relevant local, state, and federal initiatives
1.5. Align with state and local efforts to ensure a culturally competent and trauma-informed system

1.6.	Identify and pursue sustainable funding sources
1.7.	Support and enhance current efforts to integrate provider data systems
1.8.	Develop system metrics to track progress on key goals

Behavioral Health System Recommendations

2.	**Invest in prevention**
2.1.	Sustain broad-based, multifaceted community education efforts that promote better understanding and reduce stigma, discrimination, and marginalization
2.2.	Adapt and expand school-based prevention and treatment
2.3.	Expand mental health and SUD screening in primary care and social service systems
2.4.	Add evidence-based services for first-episode psychosis
3.	**Ensure all Pierce County residents have timely access to appropriate behavioral health services**
3.1.	Promote, sustain, and expand the Mental Health Resources Navigation program in 2-1-1
3.2.	Establish a universal “front door” for behavioral health, physical health, and social services
3.3.	Ensure timely and accessible crisis response services
4.	**Increase outpatient and community-based service capacity**
4.1.	Employ strategies to attract and retain a well-qualified behavioral health workforce in community-based behavioral health
4.2.	Expand access to specialty behavioral health care for non-Medicaid populations through public-private partnerships
4.3.	Ensure behavioral health is “at the table” in all bi-directional Medicaid integration efforts
4.4.	Join in efforts to ensure behavioral and physical health parity
4.5.	Address housing needs alongside behavioral health needs
4.6.	Promote employment among behavioral health service users
4.7.	Support a robust peer workforce through training and professional development
4.8.	Expand the scope of peer services within and beyond Medicaid
4.9.	Foster the development of and partnerships with peer-run organizations
4.10.	Sustain and expand support for caregivers of people with behavioral health conditions
4.11.	Expand the use of remote health interventions

5.	**Target resources strategically to reduce inpatient utilization**
5.1.	Preserve and expand current evidence-based practices and initiatives that reduce hospitalization
5.2.	Establish a centrally located behavioral health diversion center
5.3.	Develop and expand peer-delivered crisis alternatives
5.4.	Continue to study the MCIRT, and expand the program if it is successful in meeting community need
6.	**Enhance service user engagement, activation, and self-management**
6.1.	Promote shared decision-making
6.2.	Track and promote patient activation
6.3.	Encourage establishment of Mental Health Advance Directives
7.	**Develop and implement a criminal justice system strategy building on existing resources and best practice**
7.1.	Promote behavioral health training among first responders and other criminal justice professionals
7.2.	Continue to expand the Mental Health Co-Responder Program using national best practice models for collaboration and coordination
7.3.	Ensure Pierce County has stable, long-term funding to provide a full array of diversion and treatment services at the intercept of behavioral health and criminal justice
7.4.	Support state efforts to expand behavioral health services for incarcerated individuals
8.	**Foster coalitions to meet the needs of veterans and service members**

2. Background

In the spring and summer of 2016, the Human Services Research Institute (HSRI) conducted a study of the behavioral health system in Pierce County for the Pierce County Council. The main research questions were as follows:

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?

The study team synthesized quantitative and qualitative data from multiple sources to produce a comprehensive picture of treatment and prevention needs, resources, utilization and gaps. The final report, delivered in September 2016, identified significant behavioral health–related needs in the County. And though HSRI identified many unique strengths and promising initiatives in Pierce County, there were also gaps between community need and available resources.

The report included a set of recommendations organized into two categories: 1) Service and Support and 2) Infrastructure. The former related to expanding access, adjusting the service array, and ensuring a recovery-oriented, culturally competent and trauma-informed system. The latter related 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.

Over one year since the HSRI report, the County has made significant improvements in its behavioral health system, and a sweeping initiative to integrate physical and behavioral health care through Medicaid is on the horizon. Yet some gaps remain unfilled, and some challenges have persisted. The Pierce County Council invited HSRI to return to engage with stakeholders and revisit the 2016 recommendations in light of these new developments.

Process

In November and December 2017, HSRI visited Pierce County to reengage stakeholders for further consultation. HSRI held additional telephone conversations in December and January 2018. Prior to meetings, stakeholders were provided with HSRI's full report from 2016, the *Pierce County Behavioral Health System Study*, and the list of recommendations, and were asked to reflect on the following five questions:

1. Please describe any progress that has been made toward the recommendations in the 2016 report. What factors have facilitated this progress?
2. For areas where there has been no progress (or very little progress), what have been the barriers?

3. Are there any recommendations from the 2016 report that you see as no longer relevant?
4. Are there any recommendations from the 2016 report that you think should be revised or adjusted?
5. Are there any recommendations that are missing from the 2016 report that you think should be added?

HSRI identified common themes from the stakeholder interviews, and these are included in the next section. Based on stakeholder conversations and our assessment of the current environment in Pierce County, HSRI offers a set of revised recommendations in the final section of this report.

3. Common Themes

The following broad themes emerged from discussions with stakeholders in the follow-up process:

1. Entities in Pierce County have made significant positive changes, but demand for behavioral health services far exceeds current supply.
2. Behavioral health workforce shortages and a lack of affordable housing for people with behavioral health issues continue to pose significant challenges.
3. Stakeholders are concerned about ensuring that the complex needs of people with significant behavioral health conditions are met as integration takes place.
4. Now more than ever, there's a need for a central coordinating body.

Theme 1. Entities in Pierce County have made significant positive changes, but demand for behavioral health services far exceeds current supply

In the past year, the Pierce County Council has made significant investments in behavioral health services, particularly in the areas of crisis response and services for individuals with the most complex needs. These include an expansion of mental health co-responder programs and the Mobile Outreach Crisis Teams (MOCT) and a newly established Mobile Community Intervention Response Team (MCIRT). The County Council has also made a one-time contribution to the new Behavioral Health Hospital.

While Pierce County's investments have focused on services for those with intensive needs, other entities in Pierce County have made advances in more upstream activities such as wellness promotion, prevention, and ensuring access to high-quality and evidence-based outpatient and community services and supports. These include initiatives led by the Tacoma-Pierce County Public Health Department (TPCHD) and numerous planned initiatives of the Accountable Communities of Health (PCACH). As a result of the Prevent-Avert-Respond (PAR) initiative, 2,300 community members received training in Mental Health First Aid in the past year, and a 2-1-1 Mental Health Resources Navigation Program has been established. Tacoma's Whole Child Initiative has been successful and is continuing to support social and emotional development within the Tacoma School District (although other school districts have yet to adopt similar initiatives at this scale). The resource center being developed using Trueblood funds will focus on connecting individuals who are transitioning to the community to housing, employment, and social service supports. The new adolescent treatment center in the County goes some of the way toward addressing the needs of individuals experiencing a first episode of psychosis, but community-based wraparound models (i.e., those used in the NIMH RAISE study) have not been implemented. There has also been an increase in medication-assisted treatment; Northwest Integrated Health was recently awarded a

SAMHSA State Targeted Response to the Opioid Crisis (STR) grant to enhance these services throughout the County through a collaborative composed of many local groups.

Although there are a range of effective community-based services and supports in the County, the demand for these services far exceeds the supply. As discussed under Theme 2, below, workforce shortages have made it difficult for community-based service providers to innovate and expand to meet this demand. Several stakeholders said that coordinated screening efforts haven't taken place because of a concern that there are no services to refer individuals with positive screens, including children and youth. Employment support—a key strategy to enhance independence and reduce reliance on publicly funded services—continues to be underutilized in Pierce County.

Theme 2. Behavioral health workforce shortages and a lack of affordable housing for people with behavioral health issues continue to pose significant challenges

All provider stakeholders asserted that workforce shortages make it very difficult to maintain consistent and high-quality services, including high-fidelity evidence-based services. Prescribers (psychiatrists and licensed nurse practitioners), master's level professionals, and substance use disorder treatment professionals are in particularly short supply. The shortages appear to be driven by wage inflation at the hospitals and other healthcare systems in the area; newly trained professionals may take positions at community provider organizations, but they eventually leave for higher-paying positions in hospitals once they obtain their licensure. This turnover results in position vacancies and means community providers must spend additional resources on staff training and development. Because providers are just barely scraping by, there is no room to innovate and focus on new and promising practices.

Several stakeholders echoed a common theme from the 2016 interviews: the overreliance on crisis services in Pierce County all comes back to housing. Stakeholders described a cycle in which individuals are discharged from the crisis service system back to homelessness, only to cycle through the crisis service system again. Unless housing needs are addressed for those in the County who are unstably housed, crisis response services—no matter how robust—will not result in long-term wellness for these individuals, and the system will continue to bear the high costs of these often-unnecessary services.

Stakeholders said there was a lack of brick-and-mortar housing units, while the supportive services to help individuals retain housing might be comparatively easier to address. One challenge is that there are multiple housing funders—local, state, and federal—and each has different financing mechanisms with different strings attached. There have been some efforts to centralize and coordinate housing coordination efforts in the past year; these have included the formation of a Chronic Homelessness Coalition; a shift to a coordinated entry model for homeless services; and a collaborative of housing developers, led by County Human Services, to build capacity for permanent supported housing units.

Theme 3. Stakeholders are concerned about ensuring the complex needs of people with significant behavioral health conditions are met as integration takes place

Stakeholders voiced concern about the significant physical and behavioral health system changes on the horizon in Pierce County. As a Medicaid Financial Integration mid-adopter, Pierce County is embarking on a major shift in the delivery of Medicaid-funded physical and behavioral health services.

The rationale for integrating the oversight of behavioral and physical health services is sound, and 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 face a variety of barriers to 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. With a bifurcated system (the behavioral health organization [BHO] managing behavioral services for populations with complex needs and MCOs managing physical health services), there is no single point of accountability for the health and wellness of the whole person. Behavioral health services are difficult to access through primary care, resulting in lost opportunities to proactively identify and address behavioral health issues. For persons with serious behavioral health conditions, inadequate coordination of behavioral and physical health care likely contributes to a dramatically lower life expectancy (25 years lower on average, nationwide, compared to the general population).

Bi-directional integration (integrating physical health into specialty behavioral health settings in addition to integrating behavioral health services into physical health settings) has the potential to increase access to behavioral health services for those with mild and moderate issues who receive their care only in physical health settings; it also could increase access to physical health services for those with serious behavioral health conditions, who often have co-occurring

Stakeholder concerns around the integration of behavioral and physical health services

- Preserving innovative BHO-developed services
- Ensuring physical health providers and payers adhere to recovery principles and offer a full service continuum that addresses the social determinants of health
- Financial sustainability of community-based behavioral health services in the long and short term
- Addressing the needs of non-Medicaid Pierce County residents

chronic medical conditions. As with any large systems change effort, the success of integration in Pierce County will depend on its implementation. Stakeholders reported that it is currently unclear what bi-directional integration will look like. Ensuring that people with significant behavioral health–related needs don't "fall through the cracks" will take careful planning, coordination, and leadership in the coming year.

Stakeholder concerns related to integration were as follows:

Preserving Innovative BHO-Developed Services. Over the years, the BHO has developed a robust array of services to support people with serious mental health conditions—and, more recently, people with substance use disorders. For example, the BHO has been nationally recognized for expanding and promoting peer services at all levels of care. Many of these strategies have been highly effective in promoting recovery and reducing avoidable inpatient and emergency service utilization. Ensuring that these peer services are preserved in the shift to integration will require efforts to educate funders and other stakeholders about the value of peer services and fidelity standards for peer support. The BHO has also supported community education and prevention efforts in the PAR initiative. In this round of stakeholder interviews, and in the interviews completed for the original report, there was consensus that the BHO has been an effective convener and coordinator of specialty behavioral health services in the County; as the BHO role is reduced, there will be a need for another entity to step in and perform those coordinating functions. Many of the more innovative BHO offerings are financed through complex, braided funding streams, and disentangling and then reconfiguring those financing mechanisms in the shift to integration may be a challenge; however, failing to do so could disrupt the continuity of care for people who rely on these services.

Ensuring Physical Health Providers and Payers Adhere to Recovery Principles. Specialty behavioral health stakeholders were hopeful but also uncertain that the PCACH would be able to ensure that providers and payers adhered to the principles of recovery after integration. Stakeholders were concerned about the ability and willingness of physical health providers to work with the specialty behavioral health population—in terms of clinical competency and in terms of stigma and a reticence to take on individuals with complex co-occurring needs. Stakeholders expressed hope—and many expressed doubt—that MCOs would be equipped and incentivized to sustain a full outpatient and community-based service continuum for people with significant behavioral health conditions, including: outpatient mental health and substance use disorder treatment for children and adults, peer-delivered services (in community settings, and also peers in emergency rooms and Peer Bridgers), Medication-Assisted Treatment, wraparound services for children/families and adults, therapeutic courts services, jail treatment and transition services, the Mobile Integrated Clinic, supportive housing, and outreach and care coordination support.

Short- and Long-Term Sustainability of Community-Based Behavioral Health Services. Stakeholders expressed concern that as funds for behavioral and physical health services are blended, healthcare market dynamics would result in reduced reimbursement rates for specialty behavioral health services over the long term, further destabilizing community-based providers. Provider stakeholders were concerned about the administrative burden associated with having to work with four different MCOs—each with different billing processes and speeds for claims

payment, as well as different forms, processes, and utilization management practices. Stakeholders representing larger providers seemed reasonably confident they would be able to weather the transition to new rate structures and billing practices, but stakeholders were unsure whether smaller providers could survive the transition, including small providers of culturally specific and bilingual or multilingual services and organizations in rural areas. If these organizations were to close, this could further exacerbate disparities for racial and ethnic minorities and people in rural parts of the County.

Addressing the Needs of Non-Medicaid Pierce County Residents. Several stakeholders also pointed out that integration is taking place only within Medicaid. Medicaid represents a large share of the healthcare system in the County, and many individuals with complex behavioral health–related needs are Medicaid-funded. However, individuals on Medicare, individuals who are privately insured, and individuals who are uninsured will continue to need behavioral health services outside the Medicaid-funded system. While the ASO may cover crisis services, there is no single entity overseeing the adequacy of the system for these individuals. While the PCACH includes several initiatives that extend beyond Medicaid, stakeholders were unclear whether those programs would be sufficient to meet the needs of the community as a whole.

Successful implementation of Medicaid Financial Integration will hinge on the extent to which MCOs are held accountable for health outcomes of Medicaid populations. In theory, if MCOs are truly accountable for population health, they will be incentivized to invest in robust behavioral health services and supports for social determinants of health (housing, employment, social connections, etc.) to promote wellness, prevent reliance on costly crisis and inpatient services, and divert individuals with behavioral health needs from the criminal justice system. Knowing whether MCOs are effective in this regard hinges on having solid outcome measures that capture the health and well-being of the population—and on data systems that support the collection, analysis, and reporting of key social and functional outcomes.

Integration in Pierce County is undergirded in the principles of population health, which aim to improve the health and well-being of an entire population. Population health and specialty behavioral health are not incompatible, but they're also not interchangeable. Specialty behavioral health hasn't historically done a good job addressing upstream causes of behavioral health problems, and HSRI's original report highlighted that a stronger population health focus is needed in Pierce County. On the other hand, specialty behavioral health has made great strides in advancing the recovery concept and promoting self-determination and self-sufficiency for people with serious mental health conditions who 50 years ago would have been left to languish in institutions. It is vital that practices that promote recovery and self-determination not get "thrown out with the bathwater" as integration takes place. This will mean ensuring that specialty behavioral health stakeholders—providers, advocates, and, critically, people with lived experience of receiving behavioral health services—have a seat at the table in all integration initiatives.

Theme 4. Now more than ever, there's a need for a central coordinating body

Almost universally, stakeholders said the need for coordination is stronger than ever, particularly as the County is taking a larger role in behavioral health and as integration moves forward.

Stakeholders identified numerous recently developed workgroups and steering committees, each designed to address a specific facet of the system, group, or issue. Some of these groups are "grassroots" (e.g., two groups that focus on the needs of high utilizers), while others are part of large and sweeping integration efforts (e.g., the PCACH board and related committees and workgroups). Stakeholders expressed concern about duplication of efforts and "committee fatigue." That said, most stakeholders felt that most existing workgroups were needed and effective. These workgroups have been useful in creating pathways for coordination and communication, such as creating data-sharing agreements and protocols across previously disconnected systems. Stakeholders felt that the coordination taking place marks a positive step for the County.

In addition, several entities within the County have either recently hired or are in the process of hiring a staff person who specializes in behavioral health policy and issues. This includes two Behavioral Health Program Managers at the Human Services Department, a Senior Legislative Analyst focusing on behavioral health and human services issues at the County Council, and a behavioral health policy lead at the Tacoma Pierce County Public Health Department.

Given the broad scope of behavioral health needs in the County and the complexity of the County systems, all stakeholders endorsed the need for a central coordinating body that has the following functions:

- Takes a population health perspective, responsible for the social and emotional well-being of all 844,000 Pierce County residents, regardless of payer type and diagnosis
- Aims to increase direct communication between County stakeholders and promote streamlining and simplification throughout the system
- Engages in strong communication and coordination with the State legislature and Health Care Authority
- Has a process for engaging with stakeholders – including people with lived experience of the behavioral health system – and incorporating their feedback in meaningful ways
- Aligns with relevant local and state initiatives whenever possible
- Has resources and capacity to identify and respond to funding opportunities—or to coordinate responses with other County entities
- Has "skin in the game" and leverage to effect policy change, but keeps unfunded mandates to a minimum

4. Recommendations

The following recommendations, which use the recommendations from our 2016 report as a starting point, have been revised based on our follow-up and findings from 2017. The first recommendation, our **Primary Recommendation,** is related to establishing the necessary leadership infrastructure to adopt, execute, and monitor progress toward the **Behavioral Health System Recommendations** that follow. These recommendations involve ways in which the behavioral health system might be strengthened through expanded access and service array adjustments and are intended to serve as a starting point for an implementation planning process (described in Recommendation 1.3).

Primary Recommendation: Establish a central coordinating body

We recommend that a central coordinating body be established 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. HSRI recognizes that the final composition and function of the coordinating body remains a decision that should be made locally. HSRI also recognizes that the composition and function of the coordinating body will likely need to be revisited and adjusted over time. That said, we offer the following recommendations to begin the process.

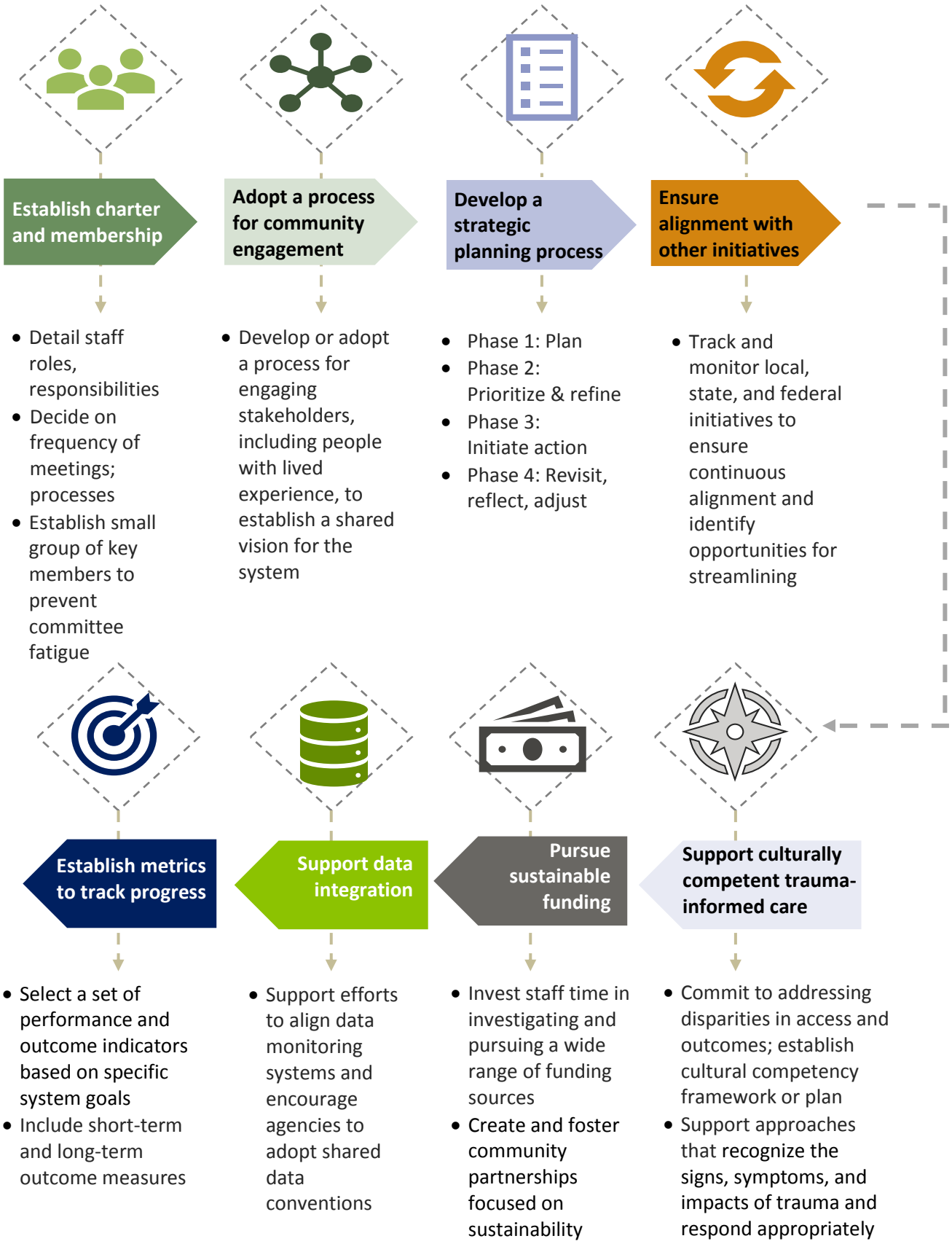
The central coordinating body should include a combination of individuals with sufficient authority to obtain support for initiatives and knowledge of systems, services, and policies. The most promising starting point for the central coordinating body is the Pierce County Integration and Oversight Board (the Board), which has been newly formed to—jointly with the HCA and in collaboration with the PCACH—create, administer, and manage the County's fully integrated managed care system. The group is composed of representatives from the County Council, the PCACH, the Office of the County Executive (including Criminal Justice and Human Services), and representatives from health providers, social service providers, and other community stakeholders.

We recommend this group as a starting point for several reasons. The Board rests at the intersection of the County, the PCACH, and the State Health Care Authority, the three key entities carrying out Medicaid Financial Integration. Through its oversight of the MCO RFP and development process, the Board is designed to ensure a smooth transition and—with the HCA—hold MCOs accountable for the well-being of the Medicaid-funded population. Beyond integration, the Board will be positioned to oversee ongoing alignment of the Medicaid-funded system with the broader County healthcare system. The two funded Behavioral Health Program Manager positions within County Human Services are well-positioned to carry out key group functions, including identifying and responding to funding opportunities. The PCACH—which was formed after the original HSRI report was released—is undertaking considerable work that aligns closely with the HSRI recommendations (though the PCACH's scope includes physical healthcare systems as well as

behavioral health). The PCACH's Community Resiliency Fund will support community-led initiatives that promote resilience and the social determinants of health and is likely to be a key resource for implementing many of the HSRI recommendations. The PCACH is also organizing a comprehensive community engagement process designed to gather feedback and input from a broad range of system stakeholders, including people with lived experience of physical and behavioral health systems, as well as provider, payers, and others.

There are two caveats to using the Board as a starting point for the central coordinating body: The first is that the Board is primarily Medicaid-focused, and the central coordinating body should oversee the County behavioral health system for *all* Pierce County residents regardless of payer type. The second issue is that the Board is focused on the behavioral health treatment system, but as the original HSRI study made clear, wellness promotion and prevention are critical components of a good and modern behavioral health system. The TPCHD is a key player in the behavioral health system in this regard and has staff and resources dedicated to the promotion of social and emotional wellness and primary and secondary prevention efforts (in addition to providing key substance use treatment services in the County). As such, HSRI recommends that TPCHD play a key role in the central coordinating body.

The graphic on the following page outlines a general roadmap for establishing and organizing the efforts of this central coordinating body; each of these steps is detailed on subsequent pages.


Establish charter and membership
Detail staff roles, responsibilities
Decide on frequency of meetings; processes
Establish small group of key members to prevent committee fatigue
Adopt a process for community engagement
Develop or adopt a process for engaging stakeholders, including people with lived experience, to establish a shared vision for the system
Develop a strategic planning process
Phase 1: Plan
Phase 2: Prioritize & refine
Phase 3: Initiate action
Phase 4: Revisit, reflect, adjust
Ensure alignment with other initiatives
Track and monitor local, state, and federal initiatives to ensure continuous alignment and identify opportunities for streamlining
Support culturally competent trauma-informed care
Commit to addressing disparities in access and outcomes; establish cultural competency framework or plan
Support approaches that recognize the signs, symptoms, and impacts of trauma and respond appropriately
Pursue sustainable funding
Invest staff time in investigating and pursuing a wide range of funding sources
Create and foster community partnerships focused on sustainability
Support data integration
Support efforts to align data monitoring systems and encourage agencies to adopt shared data conventions
Establish metrics to track progress
Select a set of performance and outcome indicators based on specific system goals
Include short-term and long-term outcome measures

1.1: Establish a charter and membership

As a first step, the central coordinating body will need to develop a charter that details staff roles and responsibilities (i.e., who convenes and hosts the group and develops group materials), frequency of meetings, the process for amending group processes, etc.

Stakeholders felt strongly that it would not be helpful for a new central coordinating body to add further to the "committee fatigue" in Pierce County. HSRI recommends that the core central coordinating body be as small as possible and incorporate community engagement practices to ensure inclusivity—rather than inviting individuals from all stakeholder groups to be standing members. This process is outlined in Recommendation 1.2.

1.2: Ensure a process of community engagement that includes full and active inclusion of service users and their families

Key behavioral health stakeholders include persons with lived experience, their family members, disability rights and behavioral health advocates, and representatives from public and private providers and health systems (behavioral and physical health), public and private payers, criminal justice, child welfare, and education. One of the first and most critical decisions for the central coordinating body will be to detail a process for engaging these stakeholders in an ongoing, inclusive way to promote a shared vision for a healthy system.

HSRI strongly recommends that the central coordinating body adopt the "nothing about us without us" principle of the disability rights movement. Because the 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 and caregivers are fully involved in all aspects of the process. It is also critical that members of the central coordinating body continuously seek out opportunities to ensure that the voices of people with lived experience are reflected in the work.

Rather than creating new engagement avenues for these groups, we recommend that the central coordinating body work with the PCACH to build on the considerable stakeholder engagement infrastructures already in place. This infrastructure—which is detailed in the PCACH Project Plan —will meet the needs of the central coordinating body without asking community stakeholders to attend additional meetings and workgroups. HSRI recommends that the PCACH continue to engage the recovery community to ensure that those with lived experience of mental health and substance use challenges and systems be well-represented on the Community Voice Council, and on other committees and workgroups as well. 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.

1.3: Adopt a process for prioritization, implementation, and continuous monitoring, review, and refinement of behavioral health system changes

The **Behavioral Health System Recommendations** included in this report—which were originally delivered in the 2016 report and have been updated and revised based on current information—are intended to serve as a starting point for the work of the central coordinating body. Once formed, the central coordinating body will need to adopt a process for transforming these recommendations into 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. It should also include strategies for identifying and addressing potential concerns as they emerge to prevent disruption in progress.

We anticipate that this work will have four phases:

Phase 1: Planning

We recommend that the basis for the work will be recommendations offered in this report, but the central coordinating body can and should carefully consider these recommendations and add and adjust as necessary to ensure they are a good fit for Pierce County.

Phase 2: Prioritization and refinement

HSRI's recommendations vary in degree of priority and ease of implementation. The prioritization and refinement phase will involve establishing a priority order for acting upon recommendations, and then refining specific goals and objectives for each recommendation.

Many of the recommendations included here may be focus areas for existing entities within the County such as the PCACH or the TPCHD (these are noted throughout). They may also be areas that require State action and are beyond the scope of the County (also noted throughout our recommendations). In these cases, the planning process may involve aligning these recommendations with that entity's strategic plan, or supporting change efforts at the State level. Other recommendations will involve the central coordinating body taking a primary role.

For defining specific, measurable goals and objectives for each recommendation, we recommend the SMART framework, which has been used successfully in previous HSRI needs assessment and planning projects. SMART offers a system for rating goals based on the extent to which they are Specific, Measurable, Attainable, Realistic, and Time-Bound.

The following basic table shows an example of how this information might be organized.

Recommendation/ Area of Focus	SMART Goal	Performance Target	Tactical Objectives	Responsibility
Promote behavioral health training among first responders and other criminal justice professionals (7.1)	By June 1, 2019, 100% of corrections deputies and representatives from each Justice Services department will have completed the GAINS Center Trauma-Informed Response Training, delivered by local trainers.	• 5 local justice services representatives will be trained in the GAINS Center Trauma-Informed Response Train-the-Trainer training by April 2018 • All (100%) corrections deputies will receive the training by June 1, 2019. • Representatives from Assigned Council, District Court, Juvenile Court, and Superior Court will receive the training by June 1, 2019	• Obtain travel funding to send five representatives to the national GAINS Center Train-the-Trainer event • Host four local training sessions for Corrections Deputies and other criminal justice professionals • Establish a schedule for ongoing and refresher trainings	• Justice Services (lead) • BH Program Managers • Central Coordinating Body

Phase 3. Initiation

This phase will consist of initiating action on recommendations in order of priority, identifying and reaching out to system stakeholders, determining responsibilities, and specifying individual tasks.

Phase 4: Continuous learning, monitoring, and sustaining

An effective ongoing monitoring strategy requires that the central coordinating body have access to information on community need, capacity, and access. Periodic, data-driven assessments of need and access will be critical to inform Phase 4. The data-related recommendations contained in this report will be one step toward ensuring this information is available.

Treating the recommendations, goals and objectives as a static plan will fail to account for inevitable shifts in local, state, and federal contexts. Rather than relying on fixed goals and

objectives, the central coordinating body should use continuous learning principles, which involve regularly revisiting and reflecting upon the group's direction and adjusting as needed. These adjustments could be minor or major, and could involve reprioritizing, adding, or eliminating goals or objectives. Regular meetings of the central coordinating body should include a standing agenda item to reflect on progress and make needed adjustments. Once goals are completed, activities may continue with monitoring ongoing functions to ensure sustainability.

1.4: Ensure alignment of all activities with relevant local, state, and federal initiatives

One of the key functions of the central coordinating body is to enhance efficiency by streamlining and simplifying processes within the County. This requires investments of staff time to track and monitor relevant local, state, and federal initiatives and ensure that the activities of the central coordinating body are in continuous alignment with these initiatives. The process will equip the County to capitalize and build on existing initiatives and—critically—to ensure behavioral health is "at the table" for relevant systems change efforts.

The PCACH will play a key role in ensuring that the work of the central coordinating body aligns with Medicaid Financial Integration. Specific areas of alignment between these recommendations and the PCACH strategic initiatives and the state's Adult Behavioral Health System Task Force (ABHS) recommendations are noted throughout the Behavioral Health System Recommendations that follow, but given the constantly evolving environment, these areas will need updating on an ongoing basis.

1.5: Align with state and local efforts to 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. These strategies may be initiated by the County, or they may involve aligning County work with other local, state, or federal initiatives.

Nationally, disparities in behavioral health care for racial and ethnic minorities have been described in many landmark documents [1, 2]. 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. (Notably, 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.[1]) 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 [3]. These researchers defined cultural competency 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 who 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 website[2] 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[3] 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."

The National Center for Trauma-Informed Care offers a variety of resources, including training and technical assistance, to assist behavioral health systems in ensuring a trauma-informed approach. The National Child Traumatic Stress Initiative, another SAMHSA program, includes additional resources specific to services for children, adolescents, and families who have experienced

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

[2] https://www.thinkculturalhealth.hhs.gov/

[3] http://www.samhsa.gov/nctic/trauma-interventions

traumatic events.[4] HSRI recommends that leadership in Pierce County follow the actions outlined in *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*[5] to ensure a system-wide orientation to trauma-informed care.

1.6: Identify and pursue sustainable funding sources

This is a period of tremendous change for health and behavioral health systems, for Washington state, and for the country. In Pierce County and nationwide, behavioral health is underfunded. There is no single funding source that will change that reality, but there are many untapped possibilities in the form of competitive grants, federal and state initiatives, and partnerships with public and private entities. Having a designated staff person 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.

Behavioral health initiatives in Pierce County 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 in our recommendations, these are by no means a comprehensive account of all possible funding streams. Identifying and pursuing funding sources requires an ongoing investment of staff time to search for existing opportunities, build partnerships to create new opportunities, develop high-quality proposals to secure funding, and create plans for sustainability of new and time-limited funding streams.

By monitoring possible funding sources and identifying and responding to opportunities, the County may capitalize on diverse funding streams and ensure a more sustainable system.

1.7: Support and enhance current efforts to integrate provider data systems

In today's healthcare environment, comprehensive, integrated data systems are considered essential to effective planning, service coordination, and delivery. There has been considerable progress in the past year to integrate provider data systems with one another and with relevant entities such as housing, criminal justice, and first responders. However, data systems are not yet fully integrated. Stakeholders noted that while there has been a lot of talk for many years about integrating data systems and developing metrics to track performance across the system, there has been limited movement thus far. However, the PCACH has strategies that will hopefully create meaningful change, particularly for Medicaid-funded systems. The Trueblood initiatives represent an opportunity to develop and test data-sharing processes as they relate to services for justice-involved individuals. The work of the high utilizers groups and the Criminal Justice Diversion Steering Committee has also created pathways for data integration and cross-sector collaboration that may be of benefit to future efforts to improve data systems throughout the County.

[4] https://www.samhsa.gov/child-trauma

[5] http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

Provider stakeholders expressed caution that imposing data requirements can be extremely burdensome, and that even small requests can result in a huge expense for the provider in terms of reprogramming. Stakeholders also noted that in the future, it is important to include housing entities in data integration efforts (for example, groups that focus on high utilizers or justice-involved individuals).

Many state behavioral 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 [4]; notably though, progress varies widely. We recommend that Pierce County leadership work in concert with the PCACH and 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 healthcare environment (corresponds with ABHS recommendation 2)[6]. This effort should include working with state agencies and within the County to align data monitoring systems and encourage agencies to adopt shared data conventions that will prepare the County for Integration 2020, 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, the PCACH, 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 quality improvement efforts
- 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)

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

1.8: Develop system metrics to track progress on key goals

Data system efforts should also include selecting a set of performance and outcome indicators based on specific system goals. The performance monitoring strategies of the PCACH serve as a model and a starting point for County-wide activities. Service users, families, providers, advocates, and other key stakeholders should be involved in the process of identifying and selecting performance and outcome indicators for the system. It is important that both process and short-term and long-term outcome measures are included. Some examples of metrics that other communities have used as part of routine reporting and dashboard systems are included in the sidebar on the right. Additionally, many communities include provider collaboration measures around referrals and data sharing.

Behavioral Health System Recommendations

Drawing from Pierce County's unique strengths and assets as well as the needs identified through this study and subsequent addendum, these recommendations are intended to serve as a roadmap for improvement efforts. We do not expect, nor do we suggest, that Pierce County will endeavor to implement these recommendations at once. We also understand that some of these recommendations overlap with the strategic initiatives of the PCACH, the TPCHD, and others. Our purpose is to present a starting point for the strategic process of the central coordinating body (described in Recommendation 1.3), based on our identification of community needs in the original HSRI study and in our follow-up.

These recommendations reflect the principles identified in a widely disseminated 2011 brief produced by SAMHSA entitled *Description of a Modern Addictions and Mental Health Service System* [5].

Example Metrics

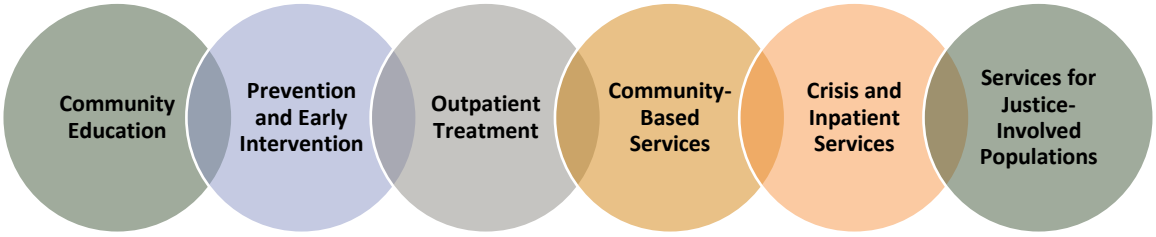
- # of inpatient bed days utilized by payer source and demographics
- # of behavioral health emergency room encounters
- # of new persons entering the system (completely new or those who have not received a service for a specified amount of time)
- # entering the system via police or other criminal justice entry point
- # receiving a follow-up service after discharge from an emergency department
- # receiving a follow-up service after discharge from an inpatient hospital
- # receiving employment support services
- # receiving housing support services
- # of service users in competitive employment
- # of service users who attain and maintain stable, integrated housing
- # receiving housing vouchers
- # of peer specialists employed
- Substance use disorder treatment, retention and engagement
- Utilization of and fidelity to evidence-based practices
- Rates of screening and other preventive activities
- Rates of engagement in coordinated specialty care for individuals experiencing a first episode of psychosis
- Service user activation (such as the Patient Activation Measure-Mental Health) and health and mental health-related functioning
- Social and functional outcomes, including competitive employment, independent housing, social connectedness, civic engagement, and quality of life

The SAMHSA 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."

HSRI views a good and modern behavioral health system as one that implements strategies across a continuum of services beginning with community education and wellness promotion, as shown in the figure below. The array includes prevention and early intervention strategies and community-based services that address the social determinants of health (e.g., housing, employment, social inclusion) in addition to a range of clinical services delivered in the least restrictive environment.

A Good and Modern Behavioral Health System Service Array



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.

Where applicable, we have included references to recommendations laid out in the 2015 Final Report of the Washington State Adult Behavioral Health System Task Force.[7] Aligning County and State priorities will likely be critical to ensure the success of any system reform efforts, capitalizing on existing efforts and avoiding redundancies in initiatives. Likewise, we have noted areas of alignment with the PCACH strategic initiatives.

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

Recommendation 2: Invest in prevention

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 whole community, not just individuals with behavioral health challenges.

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. One such opportunity is the Prevent-Avert-Respond (PAR) Mental Health Initiative, which is midway through its implementation. The TPCHD has developed a series of objectives related to promoting positive behavioral health and well-being in the County, and these TPCHD behavioral health initiatives are key elements of prevention services in Pierce County.

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 Recommendation 1.6).

2.1: Sustain broad-based, multifaceted community education efforts that promote better understanding and reduce stigma, discrimination, and marginalization

Numerous state and local community education and outreach initiatives are currently underway, from Mental Health First Aid trainings to suicide prevention to National Alliance on Mental Illness (NAMI) educational programs.

- In its first 1.5 years, the PAR initiative has supported over 90 trainings reaching approximately 2,300 individuals, with specialized engagement with members of faith communities and individuals who work with youth and older adults. The PAR initiative serves 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 PAR initiative, and conduct a continuous review of the program to ensure activities are relevant, impactful, and culturally responsive.
- PAR has also supported suicide prevention trainings throughout the County, including: a one-day suicide prevention training for 25 Pacific Lutheran University nurses, three 16-hour Applied Suicide Intervention Skills Training (ASIST) trainings, and three half-day SafeTALK trainings with the Washington chapter of the American Foundation for Suicide Prevention.
- NAMI offers a number of educational programs that are free to attend and taught by NAMI-trained volunteers. In Pierce County, a 12-week Family-to-Family class is regularly offered

but has a backlog of potential class participants because of limited trained volunteer teachers. As with the PAR initiative, additional support may be needed to expand these offerings beyond current capacity and increase numbers of volunteers to support that expansion.

All the above initiatives rely on volunteer trainers, and the PAR initiatives are supported by time-limited grant funding. Though they are not costly interventions, they do require an ongoing investment of time for organization and building a pool of volunteers, and most have modest costs for materials and meeting space.

While important, these curricula represent only one facet of community education about behavioral health, and they reach only a fraction of the Pierce County community. In addition to an expansion of current offerings, the community would also benefit from campaigns that promote greater community acceptance and integration of people with behavioral health conditions. For example, efforts focusing on outreach and education to potential employers regarding the provision of reasonable accommodations for people with psychiatric disabilities may help to reduce barriers to employment for this population.

2.2: 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 our original report, 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.[8]

The PAR initiative includes an evidence-based Mental Health and High School Curriculum designed to increase mental health literacy and decrease stigma in students and teachers. Since the beginning of the PAR initiative, 237 educators around the state have received the training, including teachers

[8] 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

from nine Pierce County school districts. Currently, advocates at the state level are working to mandate this or similar curricula in high schools. The central coordinating body could incorporate strategies to support these state-level changes and to bolster these activities to encompass substance use prevention alongside mental health prevention and sustain them in an ongoing way.

2.3: 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. Each of these initiatives has 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, there could be low-cost opportunities to expand and coordinate the following initiatives:

- 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 perform outreach to these communities in other social service settings where behavioral health screenings are taking place.
- The PAR-supported Franciscan WIC Depression and Anxiety Screening program not only screens WIC clients in Pierce County but also provides them with a Perinatal Mental Health Resource and Referral Guide. Individuals who are screened as being at possible risk for anxiety and depression are referred to counseling, and those at high risk are connected to the Crisis Line. This program appears to have been successfully implemented in CHI Franciscan Health WIC clinics and could be adopted by other WIC programs in the County with a modest investment of time and resources.
- CHI Franciscan's 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.

In addition to the above initiatives, the PCACH plans to require and support the use of mental health and SUD screenings through its bi-directional integration efforts. Coordinating and streamlining these screening initiatives will result in a more proactive and responsive behavioral health system county-wide.

2.4: 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.[9] The interventions tested in the RAISE project, Coordinated Specialty Care programs, involve multidisciplinary team-based treatment that includes

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

psychosocial supports and family education. Coordinated Specialty Care has been found to reduce symptoms and improve quality of life for people experiencing early psychosis [6]. Such interventions alter the course of illness through outreach and engagement with individuals before years-long duration of untreated psychosis occurs [7] 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.

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 [8]. 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.

We highly recommend that the County work with the State to advocate for mental health block grant funding for evidence-based first-episode psychosis services in the coming years. We also recommend the County work with the PCACH and MCOs to build first-episode psychosis capacity outside of the block grant for Medicaid-funded individuals and families. 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.

Recommendation 3: Ensure all Pierce County residents have timely access to appropriate behavioral health services

The HSRI report—and numerous reports and documents that preceded it—highlighted challenges related to accessing needed and wanted behavioral health services at the right time within Pierce County. Ensuring access to appropriate behavioral health services is no small feat and will take concerted and coordinated effort in the years to come.

3.1: Promote, sustain, and expand the Mental Health Resources Navigation program in 2-1-1

A key theme that emerged from the original HSRI study was a need for a central access point for information about behavioral health resources. Since the first HSRI report, the PAR initiative has created a Mental Health Resources Navigation Program within United Way's 2-1-1 that includes a Mental Health Resources Specialist to assist callers with identifying and connecting with mental

health resources for themselves and others, regardless of payer type and severity of need. This program is newly established, with a fully trained Mental Health Resources Specialist and an updated, comprehensive mental health services database. Stakeholders noted that at present, there is limited community knowledge about this new and important resource. PAR is currently working to educate the community about the availability of this resource, such as working with Pierce County Emergency Medical Services personnel to promote awareness. However, PAR has limited funding for this work, and its efforts could be augmented by other groups in the County to promote better public awareness.

As with all PAR activities, this program is time-limited, and it does not encompass substance use disorder treatment and prevention services. Once the PAR initiative ends, the central coordinating body should seek sustainable funding for this position, including expanding the position to facilitate access to substance use disorder treatment and prevention services in addition to mental health services. 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.

3.2: Establish a universal "front door" for behavioral health, physical health, and social services

While 2-1-1 is now equipped to serve as a universal access point for information, it is not equipped to serve as a universal front door that *ensures connection* to wanted and needed services for all Pierce County residents. Ensuring connection would require a continuum of referral, follow-up, and coordination to not only inform people about services available but also to ensure that they are connected to the right services at the right time.

The PCACH Pathways Community Hub is an evidence-based model that facilitates care coordination across physical health, behavioral health, and social services in clinical and community-based settings. There are opportunities for the PCACH to partner with 2-1-1 to align the Pathways Community Hub with the Mental Health Resources Navigation Program. Collaboration and coordination between community partners should be directed at creating a cohesive information and referral system that engages with and refers all community members—and particularly those with complex needs—to health and social services.

3.3: Ensure timely and accessible crisis response services

In the 2016 and 2017 interviews, numerous 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 evaluation and treatment centers and inpatient. The transition from working within the BHO framework to the new ASO model presents an opportunity for the County to revisit the crisis response system and explore alternative mechanisms. However, stakeholders were concerned that the new ASO model could result in fewer sustainable resources for crisis response through the loss of Medicaid funding. Therefore, the transition from BHO to ASO will also require careful planning and creative solutions to sustain crisis response services at current levels.

Recommendation 4: Increase outpatient and community-based service capacity

In the original HSRI study and in follow-up interviews, stakeholders noted that there is a high need for intensive services for individuals experiencing crisis in Pierce County. Our study found that while there may be need for additional crisis and 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

4.1: Employ strategies to attract and retain a well-qualified behavioral health workforce in community-based behavioral health

A majority of community-based behavioral health providers interviewed for this study identified workforce shortages as the most significant barrier to delivering effective services in the community. Community-based organizations compete with Western State Hospital, the Veterans Health System including Madigan Army Medical Center, and local health systems for behavioral health care providers. Given current funding levels, community-based organizations are unable to retain clinicians, who often leave positions for higher-funded jobs at hospitals and health systems. This scenario, which threatens the viability of critical community-based services, is likely to be exacerbated with the opening of the new Multicare/Franciscan hospital in the coming year. We observed a need for a coordinated effort to foster partnerships and create a multipronged strategy to increase the pool of qualified providers and promote retention within community-based provider organizations. Stakeholders noted that there may be opportunities to work with local colleges and universities—and perhaps public high schools—to increase the supply of professionals working in Pierce County. Stakeholders also expected loan forgiveness programs would be an effective way to promote retention in community-based positions.

The PCACH has developed a series of workforce strategies, including a plan to convene regional subject matter experts in 2018 to examine workforce gaps and identify opportunities for PCACH investment. The PCACH is also a member of the One-Stop System Advisory Group, recently convened by the Pierce County Workforce Development Council.[10] Through this engagement, the central coordinating body should explore and capitalize on other county efforts to address workforce deficiencies and develop a pool of qualified community-based behavioral health providers.

The central coordinating body could also work with the State Legislature to support loan forgiveness programs and other initiatives that promote retention in community-based positions (for more information about recommended state activities to promote behavioral health workforce development, see ABHS Task Force recommendations 1 and 3).[11]

In general, efforts that make Pierce a more attractive place to live and work are likely to increase the workforce pool for community-based behavioral health services.

[10] http://workforce-central.org/about/our-leadership/#workforce-development-council

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

4.2: Expand access to specialty behavioral health care for non-Medicaid populations through public-private partnerships

In addition to the workforce shortages experienced by community-based organizations, stakeholders interviewed for HSRI's original study identified workforce issues as influencing access for Pierce County residents without Medicaid. These staffing shortages were described as a core challenge in expanding the availability of outpatient behavioral health services for those with Medicare and private insurance. We observed a need for an 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.

While the PCACH efforts are focused primarily on the Medicaid-funded system, the workforce development strategies described in Recommendation 4.1 are likely to drive positive change across the County and State health systems. Through collaboration and coordination and the development of private and public partnerships, the central coordinating body can ensure that these developments result in increased access across the County, not just for individuals on Medicaid. A central coordinating body could also advocate to the state legislature to employ strategies that 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 (ABHS Task Force recommendation 3).[12]

4.3: Ensure behavioral health is "at the table" in all bi-directional Medicaid integration efforts

Significant efforts to integrate behavioral and physical health care systems are already underway in Washington state. The PCACH is taking the lead on sweeping and comprehensive bi-directional integration efforts in Pierce County. These efforts are driven by best practice in physical and behavioral health integration and hold the promise to increase access, improve the quality of services, enhance the service user experience, and result in better outcomes across the healthcare sector. 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 and—critically—in ensuring that people with significant behavioral health conditions do not "fall through the cracks" as integration continues.

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

Stakeholders we interviewed emphasized the following: ensuring the complex needs of people with significant behavioral health conditions are met in this period of monumental change will take careful planning, concerted action, and strong partnerships between physical and behavioral health stakeholders. One critical step in this process is working with the HCA in the process of selecting, contracting, and overseeing the work of the MCOs. This includes:

- **Ensuring strong provisions to maintain existing programs at the same level or higher for people with complex behavioral health–related needs in Pierce County.** Because many current programs are financed through braided funding streams, this effort will be challenging. It will be further complicated by the fact that the ASO will be taking responsibility for some portion of services that were previously funded with Medicaid dollars. Removing Medicaid funding from these services could result in insolvency, and the MCOs will need to work with the HCA and the County to employ strategies that prevent this scenario.
- **Working with the MCOs to identify and fill knowledge gaps related to people with significant behavioral health conditions.** In particular, MCOs may need support in recognizing and responding to the social determinants of behavioral health, including social inclusion, housing stability, and economic security. Numerous evidence-based and promising practices address social determinants in specialty behavioral health settings, and these services are not typically offered through physical health care systems. These include peer support, in-home and community-based outreach and engagement, wraparound approaches, and supportive housing and employment. Best practice models for these services exist throughout the country, and some are already in place in Pierce County. The central coordinating body and the HCA should ensure that the MCOs receive education and technical assistance related to these models, including information about financing, sustainability, best practice, and fidelity.

4.4: 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, many 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. HSRI recommends that the County put this topic on its lobbying agendas in Olympia and Washington, DC.

4.5: 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 in Pierce County 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.

There are numerous housing resources available to some Pierce County residents with behavioral health needs, including the SAMHSA-funded PATH program and Permanent Supportive Housing. The peer-delivered Community Builders program is also aimed at supporting individuals to maintain housing. We highly recommend the central coordinating body work to preserve and 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 Housing 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. Some examples of how other states fund housing supports through Medicaid include:

- In Illinois, Louisiana, and Washington, D.C., 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 will involve partnerships with the Washington State Housing Finance Commission and local housing authorities and developers to put new units into the development pipeline and explore other avenues to expand housing options to individuals with behavioral health needs. County Human Services is bringing together a collaborative that will focus on building capital for Permanent Supportive Housing. However, HSRI recommends that the central coordinating body develop a broader county-wide strategy for identifying and pursuing resources to address capital shortages, and a strategy for working with the state legislature to address these issues at the state level.

4.6: 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 assistance. Washington's Medicaid Transformation Waiver 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) 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.[13] 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.

4.7: Support a robust peer workforce through training and professional development

Optum Pierce, the BHO, has made significant investments in developing the peer workforce in Pierce County; since 2009, Optum has trained over 500 individuals as Certified Peer Counselors, about 200 of whom are employed in the BHO system [9]. HSRI recommends that the central coordinating body ensure that these valuable trainings continue to be offered in Pierce County.

Critically, peer services must still be delivered according to national practice standards in a manner that maintains the integrity of peer support [10]. There are several things to consider beyond the peer training, including supervision, ongoing or continuing education, and creating a career ladder for peer specialists. Clinical supervision is required for Medicaid billing; however, experience in clinical supervision does not always directly translate to working with peer specialists. Supervisors of peer specialists should have training in both basic supervision skills and specific skills related to supervising peer specialists and how the role differs from traditional clinical roles. Peer specialist supervisors have a responsibility to advocate for equal compensation and benefits for this workforce and are responsible for promoting professional and job related personal growth. Many states now require continuing education for recertification and to continue to develop career opportunities and skills for peers working in behavioral health. HSRI recommends that the central

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

coordinating body ensure that peer services are supported through these national practice standards.

Continuing to promote and expand the scope of peer services at all levels of care aligns with the ABHS Task Force recommendation 11.[14]

4.8: Expand the scope of peer services within and beyond Medicaid

The County's peer support infrastructure could be put to better use if there were increased capacity for peer specialist positions throughout the system. Integration presents several opportunities to expand the scope of peer services within and beyond specialty mental health care. This includes supporting state efforts to pursue Medicaid-reimbursement and other funding for peer-delivered SUD services[15] and enhancing the use of SUD peers throughout Pierce County. Peer support services delivered by people in recovery from SUD have been found to reduce relapse rates, increase treatment retention, and improve service user experience [11].

Through integration efforts, there will be opportunities to partner with FQHCs and private health systems to develop more peer-delivered service capacity within their service networks. For example, peer wellness coaching [12, 13] and Whole Health Action Management[16] [14]—two recovery-oriented practices that support physical health and wellness and the self-management of chronic health conditions—are effective complements to physical health services for people with complex co-occurring physical and behavioral health needs in an integrated environment [15].

HSRI recommends that the central coordinating body, in partnership with the ACH, explore and promote these peer services to further capitalize on the already-robust peer support network in the County.

4.9: Foster the development of and partnerships with peer-run organizations

Peer-run organizations are programs in which a majority of people who oversee the organization's operations are individuals with lived experience of mental health or substance use services [16]. These organizations serve as valuable community resources, providing a range of supports, education, and advocacy aimed at improving quality of life for people with lived experience of behavioral health challenges. These organizations are key partners in systems change activities, providing important linkages between and across systems and holding leadership accountable to recovery principles. One such organization in Pierce County is the Recovery Café, which is founded and operated by people with lived experience of behavioral health challenges and homelessness.

HSRI recommends the County consider ways in which it might support the development of additional peer-run organizations in Pierce County. Through SAMHSA, technical assistance is

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

[15] In its 2018 Legislative Priorities, the Washington Recovery Alliance is advocating for increasing the sustainability of SUD peer services: https://washingtonrecoveryalliance.org/home/our-current-work/

[16] https://www.integration.samhsa.gov/health-wellness/wham

available to support the operations and sustainability of peer-run organizations. Peerlink,[17] the organization assigned to Washington State, provides technical assistance and support in several topics, including organizational development and employment.

4.10: Sustain and expand support for caregivers of people with behavioral health conditions

Beyond education and peer support, services and supports for families in Pierce County could be augmented. These include intensive supports and respite services for caregivers of children, youth, and young adults experiencing a first episode of psychosis. Through a contract with the BHO, Catholic Community Services provides a Wraparound with Intensive Services (WISe), an evidence-based, in-home service delivered by a team of professionals that includes a clinician, a family support specialist, and peer counselors. While this service is only available to families on Medicaid, another service, the Family Assessment and Stabilization Team (FAST) provides in-home intensive support for families in crisis, regardless of payer type. As integration takes place, it will be important that this service be maintained.

As discussed in Recommendation 2.1, the PAR initiative includes strategies to expand NAMI's offerings for family support, which are widely used throughout the country. Supporting these efforts may lead to an increase in NAMI's membership, which might foster the development of informal connections and groups alongside formal ones and support the viability of this resource in the coming years.

4.11: Expand the use of remote health interventions

Stakeholders identified service gaps and accessibility issues for Pierce County residents living in rural areas of the County. Telemedicine is a nationally recognized approach to increasing access to care, including behavioral health care, particularly in rural areas. A 2013 literature review of studies assessing the use of telepsychiatry in the United States concluded that telepsychiatry was effective in treating individuals with a variety of mental health conditions [17]. 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.[18] 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

[17] https://www.peerlinktac.org/focus-areas/

[18] 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

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 mitigate the shortage of available psychiatrists in rural areas.

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).[19] HSRI recommends that the County support state-level initiatives to expand telehealth practices. The County should also support ACH efforts to use telehealth to increase access to behavioral health services in underserved parts of Pierce County.

Recommendation 5: Target resources strategically to reduce inpatient utilization

Targeting limited behavioral health system resources to the 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 allows for more efficient investment in targeted community-based resources that, in turn, may reduce the need for inpatient treatment. This is already taking place in some BHO programs and within the high utilizers groups, but the high rates of emergency treatment suggest that more capacity is needed.

5.1: Preserve and expand current evidence-based practices and initiatives that reduce hospitalization

As Medicaid Financial Integration takes place, the central coordinating body should support preserving and expanding current evidence-based practices shown to reduce hospitalization, such as Assertive Community Treatment. The work of the high utilizers groups should also be supported and continued. Services that are targeted toward supporting community transitions should be emphasized; these services connect individuals with appropriate services once they are released from inpatient settings and can reduce re-hospitalizations. Again, such services are already in place in Pierce County and have demonstrated proven success. The central coordinating body should work to ensure that these assets be incorporated into the PCACH Action Plan. The central coordinating body should also explore creative solutions to expand access among individuals with high levels of need who are not currently eligible for such programs, including those without Medicaid.

5.2: Establish a centrally located behavioral health diversion center

Alternative crisis services such as crisis triage centers can provide resources to divert some individuals from acute inpatient and have been shown in many studies to reduce the need for inpatient care [18]. One crisis triage center, the Recovery Response Center, currently exists in Pierce County, and this resource has proven to be effective in reducing inpatient admissions. In the

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

2016 study and the 2017 follow-up, stakeholders noted that the Recovery Response Center's location in Fife is a barrier; for first responders and others in central and south Pierce County, transport to Fife is not feasible. There has been continued discussion within the Council about the need for an additional, more centrally located crisis triage center similar to the facility in Fife that can support diversion efforts. Notably, the Council funded a study, conducted in September 2017, to explore this topic. In that document, and in discussions with HSRI, stakeholders strongly endorsed the need for such a resource. Enhancing or expanding this service to other parts of the County would likely improve access to care and further reduce rates of involuntary interventions.

We recommend that the County move forward in exploring options for creating a new more centrally located facility. In our experience, however, the long-term 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.

5.3: Develop and expand peer-delivered crisis alternatives

Emergency Department Peer Support and Peer Bridger programs have been effective in reducing inpatient admissions and readmissions in Pierce County [9]. HSRI strongly recommends that the County, together with the PCACH, explore and pursue resources to sustain this valuable resource, and to expand access to non-Medicaid populations.

Peer-delivered residential crisis alternative models, peer respites[20], are being adopted throughout the country and may serve as an additional resource for individuals in crisis [19]. 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, conducted by HSRI, 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 [20]. These and other peer-delivered and trauma-informed 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.

5.4: Continue to study the MCIRT, and expand the program if it is successful in meeting community need

By all stakeholder accounts, the MCIRT has had a positive impact in terms of meeting the very complex needs of its target population. The MCIRT is a relatively new intervention, and multiple anecdotes suggest it has been successful both in engaging individuals who previously had not accessed treatment and diverting those individuals from using costly and unnecessary emergency

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

resources. Stakeholders were quick to point out that this resource is limited to one geographic area and has limited capacity.

Understanding whether and how the MCIRT should be expanded in Pierce County requires ongoing study. Gathering process and outcomes data will inform not only whether but how the MCIRT could be expanded to meet community need. Because the MCIRT is a novel and promising innovation, this information may also be of interest to other jurisdictions struggling with similar challenges.

Recommendation 6: Enhance service user engagement, activation, and self-management

In our 2016 study, 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. Each of these practices will be addressed through the PCACH initiatives in collaboration with its Community Voice Council. HSRI recommends that the central coordinating body work with the PCACH to promote these practices beyond the Medicaid-funded system.

6.1: 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.[21] 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.[22]

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

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

6.2: Track and promote patient activation

Patient activation refers to the skills and confidence that service users have to engage in their healthcare. 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 [21]. 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 [22]. The Patient Activation Measure used in the above studies has been adapted and validated for individuals with mental health conditions[23], 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 [23].

6.3: 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[24]. 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% [24]. A Washington state statute[25] permits the execution of legally binding mental health advance directives. Although many states have such legislation, Mental Health Advance Directives are largely underutilized nationwide [25]. Stakeholders in Pierce County noted that this tool is underutilized locally as well.

The state of Virginia has been lauded as pioneering policy innovations in this area, and an article in the journal *Psychiatric Services* describes these efforts [26].[26] The National Resource Center on Psychiatric Advance Directives[27] is also a useful resource for individuals, family members, and providers. Successful County-wide adoption of psychiatric advance directives will likely require identifying and reducing barriers to use. These may include a lack of awareness among service users and family members, administrative burden for providers, and data limitations (no process for identifying whether a person has an advance directive and accessing the document when an individual is in crisis).

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

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

[25] 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

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

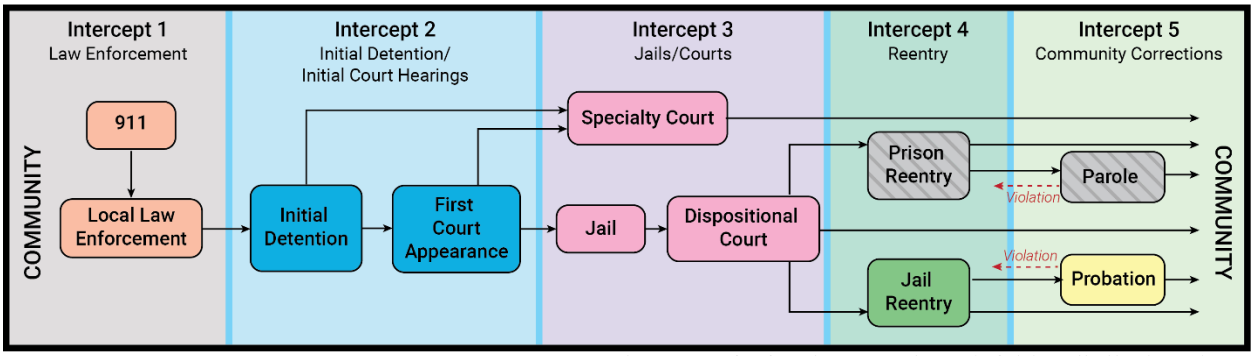
[27] http://www.nrc-pad.org/

HSRI recommends that the central coordinating body establish a mechanism to promote the existence, value, and use of psychiatric advance directives. This tool is 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.

Recommendation 7: 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 [27]. The version of the model in the graphic below, developed by the SAMHSA GAINS Center, is a tool for organizing and evaluating initiatives in Pierce County.

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.

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. In 2017, stakeholders made clear that there have been great improvements in the quality and impact of collaborations to address behavioral health-related needs in the criminal justice system. HSRI recommends that the central coordinating body build on this momentum and work to make these high-quality collaboration and communication practices permanent within the County.

7.1: Promote behavioral health training among first responders and other criminal justice professionals

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 [28]. 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.

HSRI also recommends trainings for corrections officers so that they have a better understanding of behavioral health issues and can respond to these issues in trauma-informed ways in correctional settings. Several states have adapted CIT training for corrections officers.[28] In addition, the SAMHSA GAINS Center has developed a free Trauma-Informed Response Training for criminal justice professionals to raise awareness about trauma and its effects.[29]

7.2: Continue to expand the Mental Health Co-Responder Program using national best practice models for collaboration and coordination

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 successful in diverting people into treatment and away from jails and emergency rooms. In 2017, Pierce County's supplemental budget enabled the Pierce County Sheriff's Department to develop its own co-responder program.

Preliminary research evidence on mental health co-responder models suggest that these programs are effective at reducing pressure on criminal justice systems and creating linkages with community services [29]. However, there is not yet research consensus on best practice for the organization and delivery of mental health co-responder programs. Because law enforcement agencies vary from region to region, local context is important, and decisions regarding how these programs are structured, governed, and administered depends on the unique needs and resources of each community. There does, however, seem to be good indication that mental health co-responder programs require significant collaboration and strong partnerships between law enforcement and behavioral health agencies. Partnerships and coordination activities should include ensuring referral and connection with behavioral health services for individuals with

[28] http://www.pacenterofexcellence.pitt.edu/documents/Maine%20NAMI%20CIT-3.pdf, https://www.merage-equitas.org/wp-content/uploads/2014/06/Training-US-Correctional-Officers-in-Mental-Health-Response.pdf, https://www.correctionsone.com/jail-management/articles/4206236-Crisis-intervention-in-a-correctional-setting/

[29] https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals

identified unmet needs, and these services should include ongoing/wraparound supports, not just crisis services. HSRI recommends that the central coordinating body work to explore best practice for partnerships and collaboration in mental health co-responder programs and incorporate that best practice as these programs expand in the County.

7.3: Ensure Pierce County has stable, long-term funding to provide a full array of diversion and treatment services at the intercept of behavioral health and criminal justice

Pierce County is home to many 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. Many of these services are currently supported through the BHO, and ensuring that these services remain fully funded in the coming years will take concerted effort on the part of the County.

7.4: 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 advocate for the suspension rather than termination of Medicaid benefits for incarcerated individuals (aligns with ABHS Task Force recommendation 6)[30]. These state-level efforts are consistent with the approach supported by CMS in a recent guidance letter to states.[31]

Recommendation 8: Foster coalitions to meet the needs of veterans and service members

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 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.

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

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

References

[1] New Freedom Commission on Mental Health, (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Department of Health and Human Services: Rockville, MD.

[2] CMHS, (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services: Rockville, MD.

[3] Cross T.L., Bazron B.J., Dennis K.W., & Issaacs M.R. (1989). *Towards a culturally competent system of care. Vol 1*. Washington, D.C.: The Georgetown University Child Development Center. Available at http://files.eric.ed.gov/fulltext/ED330171.pdf

[4] Lutterman, T., Phelan, B., Berhane, A., Shaw, R., & Rana, V. (2008). *Characteristics of State Mental Health Agency Data Systems*. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: Rockville, MD.

[5] SAMHSA, (2011). *Description of a Good and Modern Addictions and Mental Health Service System*. Substance Abuse and Mental Health Services Administration: Rockville, MD Available at: http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

[6] Kane, J.M., et al., (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, *173*(4): p. 362-372. Available at: http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2015.15050632

[7] Addington, J., Heinssen, R.K., Robinson, D.G., Schooler, N.R., Marcy, P., Brunette, M.F., Correll, C.U., … Kane, J.M. (2015). Duration of untreated psychosis in community treatment settings in the United States. *Psychiatric Services, 66*, 753-756.

[8] Ibid.

[9] Daniels, A. (2015). *An Assessment of Innovative Models of Peer Support Services in Behavioral Health to Reduce Preventable Acute Hospitalization and Readmissions*. Westat. Available at: https://aspe.hhs.gov/report/assessment-innovative-models-peer-support-services-behavioral-health-reduce-preventable-acute-hospitalization-and-readmissions.

[10] Daniels, A.S., Tunner, T.P., Powell, I., Fricks, L., & Ashenden, P. (2015). *Pillars of Peer Support – VI: Peer Specialist Supervision*. Available at: www.pillarsofpeersupport.org

[11] Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), 853-861. doi:10.1176/appi.ps.201400047

[12] Swarbrick, M. (2013). Integrated care: wellness-oriented peer approaches: A key ingredient for integrated care. *Psychiatric Services, 64*(8), 723-726.

[13] Brice G., Swarbrick, M.A., & Gill, K. (2014). Promoting wellness of peer providers through coaching. *Journal of Psychosocial Nursing and Mental Health Services, 52*(1), 41-45.

[14] Druss, B. G., Zhao, L., von Esenwein, S. A., Bona, J. R., Fricks, L., Jenkins-Tucker, S., . . . Lorig, K. (2010). The Health and Recovery Peer (HARP) program: A peer-led intervention to improve

medical self-management for persons with serious mental illness. *Schizophrenia Research, 118*(1-3), 264-270. doi:10.1016/j.schres.2010.01.026

[15] Cabassa, L. J., Camacho, D., Velez-Grau, C. M., & Stefancic, A. (2017). Peer-based health interventions for people with serious mental illness: A systematic literature review. *Journal of Psychiatric Research, 84*, 80-89. doi:10.1016/j.jpsychires.2016.09.021

[16] Ostrow, L. & Hayes, S. L. (2015). Leadership and characteristics of nonprofit mental health peer-run organizations nationwide. *Psychiatric Services, 66*(4), 421-425. doi:10.1176/appi.ps.201400080

[17] Deslich, M.S., Stec, B., Tomblin, S., & Coustasse, A. (2013). Telepsychiatry in the 21st century: Transforming healthcare with technology. *Perspectives in Health Information Management.* Available at: http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczTOmd3vIU

[18] Thomas, K.A. & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: A systematic review. *Psychiatric Services*, *64*(11), 1140-1149.

[19] Ostrow, L. & Croft. B. (2015). Peer respites: A research and practice agenda*. Psychiatric Services*, *66*(6), 638-640. Available at: http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201400422.

[20] Croft, B. & Isvan, N. (2015). Impact of the 2nd Story peer respite program on use of inpatient and emergency services*. Psychiatric Services*, *66*(6), 632-637. Available at: http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201400266.

[21] Hibbard, J.H., Greene, J. & Overton, V. (2013). Patients with lower activation associated with higher costs; delivery systems should know their patients' scores. *Health Affairs*, *32*(2), 216-222. Available at: http://content.healthaffairs.org/content/32/2/216.abstract.

[22] Hibbard, J.H. & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs*. Health Affairs*, *32*(2), 207-214. Available at: http://content.healthaffairs.org/content/32/2/207.abstract.

[23] Green, C.A., et al. (2010). Development of the patient activation measure for mental health*. Administration and Policy in Mental Health and Mental Health Services Research*, *37*(4), 327-333.

[24] de Jong, M.H., et al. (2016). Interventions to reduce compulsory psychiatric admissions: A systematic review and meta-analysis*. JAMA Psychiatry*, *73*(7), 657-664. Available at: http://dx.doi.org/10.1001/jamapsychiatry.2016.0501.

[25] Zelle, H., Kemp, K., & Bonnie, R.J. (2015). Advance directives for mental health care: Innovation in law, policy, and practice. *Psychiatric Services*, *66*(1), 7-9. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25554231.

[26] ibid

[27] Munetz, M.R. & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, *57*(4), 544-549. Available at: http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2006.57.4.544.

[28] Teller, J.L.S., et al., (2006). *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls. Psychiatric Services*, *57*(2), 232-237. Available at: http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.57.2.232.

[29] Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health, 42*(5), 606-620. doi:10.1007/s10488-014-0594-9