

LEWIS COUNTY
LEWIS COUNTY

Mental Health Strategic
Plan

June 2010

Table of Contents

Charter	3
Goal Statement	
Objectives	
Executive Summary	4
The Problem	4
The Desired Outcomes	6
The Proposed Solutions	7
Background	8
Mental Health Needs Work Group: formation and goal	8
Our Community Process	8
Local Collaboration	8
Coordination with State Mental Health Transformation Project	8
Our Core Values and Principles	8
Assessment of Need	9
Assessment of Services and Service Delivery: Gaps and Barriers	11
Assessment of Funding for Mental Health	13
Outcomes	14
Environmental Factors	15
Mental Health Issues	17
Mental Health Services	17
Service Delivery	18
Funding Factors	20
References	21
Partners in Strategic Plan Development	23

Charter

The Mental Health Coalition is a highly inclusive community-based group sponsored by the Lewis County Community Health Partnership and supported by county government and other community stakeholders to refine and implement a strategic plan for system change and improved service delivery for individuals and families of Lewis County with mental and behavioral needs as defined by MHTP (Mental Health Transformation Project).

Goal Statement

We want to:

- a) reduce the impact of environmental factors such as housing, food and the economy that contribute to poor mental health * conditions and substance abuse issues;
- b) provide improved mental health and substance abuse services;
- c) and adequately fund a strong service delivery system.

**Mental health can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (World Health Organization, Fact Sheet #220, 2007)*

Objectives

Refine and implement the Lewis County Mental Health Strategic Plan.

Develop sustainable funding for improved service delivery.

Continually reassess, document, and publish community mental and behavioral health needs as defined in MHTP in collaboration with Lewis County Public Health and Social Services Department.

Continually evaluate and improve effective evidence based, emerging and most promising mental health services.

Continually increase community participation in solutions and continually decrease the stigma of mental illness and substance abuse.

Continually provide community education on what mental and behavioral health is and what resources are available, with primary emphasis on individuals and families.

Executive Summary

The Mental Health Needs Work Group is a highly inclusive community effort, generously supported by county government, to create and implement a strategic plan for system change and improved service delivery.

The Problem

Environmental factors have created and contributed to mental health and co-occurring substance abuse issues, the resolution of which is hampered by inadequate mental health services, inadequate service delivery system and inadequate funding.

Environmental Factors

Lack of income, stable housing, education, social support, and presence of disability are all identified risk factors for mental stress and illness.

- The county unemployment rate has been higher than the state rate for the last 25 years and per capita personal income (PCPI) is only 71% of the state PCPI.
- Low income housing needs and increasing suburbanization of the northern I-5 corridor pushing up median housing costs, further stresses and marginalizes the low-income population.
- 20% of county individuals aged 25 and older have less than a high school education, 33% have a high school diploma or GED and only 13% have a bachelor's degree (Hale, 2006).
- 18% of those aged 15-64 have a self-identified disability, 45% of those who are disabled are 65 or older, and 31% of this age group lives alone.

Community readiness to deal effectively with these issues is inconsistent. While a laudable “can do” pioneer spirit pervades Lewis County, some residents are also in denial and problems go unacknowledged or the search for solutions is delayed.

Mental Health Issues

Increased levels of both mental illness and substance abuse are found in Lewis County.

- National studies project that a population the size of Lewis County would have about 18,685 people with mental disorders, with 4,396 having severe mental illness (National Alliance on Mental Illness, 2010).

Arrests for drug violations and enrollment in drug programs are higher than the state average.

Mental Health Services

Nation-wide, mental health services in the areas of prevention and early detection and intervention are severely under-funded or non-existent.

- In Washington, safety net mental health services are funded primarily through Regional Support Networks (RSN), where limited federal Medicaid dollars and State funding limits provision of services to all but the most severely and persistently mentally ill (Washington State Dept. of Social & Health Services, 2006).
- A local survey of the 24 self-identified private mental health providers in the county indicated limited services provided on a part-time, fee-for-service basis, with no apparent prevention, support, or early intervention services (Mental Health Needs Work Group, 2006).
- Available child services typically do not focus on intervention services early enough, nor do they sufficiently address the whole family.
- Culturally-appropriate services for our large and growing Spanish-speaking population are insufficient.

Service Delivery System

The mental health service delivery system is fragmented, and uncoordinated. Insufficient funds are applied to the most costly crisis services rather than to root cause prevention or to early intervention to increase protective factors. Large portions of the population in need receive no services or are cared for in somewhat inappropriate sites.

- Mental healthcare funding cuts and deinstitutionalization over the last two decades have made jails the de facto mental health institutions, a role they are ill equipped to play.
- Likewise, the primary care medical system also has become the new outpatient mental health system, a role for which they are ill prepared. 70% of all primary care visits have a psychosocial driver; 90% of the most common primary care complaints lack an organic basis; Primary Care Providers (PCP) prescribe 67% of all psychoactive agents and 80% of all anti-depressants (Strosahl, 2006).
- Nationally and locally, service delivery is hampered by a lack of service providers, a lack of coordination between primary care and mental health providers and between mental health and substance use providers regarding those with co-occurring disorders.
- No dedicated inpatient mental health or substance abuse beds exist in the county. No central referral resource is available for mental health or substance use providers and services. A team approach (e.g., integrated with primary care) to screening and prevention or brief intervention is not yet a focus.

Funding

- Despite the high proportion of services driven by psychosocial factors, the DSHS budget allocates only 1% for alcohol and substance abuse treatment and 8% for mental health treatment (DSHS, 2006). Within that 8% lies RSN funding, which, as previously noted, provides access only for diagnoses considered severe, and strictly limits outpatient visits and inpatient days (DSHS, 2006).
- Other state and state/federal coverage plans (Basic Health, CHIP and SCHIP, Medicare) pay for very limited mental health services. Medicare payments are subject to deductible, co-payment, and co-insurance amounts that often make them prohibitive for beneficiaries (MHNWG, 2006).
- Private insurance plans offer limited mental health coverage in varying degrees, likewise subject to significant deductibles, co-payments and co-insurance amounts.
- Out-of-pocket private pay mental health services are far too expensive for the low income and uninsured populations, and are frequently prohibitive for the middle-income population beyond brief intervention (MHNWG, 2006).

When adequate mental health and substance abuse services provide long-term stability and robust protective factors to affected individuals, potential funding for expanded services may come from cost offsets in the medical care and law enforcement systems.

The Desired Outcomes

Environment:

- The community becomes deeply aware of the link between poverty, homelessness, education level, and mental health, and effectively addresses these factors over time.

Mental Health Issues:

- The community recognizes that mental illness can be prevented, effectively managed, and treated. The number of people presenting with mental health and co-occurring disorders is significantly reduced.

Service Delivery :

- Community mobilization increases understanding and decreases the stigma of mental illness. The community is ready to provide significant interventions and the means to access those interventions.
- The full spectrum of health and human service providers collaborate to provide fully accessible, effective, coordinated, resource-efficient care into which evidence-based mental health services are seamlessly integrated.
- Consequently, fewer people with mental illness enter or reenter the criminal justice system or consume high cost medical resources.
- The mental health delivery system incorporates continuous quality improvement, encourages wide involvement and feedback, and facilitates training to eliminate knowledge and skill gaps.

Mental Health Services:

- Mental health services emphasize wellness, include the continuum from prevention through treatment and recovery, and utilize evidence-based standards of practice while incorporating “emerging and most promising” practices.
- Services are widely available, affordable, client-centered, and culturally appropriate. They encourage involvement of the community, peers, friends, and family, and thereby enhance community integration.

Funding:

- Sustainable private, local, state and federal resources fund a full continuum of mental health services to all county residents as needed.
- All insurers provide a comprehensive package of affordable mental health benefits, adequately reimbursing the full spectrum of qualified licensed providers.
- Provision of early and effective mental health services creates savings in the form of cost offsets in medical care and law and justice services. These savings are redirected to serve more people at less cost.

The Proposed Solutions

Environment:

- All entities/groups having a stake in mental/behavioral health services should be brought together in a meaningful, ongoing way to purposefully coordinate actions.
- Build partnerships with all sectors of the community in order to engage in community discussion and education about what constitutes mental health and illness.
- Supportive housing for the mentally ill that enables residents to remain housed and functioning in the community instead of homeless, ill, and/or institutionalized.
- Structured employment that identifies, honors, and builds each person's capacity to be productive.

Funding:

- Review and implement traditional and innovative financing options to fund desired improvements noted in this strategic plan.

Service and Service Delivery:

- Create a prevention and early intervention strategy that screens and intervenes early to eliminate the need for further services.
- Appropriately divert problem individuals/offenders with mental health issues by providing alternative structured support and treatment services.
- Integrate behavioral health services with primary care, other health settings, schools, and jails.
- Appropriately increase the breadth of mental health treatment services and number of treatment providers to address community need.

Background

Mental Health Needs Work Group: Formation and Goal

The *Lewis County Community Health Partnership*, founded in 1997 by a consortium of concerned community agencies, is dedicated to improving the health of the community through education, collaboration, and partnerships. It targets specific health issues in our community and sponsors inclusive work groups of community stakeholders to identify and implement solutions that result in improved community health.

For instance, the Partnership was instrumental in forming the Children's Oral Health Coalition and increasing safety net dental services in collaboration with the UW Dental School and local dentists. It also was instrumental in the creation of Valley View Health Center, a Federally Qualified Health Center in Lewis County.

In March 2006, in response to obvious need, the Partnership formed the *Mental Health Needs Work Group* (MHNWG) to engage the full spectrum of community stakeholders in a strategic planning process that would result in identification and documentation of need, desired outcomes, and effective solutions that could be implemented over time in a way that improved mental health care access, quality, and outcomes in Lewis County. At the same time, Dr. Christianne Hale performed a Lewis County Demographics Study and presented this information in multiple community forums. Her research is referenced throughout this document. The following sections of this strategic plan are intended to provide that documentation and act as a dynamic guiding reference in the implementation of specific solutions.

Our Community Process

Local Collaboration

This plan is indebted to the wide variety of individuals who have participated in the MHNWG and its various subgroups.

Through the efforts of the MHNWG we have been able to engage a significant amount of community participation in a one-day conference designed to deepen community input to specific solutions and commitment to implementation over time. A major outcome of the conference will be the formation of a permanent Lewis County Mental Health Coalition to own and continually update this strategic plan, to oversee its implementation, and to continually mobilize community participation.

Coordination with the Washington State Mental Health Transformation Project (MHTP)

We also are indebted to Ken Stark, David Brenna, and others from the State Mental Health Transformation Project for invaluable input and assistance. Throughout our process we have drawn on the written materials of the Transformation Work Group. We expect to continue to collaborate with the Transformation Project and to be in alignment with its goals and solutions.

Our Core Values and Principles

- The need for mental and behavioral health is a public health issue. We work to improve community understanding and to educate elected officials about need and solutions.
- Emphasis must be placed on prevention and early intervention in order to reduce serious and costly mental illness.
- Environmental factors (housing, employment, nutrition, community acceptance and involvement) are critical to providing effective prevention, early intervention, and treatment.
- Effective mental health treatment can produce cost-offset savings, which can be used to serve more people.
- We value collaboration for common community benefit, not just the benefit of single programs.

Assessment of Need

Overview

Environmental factors have created and contributed to mental health and co-occurring substance abuse issues, the resolution of which is hampered by inadequate mental health services, an inadequate service delivery system, and inadequate funding.

Environmental Factors

Lewis County is geographically the largest county in western Washington, stretching from lowland agriculture in the west to the Cascades in the east. Most of the population and most of the growth is in the western county along the I-5 corridor. The county has had a resource-based economy that has struggled for decades, most recently with the closing of the TransAlta mine. These economic struggles have created an unemployment rate higher than the state rate for the last 25 years and a per capita personal income (PCPI) that is only 71% of the state PCPI. This has led to a high poverty rate (38% under 200% FPL) which highly impacts families (Hale, 2006). Thirty-six percent of Lewis County residents living in poverty are married couples both under the age of 65, but 59% reside in single parent, female-headed families; 40% of county births are to unmarried women, contributing to the roughly 3400 children in Lewis County who live in poverty (Hale, 2006).

Poverty has long been shown to be associated with mental illness. Lack of financial resources reduces treatment options, including coordinated case management and drug therapy compliance, which can lead to increasingly severe symptoms for those with mental illness.

*Primary Environmental
Factors:
Lack of Housing
High Unemployment*

An increase in low income housing needs and increasing suburbanization of the northern I-5 corridor pushing up median housing costs, further stresses and marginalizes the low-income population.

Of those who rent in Lewis County, 25% spend 50% or more of their monthly wage on housing, putting them at great risk for homelessness (Hale, 2006). Local homeless shelters report accommodating 483 individuals, while during the same time period, turn away 1,322 individuals because of lack of capacity (CTED, 2005). Housing stock for people with mental illness is especially limited. County landlords generally are reluctant to rent to those with mental illness because of its stigma. Those who are willing often require a co-signer for fear of financial loss, though this is not the standard expectation for other low-income individuals. Cascade Mental Health Care has a limited amount of supported housing but only its enrolled clients are eligible. One HUD apartment complex is known to have a maximum of 12 single-occupant apartments designated for individuals with mental illness.

In Lewis County, 20% of those age 15-64 years old have a self-identified disability, which is disturbing because this age group contains those at the peak of family formation and work productivity. Additionally, 45% of those who are disabled are 65 or older, and 31% of this age group lives alone, which may indicate a lack of social support (US Census Bureau, 2000).

Disability or lack of social support may predispose someone to mental illness, and someone who has mentally illness may be more likely to identify themselves as disabled and lacking social support. For instance, meals shared as a family decrease suicide ideation, while experiencing bullying and discrimination increase it (DOH, 2010). Also, unmarried single parents are more likely to experience inadequate social support, increasing the likelihood of poor mental health or well-being.

Education is an Environmental Factor

In Lewis County, 19% of individuals aged 25 and older have less than a high school education, 33% have a high school diploma or GED, 35% have some post high school education, and only 13% have a bachelor’s degree or more (Hale, 2006).

Community readiness is a crucial factor in successfully dealing with mental health and co-occurring substance abuse issues. A laudable “can do” pioneer spirit pervades Lewis County; however, it can become problematic when it causes problems to go unacknowledged or the search for solutions (either individual or community-wide) to be delayed.

A local community readiness survey indicated community acknowledgement that substance abuse is a problem in Lewis County; alcohol and drug abuse were among the top three community challenges, while mental and emotional issues were listed among the top 15 challenges. Results from a focus group comprised of members of the professional community supported this finding, identifying mental health and substance abuse as the two most significant community issues. However, some residents are also in denial, showing no acknowledgement of alcohol and substance abuse as an issue. According to the 2008 Healthy Youth Survey (HYS), alcohol consumption in 8th, 10th, and 12th graders exceeded the state average. Forty-six percent of Lewis County 12th graders self-report having used alcohol in the last 30 days (DOH, 2010). Alarming, 48% of 10th graders reported that they would not likely seek assistance if they were feeling depressed or suicidal (DOH, 2010).

Percentage of Students Currently using Alcohol

Grade	8	10	12
Local	18%	34%	46%
State	16%	32%	41%

Mental Health

According to the National Institute on Mental Health, roughly one in four adults experience a mental health issue in a given year. For a population the size of Lewis County, that translates to 18,685 people having mental health issues, with 4,396 of those having severe or severe and persistent mental health issues (NAMI, 2010).

Sixty-two percent of children ages 2-17 seek and receive mental health care in Washington State according to the National Survey of Children’s Health (2007).

Substance abuse, often co-occurring with mental illness, is found at increased levels in Lewis County. Arrests for drug violations are higher than the state average and the number of people enrolled in drug programs is higher than the state average as well. In Lewis County, young men ages 25 to 44 also are dying at high rates, with suicide accounting for 17% of those deaths (Hale, 2006).

Mental health needs (63%) are the highest need identified in the state juvenile justice system (DSHS, 2010). A majority of these youths (68%) have multiple, co-occurring service needs such as treatment for addictions, sexual misconduct, and cognitive impairment (DSHS, 2010).

Contrary to popular belief, mental illness is not a risk factor for increased violence in the community (Busko, 2009). Other characteristics have greater impact on violent crime, such as history of physical abuse, divorce, parental crime history, and history of juvenile detention. However, having a mental illness and substance abuse issues combined with one or more of these other characteristics increases the likelihood of future violence ten-fold (Busko, 2009).

Assessment of Services and Service Delivery: Gaps and Barriers

Mental Health Services

According to The National Council on Behavioral Healthcare, community mental health services are vastly underfunded, and reimbursement for the most basic services are low. Similarly, the Washington State NAMI Summit Report on “Recidivism in Youthful Offenders” indicates that services provided are often based on non-scientific /non-empirical data and also states that post-release services to the mentally ill are inadequate. Despite best efforts within Lewis County, mentally ill offenders suffer with pre-release and post-release services that are sparse and under funded.

In Lewis County, Cascade Mental Health Care is the primary provider of mental health services, funded primarily by the Regional Support Network through Federal Medicaid dollars and secondly through limited State funding. However, tight eligibility standards limit provision of services to all but those who have the more persistent and severe mental illness (DSHS, 2006). In addition, the limited state dollars must first be used to provide to Medicaid clients those eligible services which Medicaid will not cover. Crisis services for Medicaid and non-Medicaid clients and hospital services for non-Medicaid clients must be covered next. This leaves a very limited amount of RSN dollars to provide services for individuals who have no other means of paying for services or whose diagnoses are not considered severe. The intensity of services is limited by the contracted mental health care coordinators using Access to Care Standards, with some clients receiving a maximum of 10 to 12 hours of service per year.

Though the community has identified co-occurring mental health/substance abuse as a significant issue, there has been an insufficient focus on the mental health services necessary to address this significant issue. early intervention services.

For instance, while Cascade’s funding includes services for co-occurring disorders, it does not include provision of prevention or early intervention services. A local survey of the 24 self-identified private mental health providers in the county indicated limited services provided on a part-time, fee-for-service basis, with no apparent prevention, support, or early intervention services (MHNWG, 2006). Available child services typically do not focus on intervention services early enough (ages 3-5), nor do they sufficiently address the whole family.

Culturally-appropriate services for our large and growing Spanish-speaking population are insufficient. Current services focus predominantly on crisis, leaving caregivers for people with mental illness searching desperately for prevention and early intervention services (MHNWG, 2006). Access to brief counseling through local faith-based organizations provides some relief to less severe mental health issues.

Service Delivery System

The mental health service delivery system is fragmented and uncoordinated. Insufficient funds are applied to the most-costly, least-effective, symptomatic crisis services rather than to root-cause prevention or protective factor-building early intervention. Large portions of the population in need—those with less than severe mentally illness; those over 200% of the federal poverty level (FPL) but uninsured; veterans; and those without the “right” diagnosis—fall through the gaping holes in the delivery system. Many are taken care of in somewhat inappropriate sites—jails, emergency departments, and primary care offices. The organization of the delivery system is itself a barrier to access, which is tragedy enough, but the lack of available services themselves is equally disturbing (MHNWG, 2006).

Justice System

Jails have become the de facto mental health institutions as a result of funding cuts and deinstitutionalization over the last two decades. According to the State of Washington Department of Corrections (2008), "32% of the 98,595 medically disabled clients in fiscal year 2006 had been arrested at least once between fiscal 1997 and 2006 (p.2). Not only is the jail system overpopulated with mentally ill offenders, it is ill equipped to cope with them. Locally, Lewis County Sheriff's Office (2006) asserts wait times for court-ordered evaluation and competency hearings are over 6 weeks forcing mentally ill offenders to spend 3 to 6 times longer in jail than non-mentally ill offenders, depending on the offense. Local judges are frustrated by the lack of options outside of jail time.

Primary Care System

With the mental health funding cuts over the last two decades, the primary care medical system has become the new outpatient mental health system. Dr. Kirk Strosahl (2006) indicates that 70% of all primary care visits have a psychosocial driver; 90% of the most common primary care complaints have no organic basis; 67% of all psychoactive agents are prescribed by PCP's and 80% of all anti-depressants are PCP prescribed.

System Breakdowns-

- the primary care system is ill-prepared to deal with increasing numbers of patients who suffer from co-occurring mental health/substance abuse issues;
- coordination between the PCP and MHP is deficient, severely hampered by significantly more restrictive confidentiality requirements for mental health diagnoses out of fear of stigmatization;
- within the mental health system there is insufficient training of some personnel, some use of non-evidence based therapies, and inadequate reimbursement for services provided. - Kirk Strosahl, PhD, 2006

To be sure, inadequate funding results directly in an insufficient number of trained personnel, making case loads large and regular contact with clients difficult; and while evidence-based therapies are used, the cost of some, combined with poor reimbursement, make them prohibitive to use on even a limited scale.

Mental Health System

Despite mental health services delivered through the jail and primary care systems, the professional community has identified mental health/substance abuse needs as a significant issue that lacks sufficient focus on, and resources for, treatment delivery. Sixty-one local providers of primary care, social, and justice services regarding community need indicated for the 2622 individuals served in 2006, over 22% had a mental health need, 4% were referred for mental health treatment, and an additional 8% would have been referred had services been available (MHNWG, 2006). Fifty-two percent of service providers indicated that they would have made more referrals if they could have (MHNWG, 2006).

This unmet demand for MH services is understandable given the results of a 2006 local mental health workforce survey identifying 24 private non-prescribing mental health providers in Lewis County. Information shared about qualifications, fees, and actual FTE was varied, so the level of training, skill, and availability are difficult to measure. Sixty-three percent of the providers indicated having a sliding fee schedule, but the nature of the discount was unclear (MHNWG, 2006). Almost 50% of providers had at least 75% of their practice as out of pocket private pay. Fifty-three percent of the providers indicated they work off hours (evenings, by appointment as needed). Of referrals these providers made for further mental health treatment, 36% go to Cascade Mental Health Care and 12% to Olympia (MHNWG, 2006). This possibly indicates a lack of depth and range to the services initially provided.

Additionally, an informal survey of local pastoral counselors indicated that only two in Lewis County are members of the American Association of Pastoral Counseling (D. Degener, personal communication, October, 2007). Most counseling through faith-based organizations is brief and varied, based on the pastor's training and experience. No known standard of practice exists for this group and no formal transfer process exists if a mental health issue exceeds the pastor's scope of training.

What is missing?

It seems apparent that service delivery is hampered by a lack of service providers, a lack of coordination between primary care and mental health providers, and between mental health and substance abuse providers regarding those with co-occurring disorders. There are no dedicated inpatient mental health or substance abuse beds in the county, leaving Providence Centralia Hospital and providers scrambling when out of county resources are on diversion. There is no central referral resource available for mental health or substance abuse providers and services. In addition, a team approach to care, such as integrated primary care, for screening and prevention or brief intervention, is not funded at this time.

Assessment of Funding for Mental Health

Budgets for mental health services and systems have been steadily declining over the last two decades (Strosahl, 2006). Today, only 1% of the DSHS budget is for alcohol and substance abuse treatment while mental health treatment constitutes only 8% of the DSHS budget, despite the high proportion of services driven by psychosocial factors. Within that 8% lies RSN funding the primary source of payment for mental health services in the state.

While every Medicaid recipient is entitled to an intake to determine need for medically necessary treatment, Medicaid does not pay for prevention or early intervention services or for diagnoses not meeting the State Access to Care Standards. The number of outpatient visits and inpatient days reimbursed is generally quite limited and community mental health agencies are encouraged to refer clients to PCPs or to discontinue services when the client is considered "stable".

State and State/Federal coverage plans (Basic Health, CHIP and SCHIP) pay for very limited mental health services. These services are administered through the health plans contracted to serve the BHP, CHIP and SCHIP enrollees. Medicare pays for some outpatient and inpatient mental health services provided by a psychiatrist, clinical psychologist, or licensed clinical social worker.

These reimbursements are subject to standard deductible, co-payment, and co-insurance amounts that often make them prohibitive for beneficiaries. With the passage of the *Wellstone/Domenici Mental Health Parity and Addiction Equity Act*, private health insurance plans will be forced to provide mental health coverage as of July 1, 2010.

Mental Health Parity Act-

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan
- Provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) (DOL, 2008).

We have yet to see how this bill will play out at the community level. At this time, private insurance plans offer mental health coverage in varying degrees, though many benefit plans offer no such coverage.

The coverage is almost always very limited and subject to significant deductibles, co-payments and co-insurance amounts. Out-of-pocket private pay mental health services are far too expensive for the low income uninsured population and frequently prohibitive for the middle-income population beyond brief intervention.

Cost Offsets

Potential funding for mental health services comes from analysis of cost offsets in the medical care and law enforcement systems when adequate mental health services provide long-term, continuous stability to mentally ill populations, or provide robust protective factors to individuals at risk of developing or exacerbating mental illness.

Because 50% to 70% of patients' medical ailments are highly related to psychological factors, mental health care reduces medical utilization and generates cost savings (VandenBos & DeLeon, 1988). Currently only 5% of those experiencing a mental disorder see a mental health professional; the other 95% see a family physician (Lechnyr, 1993). Those with severe mental illness realize some offset by slowing the rate at which they consume expensive medical services (Borus & Olendzki, 1985). In a closed military hospital system, an increase in size and scope of outpatient mental health services reduced the net cost of mental health services by \$1.7 million by reducing inpatient admissions (Armstrong & Took, 1993). Prevention and early intervention or outpatient treatment promise to be less expensive and more effective than incarceration. Finally, co-occurring alcohol and substance use diagnoses rapidly escalate individual medical costs. Cummings, Dorken, Pallak, et al. (1990) found that those with co-occurring substance abuse and mental illness who failed to receive mental health treatment increased medical costs almost 100% during the study period, while those receiving treatment actually decreased their medical costs over the same period.

Desired Long Term Outcomes

The Mental Health Needs Work Group (MHNWG) organized the outcomes for the Mental Health Strategic Plan into *five desired outcomes*, or objectives. The MHNWG developed a Solution Planning Group (SPG) to research and identify possible actions that may assist to reach our outcomes. The MHNWG also convened a community-wide mental health conference in May 2008, attended by over 100 individuals engaged in systems, agencies, and the community at large touched, or invested in the mental well-being of the community members of Lewis County. Conference attendees provided further information for action steps to achieve our long term outcomes.

Outcome 1: Environmental Factors

- ❖❖ The community becomes deeply aware of the link between poverty, homelessness, education level, and mental well-being.
- ❖❖ The community is widely engaged and inspired to effectively address these environmental factors over time.

Solution 1

All entities/groups having a stake in mental/behavioral health services should be brought together in a meaningful, on-going way to purposefully coordinate action that build bridges across “silos.”

Action Steps

- ◆ *Develop a Lewis County Mental Health Coalition to provide on-going, permanent oversight of the strategic plan content and implementation.*
- ◆ *Hire mental health coordinator/staff to look at blending of services.*
- ◆ *Create on-line resource directory. Create a forum to share/exchange ideas for providers.*
- ◆ *Hold community meetings to share program and resources available. Present to Chamber of Commerce and service clubs to highlight success stories of individuals to raise awareness.*
- ◆ *Create formal agreement among service providers to coordinate services, standardize and share data collection and reporting, and conduct collaborative public awareness and education opportunities.*

Solution 2

Build partnerships with all sectors of the community in order to engage in community discussion and education about what constitutes mental health and illness.

Action Steps

- ◆ *Develop a common language and culturally relevant messages to educate the community about mental illness. Use NAMI and Centralia College to continually educate and engage the community.*
- ◆ *Reduce Stigma. Use mental health professionals and successfully recovering individuals as spokespeople to raise awareness in schools and community groups. Create forum for physicians to work on partnerships and endorse cultural competency. Enlist mental health professionals to educate groups.*
- ◆ *Create community desire to mobilize around the solutions in this strategic plan. Contact media (T.V., newspapers) with 5 common languages/messages.*

Outcome 1: Environmental Factors (Continued)

- ❖❖ The community becomes deeply aware of the link between poverty, homelessness, education level, and mental well-being.
- ❖❖ The community is widely engaged and inspired to effectively address these environmental factors over time.

Solution 3

Create affordable, supportive housing for people with mental illness that provides socialization, on-site treatment, and support services so residents remain housed and functioning in the community instead of homeless, ill, and institutionalized.

Action Steps

- ◆ *Work with Longview Housing Authority and the Affordable Housing Network to increase services available in county.
Define values around housing as a basic need with emphasis on recovery, transition and upward mobility.
On-site managers/case managers, groups homes for adolescents, non-reject able public housing (wet housing).*
- ◆ *Educate county landlords about the purpose and value of Treatment-based Rental Assistance as a way to increase the stock of affordable housing.*
- ◆ *Engage realtors as a community sector to help develop ways to increase the amount of affordable housing.*

Solution 4

Provide supported employment opportunities that identify, honor, and build each person's productive capacity while addressing community mental health and providing stable income.

Action Steps

- ◆ *Engage and support the Chamber and employers, as a community sector, to provide jobs to those with mental illness. Educate employers to understand mental illness and the productive capacity of those in recovery.
Explore and create financial incentives for employers.*
- ◆ *Support those seeking employment: Identify and partner with those who may provide assessment and vocational capacity.
Determine and provide wrap-around services to support success.*

Outcome 2: Mental Health Issues

- ❖❖ The community recognizes mental illness as a health condition that can be effectively managed and treated.
- ❖❖ Through prevention and early intervention the number of people presenting with mental health and co-occurring disorders and the number of people experiencing severe mental illness is significantly reduced.

NOTE: *Solutions and Action Steps for Outcome 2 are addressed in Mental Health Services (Outcome 3) and Service Delivery (Outcome 4)*

Outcome 3: Mental Health Services

- ❖❖ Mental Health services emphasize wellness as well as illness, include screening, assessment, prevention, early intervention, intensive treatment, and rehabilitation/recovery.



Create a prevention and early intervention strategy that intervenes early to eliminate the need for further services. Such a strategy would focus on 1) integration; 2) transitions across the lifespan; 3) need & function rather than diagnosis; 4) age-appropriateness & cultural sensitivity; 5) systemic trauma sensitivity.

Action Steps

- ◆ *Provide continuing medical education to treatment providers regarding evidence-based practice guidelines for screening, non-drug treatment, and mental health medications prescribing.*
- ◆ *Use lay workers, volunteers, and peers to identify and support those who are behaviorally or mentally at-risk.*
- ◆ *Identify new parents' need and encourage participation in parenting skills training and encourage community expectation for this training to be financially available to all. Use culturally-appropriate community health workers to support folks at risk.*
- ◆ *Screen pre-school and school age children for mental/behavioral health risk/protective factors and provide education.*
- ◆ *Provide support for family wellness activities; Restart Family Policy Council-sponsored Lewis County Community Public Health and Safety Network.*
- ◆ *Provide community education and awareness in schools around mental illness to reduce stigma.*
- ◆ *Provide specialized support and advocacy for child victims of abuse and violence.*

Outcome 4: Service Delivery

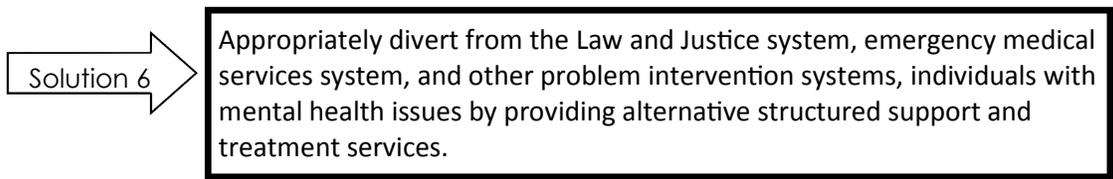
❖❖ Comprehensive community mobilization increases understanding and empowerment with the goal of removing the stigma of mental illness. It also creates community readiness to provide significant interventions and strategies to access those interventions.

❖❖ Thorough multi-disciplinary teams, mental health providers, and the full spectrum of allied health and human services providers (medical, dental, school, vocational rehabilitation, supported employment...) collaborate to provide effective coordinated, non-duplicative care for individual patients. Evidence-based mental health services are seamlessly integrated into primary medical care and other health/human services in a way which provides highly inclusive access on demand to screening, assessment, prevention, early intervention, treatment, and recovery services.

❖❖ A decreased number of people with mental illness enter or reenter the criminal justice system because they: 1) receive adequate prevention or early intervention services prior to offending; 2) are diverted by mental health court or other diversion programs; 3) receive pre- and post-release treatment reduces or eliminates reoffending behavior.

❖❖ A decreased number of people with mental illness visit the hospital emergency department because they are treated adequately in an integrated primary care setting or are diverted through care coordination into effective treatment that eliminates the need for emergent services.

❖❖ The mental health delivery system provides continuous quality improvement based on evidence-based standards of practice, and encourages the involvement and feedback of clients, families, friends, peers, providers, and community. The system provides resources to help those involved identify knowledge and skill gaps, and to facilitate acquisition of knowledge and training to eliminate gaps.



Action Steps
<ul style="list-style-type: none"> ◆ <i>Using GAINS/Sequential Intercept Model to appropriately divert individuals to more appropriate alternatives to incarceration. Create a plan to implement them.</i> ◆ <i>Expand efforts by the law and justice system to recognize co-occurring mental illness in individuals in Drug Court. Consider creating a Mental Health Court.</i> ◆ <i>Train law enforcement and other first responders in crisis intervention (CIT).</i> ◆ <i>Identify individuals with mental illness that are frequently engaged in the law and justice system and create individualized and supportive plans to decrease recidivism with multi-systemic involvement.</i>

Outcome 4: Service Delivery (Continued)

Solution 7

Integrate behavioral health services with primary care, other health settings, schools, and jail.

Action Steps

- ◆ *Extend behavioral health specialist services by developing peer support services.*
- ◆ *Examine possibility of creating “Hub” of specialized behavioral/mental health specialists to support primary care practices.*
- ◆ *Create and use common forms, reports, and collection of common data sets.*
- ◆ *Continue and expand services like the Children’s Oversight Committee and Aging and Adult Services to other service programs.*
- ◆ *Using community forum (in Solution 1), support providers in planning integration.*
- ◆ *Support mental health care in jail system.*
- ◆ *Train culturally-sensitive community health workers (e.g. Promotoras) to support clients in accessing community resources and services.*
- ◆ *Create vehicle to connect and coordinate existing systems and planning processes.*
- ◆ *Support expansion of integrated behavioral health services in federally-qualified health centers (FQHC), and community mental health centers (CMHC).*

Solution 8

Appropriately increase the depth and breadth of mental health treatment services and the community’s capacity to meet community need.

Action Steps

- ◆ *Increase coordination between mental health system and other systems.*
- ◆ *Help retain mental health providers by working to improve compensation. Recruit additional providers by creating/coordinating internships opportunities.*
- ◆ *Explore alternative treatment capacity-community/lay volunteers (e.g. Listeners), faith-based community, peer-to-peer counseling, and neighboring/grand parenting (Whatcom Model).*
- ◆ *Increase capacity to provide non-clinical services to young children and families (e.g. CPS Homebuilders, ECAP/HS kids) in natural settings.*
- ◆ *Exchange professional expertise for no-fee trainings—LEO train MH re: jail, MH train LEO re: MH issues*

Outcome 5: Funding Factors

- ❖❖ Advocating for, creating, and using sustainable private, local, state, and federal funding to support all Lewis County residents with the full continuum of mental health services, regardless of insurance coverage or ability to pay.
- ❖❖ All public and private health insurers provide a comprehensive package of affordable mental health benefits, adequately reimbursing the wide spectrum of qualified licensed providers for the services they provide.
- ❖❖ Mental health services are provided in a manner that creates cost savings, which are then redirected to serve more people. These savings are in the form of cost offsets in medical care and law and justice services, which are created by the provision of early and effective mental health services.



Review and implement traditional and innovative financing options to fund desired improvements noted in this strategic plan.

Action Steps

- ◆ *Complete a comprehensive funding needs assessment.*
- ◆ *Develop a plan and community support for use of the 1/10 of 1% tax to fund mental health and substance abuse programs.*
- ◆ *Identify, harness, and reinvest the available cost offsets in medical care and law and justice resulting from increased mental health services.*
- ◆ *Collaborate across organizations to share funding, write grants, and tap new resources such as faith-based or business resources.*
- ◆ *Advocate for legislative and regulatory changes in mental health benefit design and parity laws to improve reimbursement for evidence-based mental health services provided by qualified providers.*

References

- Armstrong, S.C. & Took, K.J. (1993). Psychiatric managed care at a rural MEDDAC. *Military Medicine*, 11, 717-721.
- Borus, J.F. & Olendzki, M.C. (1985). The offset effect of mental health treatment on ambulatory medical care utilization and charges. *Archives of General Psychiatry*, 42, 573-580.
- Busko, M. (2009). Severe mental illness alone does not predict violent crime. *Medscape Medical News*. Retrieved from <http://www.medscape.com/viewarticle/587839>
- Cummings, N.A., Dorken, H., Pallak, M.S. et al. (1990). The impact of psychological intervention on health care utilization and costs. *Biodyne Institute*, April 1990.
- Community Trade and Economic Development. (2005). Homeless point in time survey, 2005. Retrieved from <http://www.commerce.wa.gov/site/1064/default.aspx>
- Hale, C. (2006). *Lewis County Demographics Study*. [PowerPoint slides, available from Lewis County Public Health and Social Services].
- Lechnyr, R. (1993). The cost savings of mental health services. *EAP Digest*, 22.
- Lewis County Community Health Partnership. (2006). Lewis County Needs Assessment.
- Mental Health Needs Work Group, Funding Sub-committee. (2006).
- Lewis County Community Health Partnership. (2006). Mental Health Needs Work Group, Mapping Sub-committee. [Available from Lewis County Public Health & Social Services].
- Lewis County Sheriff's Office. (2006). Case study report. [Available from Lewis County Sheriff's Office].
- National Alliance on Mental Illness. (2010). What is mental illness: Mental illness facts. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm
- National Survey of Children's Health. (2007). Retrieved from <http://nschdata.org/StateProfiles/CustomProfile07.aspx?rid=5&geo2=Nationwide&geo=Washington>
- State of Washington Department of Corrections. (2008). Mental health treatment services. Retrieved from <http://www.doc.wa.gov/aboutdoc/docs/p351gmentalhealthtreatment-servicesfactsheet.pdf>
- Strosahl, K. (2006). Presentation to Lewis County Needs Assessment Team.

References

United States Census Bureau. (2010). Lewis County Quick Facts. Retrieved from <http://quickfacts.census.gov/qfd/states/53/53041.html>

VandenBos, G.R. & DeLeon, P.H. (1988). The use of psychotherapy to improve physical health. *Psychotherapy, 25*, 335-343.

Washington State Department of Health. (2009). Healthy Youth Survey, 2008. Retrieved from https://www.askhys.net/PDF_Output/HYS92_Public58243093.PDF

Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration. (March, 2010). Retrieved from <http://www.dshs.wa.gov/jra/facts/needs.shtml>

Washington State Department of Social and Health Services, Regional Support Network. (2006) Access to care standards. Retrieved from http://www.dshs.wa.gov/pdf/hrsa/mh/Access_to_Care_Standards20060101.pdf

Partners in Strategic Plan Development

Membership of the Lewis County Community Health Partnership

Centralia College—Dr Cheri Raff, Dean of Child and Family Studies Department
CHOICE Regional Health Network—Doug Busch, Community Development staff
Families Forward—Holli Spanski, Juvenile Court Administrator
Human Response Network— Joan Caywood, Director
Lewis County Economic Development Council— Richard Larmon, Executive Director
Lewis County Public Health and Social Services—Kathleen Eussen, Director
Pope’s Kids Place/ Lewis County Children with Special Needs—Dr. Isaac Pope
Providence Centralia Hospital—Ken Boucher, Assistant Administrator
Thorbecke’s Fitlife Centers-- Jenni Bodnar, General Manager
United Way of Lewis County—Debbie Campbell, Executive Director
Valley View Health Center—Steve Clark, Executive Director
Community Mental Health --Donna Karvia, Vice-President of the Board, TRSN and NAMI Lewis County

Membership of the Mental Health Needs Work Group

Becky Boucher, RN, Lewis County Public Health and Social Services Department
Carolyn Price, MSW, Mental Health Liaison, Lewis County Public Health and Social Services
Chandra Brady, Chief, Lewis County Jail
Cheri Raff, EdD, Centralia College
Donna Karvia, TRSN and NAMI Lewis County
Isaac Pope MD, Pope’s Kids Place
Jennifer Soper-Baker, Lewis County Superior Court
Kathleen Eussen, Director, Lewis County Public Health and Social Services Department
Kennethia Ishman, Washington Association of Community and Migrant Health Centers
Linda Wilcox, MA, Centralia College
Mary Chmelik, ARNP, Pope’s Kids Place
Matt Patten, Cascade Mental Health Care
Rebecca Giardina, RN, Lewis County Public Health and Social Services Department
Rebecca Reibestein, Health Educator, Lewis County Public Health and Social Services
Steve Clark, Executive Director, Valley View Health Center
Sue Killillay, Director, Cascade Mental Health Care
Tara Smith, Social Services Manager, Lewis County Public Health and Social Services
Doug Busch, CHOICE Regional Health Network

Additional Participants

Gail Stewart, RN, Providence Centralia Hospital
Juno Whittaker, Department of Health
Becky Turnbull, ESD 113
Michael Golden, Lewis County Prosecutor
Victoria Byerly, Assistant Prosecutor
Holli Spanski, Lewis County Juvenile Court
Kathleen Mulkins, Salvation Army
Carol Druckman, LOVE, INC
Brett Mitchell, Reliable Enterprises
Doug Wilson, Department of Social and Health Services
Rebecca Ambrose, Lewis County Shelter Program

Our gratitude to the Lewis County Board of County Commissioners for their support

For copies of this report, please contact:

Lewis County Public Health and Social Services
Mental Health Liaison
360 NW North Street
Chehalis, Wa. 98532
360-740-1430

<http://lewiscountywa.gov/publichealth/mental-health>



Always Working For a Safer and Healthier Community