Mental Health Panel 2013

Recommendations

For

Snohomish County

February 2014

Background and Purpose

The Affordable Care Act expands health coverage for citizens who previously were uninsured or under-insured. Expanded coverage includes parity for mental health treatment equal to physical health. While the Affordable Care Act expands coverage, local system coordination and availability of needed services is often challenging for patients, their families and practitioners.

Snohomish County Executive John Lovick convened a mental health panel in the fall of 2013 with the task of identifying ways to improve county services for individuals needing mental health care. The Executive's Office solicited letters of interest to serve on the panel from licensed practitioners working in the non-profit and private sectors.

Panel members held three meetings to discuss improving crisis services, improving access to care, identifying gaps in services, and coordination with health plans and the Regional Support Network. The panel is presenting the following four recommendations to Executive Lovick: Communication and Marketing, Health Insurance Coordination, Mental Health Court, and Mental Health System Capacity and Coordination.

Communication / Marketing

One of the gaps in the current Mental Health (MH) system is the lack of a "No wrong door", easily identifiable access point. Individuals in crisis are often unsure where to turn for help, and as a result inappropriately use 911, First Responders and Hospital Emergency Departments to request services. That is an expensive alternative that costs both the consumer and taxpayers a great deal of money.

This committee proposes the expansion of the existing 2-1-1 call system to provide a centralized, easily recognizable, 24/7 access-point as a gateway to the array of MH services offered in the community. To accomplish this, the following is requested:

1. In order to handle the anticipated increase in call volumes, provide 24/7 shift coverage and ensure prompt and efficient customer service, additional revenue will be needed to cover wages, benefits and training. All staff (including first responders) shall be provided Evidenced Based Best Practice trainings, including (not limited to): ACES (Adverse Childhood Experiences), Crisis Intervention Training, Suicide Intervention, Psychological/Mental Health First Aid and issues related to Aging.

2. Using existing marketing resources provided by WIN 211, staff time will be donated to reach out to educate the community and solidify working agreements with agencies, providers and resources to ensure seamless and relevant referrals to appropriate services.

3. In recognition of our Veterans and their unique needs, Veteran-specific education, training, resources and service program offerings need to be highlighted in communication and marketing materials.

Health Insurance Coordination

Lack of continuity and universal coverage with both commercial and publicly-funded insurance adds to the complexity for accessing MH services. This lack of standardization also imposes barriers for therapists and other practitioners attempting to deliver MH care.

1. Continue and intensify the **dialogue between the major private insurance companies/health plans providing insurance, with county Human Services and the RSN** to discuss options of co-utilizing and co-funding a full spectrum of behavioral health services that are cost effective for all patients regardless of the individual's public or private payment coverage. These services might include crisis beds, partial hospitalization; day treatment programs/peer centers, detox programs, inpatient chemical dependency, residential treatment, crisis housing and support for permanent housing.

2. Advocate with insurance companies to provide **universal coverage for modalities of treatment** sometimes excluded: group therapy, family therapy, partial hospitalization, intensive MH outpatient in which patients can receive counseling several times a week to avoid hospitalization.

3. Develop a **seamless process of coordinated, continued coverage of behavioral health services** including counseling, and psychiatric medication, when an individual is transitioning from one payer source to another. Advocate that payers develop a panel of providers that can accept both public and private reimbursement, rather than separate providers for different funding sources. Changes in coverage are inevitable and a plan/process to prevent costly disruptions in care is needed.

4. Develop a **plan for more community counseling programs to provide sliding scale fees** for counseling for those individuals and families finding it difficult to access services due to high co-share insurance costs.

Mental Health Court

Snohomish County fully embraced the development of a Mental Health Court (MHC) pilot in 2012. To maximize this diversion alternative, a deeper understanding of the existing MHC system (i.e. the charging process) and associated resources (i.e. in-patient treatment, housing, etc.) is needed. Additionally, continued MH training for the MHC team, a notable increase in team involvement, and increased communication would be beneficial.

1. To ensure the maximum results of the MHC pilot, quarterly trainings and collaboration with other specialty courts would be advantageous.

2. To expand the number of participants in the MHC, explore the possible inclusion of felony cases in the MHC pilot. This inclusion would offset the imbalance of misdemeanor charge and length of time in MHC. The addition of a probation officer who is a Master's Level Mental Health Clinician as part of the MHC may curb resistance from the Prosecutor's Office when considering high-risk cases.

Mental Health System Capacity and Coordination

There is insufficient capacity to meet the needs of individuals with MH and/or Chemical Dependency (CD) issues. In addition to capacity, increased coordination is needed as part of a robust system of care as individuals utilize different components of the system.

1. **Increased Funding for Inpatient Psychiatric/Medical Detoxification**
   Increased resources are needed including psychiatric beds for citizens regardless of their ability to pay. As with any behavioral health service we institute, provision needs to be done in an integrated fashion. Hospitalization and Triage for Psych and Detox need to go hand and hand. The current system does not provide much of an opportunity for an integrated approach in acute care settings. Looking at business models including staffing with integrated approaches and co-occurring clinical expertise that make this difficult work possible in these settings is key.

2. **Integrated Co-Occurring Beds for Acute Psych and Detox**
   Increase the number of Triage and Detox beds while making sure that well trained and capable staff are able to handle the co-occurring client as well. Detox for public or non-funded clients is offered but is difficult to access and in extremely short supply in Snohomish County. While private insurance detox is available, possibly those programs may be persuaded to work with the public and unfunded clients and to integrate more with MH.

   If we can offer more truly community-based and coordinated "step down" options for individuals from ER/Hospitalization/Jail in Snohomish County, for the high utilizers in particular, that would be most helpful. The availability must match the need and it is important that continuity of care with other resources beyond these services is provided so that we maximize the potential of these key resources. Unfunded individuals need access to stabilization beds and short-term transitional housing as well. Ideally, these resources would be available in all four quadrants of the County (North, South, East and West).

3. **Triage Personnel in Emergency Room (ER)**
   Having co-occurring trained staff that are an integral part of the "Community Triage Team" in the ER where individuals needing acute behavioral health care show up makes the engagement, referral and continuity of care in this process much more fluid. These staff will be performing the difficult task of client engagement using motivational techniques to hopefully facilitate the client choosing more appropriate service connections. They will be that point of care facilitator getting services sorted out and building rapport so that when the next opportunity comes for connection they will be further along in the engagement process and the client will be more familiar with them and their options. Clinicians working in this capacity will need to be good at resource development and networking. Long term engagement skills and opportunities to use them are very important.

4. **Intensive Co-Occurring Case Management Services**
   It is important that with all of these programs the staff are trained to work with the co-occurring disorder client. Behavioral health outpatient agencies are becoming more and more integrated offering concurrent MH and CD disorder treatment. If ER/inpatient and stabilization programs were more integrated then the co-occurring case management follow-up would be easier. Having co-occurring disorder triage clinicians would change service delivery. Open access can happen if community partners agree to work together.

5. **Communication With and Marketing to First Responders**
   Relationships with Police and EMT/Fire Districts are always crucial; they are a component of the community triage and crisis stabilization team. Working out the details of how to make a referral/bring someone to Crisis Stabilization/Triage or sorting out how things are handled is a process that needs to be established. Quality cross training is critical.

6. **Transitional Housing With Intensive Case Management**
   For longer term stabilization and recovery, quality Intensive Co-Occurring Disorder Outreach, Case Management and Treatment Service Teams would be beneficial. A "Housing First" model works. Offering immediate short-term transitional housing to those entering intensive integrated outpatient services is a key element in helping those in a behavioral health crisis. Many will need longer term housing options as well. Having a system that allows an individual in crisis to remain housed allows for the possibility of a positive outcome and aids in providing outpatient medication management, ongoing detox, relapse prevention and other necessary crisis stabilization services.

Participants

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