Kitsap County Behavioral Health Strategic Plan

February 2014

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ACKNOWLEDGEMENTS

Kitsap County Behavioral Health Strategic Planning Team

August 2013

The Behavioral Health Strategic Planning Team was established and approved by the Kitsap County Board of Commissioners in August 2013. Made up of subject matter experts, this team was responsible to research existing local data for behavioral health service needs, existing capacities, gaps in service, and community readiness to address the needs and gaps. The Team created the Kitsap County Behavioral Health Plan with goals, objectives, and strategies aimed at meeting the behavioral health needs of the Kitsap community.

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Judge James Docter	**Bremerton Municipal Court**
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BACKGROUND

In 2005 Washington State approved legislation allowing counties to raise their local sales tax by one-tenth of one percent to augment state funding of mental health and chemical dependency programs and services (including but not limited to, treatment services, case management, and housing that are a component of a coordinated chemical dependency or mental health treatment program or service) and for the operation or delivery of therapeutic court programs or services - one penny for every $10 of purchases or $10 for every $10,000 of purchases. Programs are required to be new or expanded. To date, 20 counties have adopted this sales tax, including the surrounding Mason, Jefferson, Clallam, and King counties.

Purpose:
To fund a county wide infrastructure for behavioral health treatment programs and services that benefits Kitsap County youth and adults who are impacted by chemical dependency and mental illness. These programs and services will increase public safety as well as reduce the costs of recidivism and unnecessary involvement in the criminal justice system, emergency medical systems, and associated homelessness.

Mission:
Prevent and reduce the impacts of disabling chemical dependency and mental illness by creating and investing in effective, data driven programs for a continuum of recovery-oriented systems of care.

Meaningful Outcomes:
Kitsap County seeks to assure that citizens and policy makers spend the funds collected in an accountable and transparent manner, with community input and support, and with measures to determine the effectiveness of these publicly-funded investments. The county will require appropriate oversight, accountability, and status and progress reports for programs supported with the Treatment Sales Tax. Each funded program will be evaluated according to performance measures regarding cost effectiveness and the ability to attain stated goals. These programs shall achieve the following policy goals:

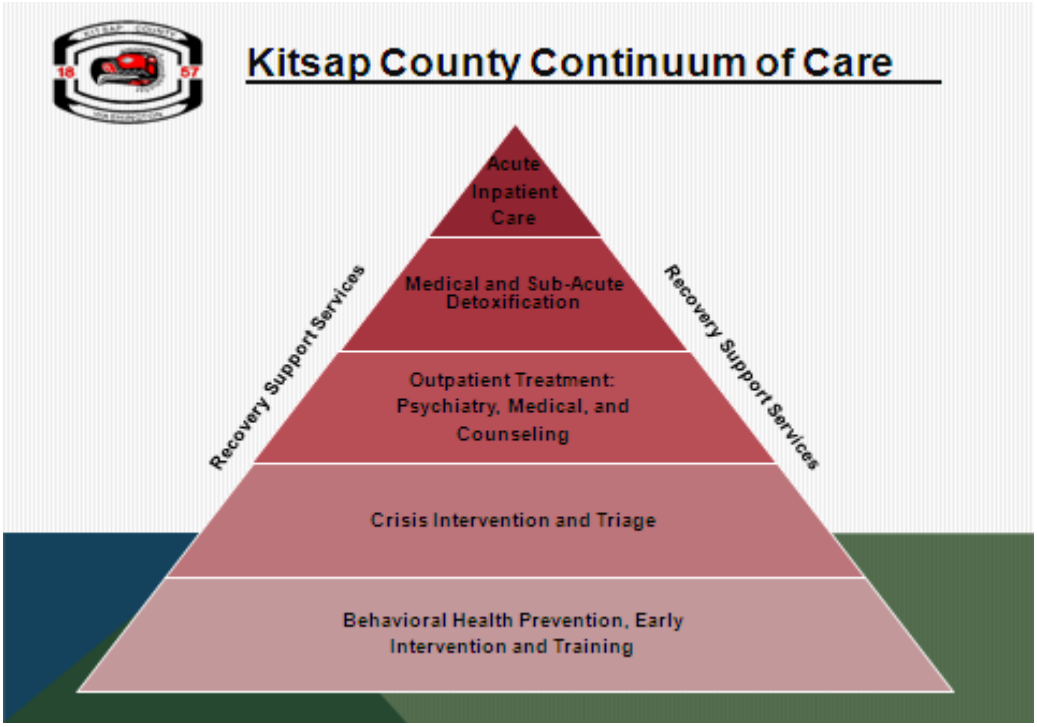
- Improve the health status and wellbeing of Kitsap County residents.
- Reduce the incident and severity of chemical dependency and/or mental health disorders in adults and youth.
- Reduce the number of chemically dependent and mentally ill youth and adults from initial or further criminal justice system involvement.
- Reduce the number of people in Kitsap County who recycle through our criminal justice systems, including jails and prisons.
- Reduce the number of people in Kitsap County who use costly interventions including hospitals, emergency rooms, and crisis services.
- Increase the number of stable housing options for chemically dependent and mentally ill residents of Kitsap County.

DEFINITIONS

Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness.

Co-Occurring Mental and Substance Use Disorders are mental illnesses and substance use disorders that occur together. Sometimes one disorder can be a contributing factor to or can exacerbate the other. Sometimes they simply occur at the same time.

Continuum of Care is a comprehensive approach to addressing behavioral health issues at all levels including prevention, early intervention and training; crisis intervention and triage; outpatient treatment; medical and sub-acute detox; acute inpatient care; recovery support services.



Mental Health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. I n this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

Mental Illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” Under these definitions, substance use might be classified as either a mental health problem or a mental illness, depending on its intensity, duration, and effects.

Mental Health Promotion consists of interventions to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, wellbeing, and social inclusion and to strengthen the ability to cope with adversity. This ability to cope is referred to as resilience.

Mental Health Treatment is the provision of specific intervention techniques by a professional for conditions identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). These interventions should have proven effectiveness, the ability to produce measurable changes in behaviors and symptoms, and should be person-and family-centered and culturally and linguistically appropriate.

Prevention is a step or set of steps along a continuum to promote individual, family, and community health; prevent mental and substance use disorders; support resilience and recovery; and prevent relapse.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. People with mental illnesses can and do recover from these conditions, and hope plays an essential part in overcoming the internal and external challenges, barriers, and obstacles. Controlling or managing symptoms is part of this process. Reducing or eliminating substance use is critical for recovery from addiction.

Recovery Oriented Systems of Care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.'

Recovery Support Services include a focus on providing for the health, housing, vocational, and social support needs of people with mental health problems. These include peer- and family-operated services.

Substance Abuse is defined as the use of alcohol or drugs despite negative consequences.

Substance Use is defined as the consumption of low or infrequent doses of alcohol and other drugs, sometimes called experimental, casual, or social use.

Substance Use Disorders involve the dependence on or abuse of alcohol and/or drugs, including the nonmedical use of prescription drugs

Suicide is a serious problem that causes immeasurable pain, suffering, and loss to individuals, families and communities nationwide. Millions of people consider, plan, or attempt suicide each year; many die as a result.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

ORGANIZATIONAL STRUCTURE

Kitsap County Board of Commissioners is responsible for setting Treatment Sales Tax funding priorities and strategic direction. The Board of Commissioners will adopt the implementation plan(s) for the Treatment Sales Tax funded programs and services, and allocate resources for programs funded under this plan.

Kitsap County Human Service Department has expertise in chemical dependency, mental illness and treatment services, and is responsible for providing professional and administrative staff support to the advisory committee. The Department will implement the program including budget, contract management, oversight, treatment outcomes and evaluation; as well as allocation of Treatment Sales Tax plan and funded programs and services. The department, in consultation with the Citizen Advisory Committee, will develop criteria for distributing Treatment Sales Tax funds for behavioral health services according to the strategic direction and priorities established by the Kitsap County Board of Commissioners. These criteria will include annual performance measures for individual funding recipients and for cumulative progress towards County behavioral health service goals.

The Behavioral Health Strategic Planning Team is made up of subject matter experts and this team is responsible to research existing local data for behavioral health service needs, existing capacities, gaps in service, and community readiness to address the needs and gaps. The Team will create a plan with goals, objectives, and strategies aimed at meeting the behavioral health needs of the Kitsap community. They will make recommendations to the Citizen Advisory Committee for implementing chemical dependency, mental health and therapeutic court treatment services. The team will also provide the advisory committee with technical expertise and education on the continuum of care for treating chemical dependency and mental health in Kitsap County.

The Kitsap County Human Services Director and the Human Service Department will facilitate the team and provide administrative staff support. Members of the Behavioral Health Strategic Planning Team, (to include individuals with expertise in chemical dependency and mental health treatment, therapeutic courts, law enforcement, housing, medical and emergency services, public health, and education) will be appointed by the Kitsap County Board of Commissioners.

Citizen Advisory Committee will assist the County Commissioners in obtaining public input and support for recommending allocation of funds and providing program oversight to ensure a responsible funding process. The Committee also serves as the Review Team in the Request for Proposals (RFP) process and helps guide evaluation of the funded programs. They will review recommendations from the Behavioral Health Strategic Planning Team for implementing chemical dependency, mental health and therapeutic court treatment services and advise the Board of Commissioners regarding funds for treatment programs and services.

CITIZEN ADVISORY COMMITTEE

The Citizen Advisory Committee will be appointed by the Kitsap County Board of Commissioners. This committee serves the citizens of Kitsap County by gathering information,

reviewing options and submitting recommendations for consideration to the Kitsap County Board of Commissioners on the Treatment Sales Tax. Advisory committee responsibilities are to:

1) Review the Behavioral Health Strategic Planning Teams needs assessment, goals, objectives and strategies aimed to meet the behavioral health needs of the community.
2) Review applications for funding based on the Board of Commissioners' strategic direction and priorities and criteria for distribution. Upon assessment of the applications, the committee will recommend to the Board of Commissioners the appropriate proposals and funding levels to meet the County's behavioral health service needs.
3) Annually review performance measures to determine the success of funded proposals and achievement of County behavioral health goals.
4) Submit an annual report to the Board of Commissioners that lists programs funded, amounts allocated and expended, number of individuals served, and performances measured along with recommended program and/or process changes based on the measurement and evaluation data.
5) Review the Behavioral Health Strategic Plan every three years, in coordination with the Request for Proposal process, to assess the overall progress towards achieving Kitsap County's behavioral health goals.
6) Ensure that the implementation and evaluation of the strategies and programs funded by the Treatment Sales Tax are transparent, accountable and collaborative.

The citizen advisory committee will be comprised of 11 members:

- One (1) from the Peninsula Regional Support Network Advisory Board
- One (1) from the Kitsap County Substance Abuse Advisory Board
- One (1) from the Commission on Children and Youth
- One (1) from the Area Agency on Aging
- One (1) from Law and Justice
- One (1) from Education
- Five (5) At-Large representing a broad spectrum of community members whose background and expertise will enhance the function and effectiveness of the Advisory Committee in fulfilling their responsibilities

To ensure continuity, the initial committee will be made up of four members appointed for one-year terms; four members will serve two year terms and five members, three-year terms. Subsequent applicants will be appointed to three year terms.

No citizen advisory committee member shall engage in any activity, including participation in the selection, award, or administration of a sub-grant or contract supported by the Treatment Sales Tax funds if a conflict of interest, real or apparent, exists. Such a conflict would arise when: 1) the individual, 2) any member of the individual's immediate family, 3) the individual's partner, or 4) an organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm or organization selected for award.

THE DEVELOPMENT PROCESS

Substance abuse and mental health services are viewed as existing on a continuum of prevention, intervention, treatment and recovery support services. As with all continuums, the boundaries between one discipline and the next are not always clearly drawn. A comprehensive behavioral health continuum combines many programs, policies, and practices in order to produce significant changes and reduce substance abuse in communities. A continuum of care may include local services ranging from family home visiting programs, to student assistance programs, to outpatient and residential treatment, to community-based ongoing recovery support services.

For purposes of this plan, Kitsap County established the following continuum of care to complete a thorough gap analysis and develop a complete array of recommendations for the behavioral health needs of the County.

Prevention, Early Intervention and Training
Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. Includes evidence based mental health and substance abuse early prevention and intervention parent programs; community and school based curriculums; and training to identify the effects of behavioral health problems.

Crisis Intervention and Triage
Services provided on a very short term basis to intoxicated or incapacitated individuals on the streets or in other public places and may include general assessment of the patient's condition, an interview for diagnostic or therapeutic purposes, and transportation home or to an approved treatment facility. Mobile or other outreach staff at a variety of community sites to identify hard to reach individuals who are abusing alcohol and other drugs, or have a mental illness for the purpose of facilitating their enrollment into treatment, to include motivational counseling, behavioral health information and education, referral to assessment, referral to treatment, and linkage with support services.

Outpatient Treatment – Psychiatry, Medical and Medication Management, Counseling
Group, Individual or family counseling services provided in a non-residential chemical dependency or mental health treatment facility. Services associated with case planning, case consultation and referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. Includes medication management.

Medical and Sub-Acute Detoxification
Treatment of patients either in a medical or social setting while the patient recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

Acute Inpatient Care
Concentrated program of mental health or chemical dependency treatment, individual and group counseling, education, and related activities including room and board in a twenty-four-hour-a-day supervised facility.

Recovery Support Services
Includes a focus on providing for the health, housing, vocational, and social support needs of people with mental health problems. These include peer- and family-operated services.

Development of Key Recommendations
The Behavioral Health Strategic Planning Team was established and approved by the Kitsap County Board of Commissioners in August 2013. Made up of subject matter experts, this team was responsible to research existing local data for behavioral health service needs, existing capacities, gaps in service, and community readiness to address the needs and gaps.

Key informant interviews were conducted with members of the Strategic Planning Team and subject matter experts in the community to identify gaps in service along the above defined continuum of care. A system map was completed with the assistance of the Strategic Planning Team and catalogs an extensive range of services along the continuum that are currently in place. It also identifies local gaps in service. This information, along with a review of local data has been used to establish the following recommendations within this strategic plan.

The overview of needs and key recommendations evolved out of the interviews with the Strategic Planning Team and are presented in the following order:

- Substance Use Disorders and Adults
- Mental Illness and Adults
- Substance Use Disorders, Mental Illness and Youth
- Substance Use Disorders, Mental Illness and Homeless
- Substance Use Disorders, Mental Illness and the Adult Criminal Justice System
- Substance Use Disorders, Mental Illness and the Juvenile Justice System

Data and recommendations for gaps in service along the continuum of care are presented for each topic listed above.

OVERVIEW OF NEED AND KEY RECOMMENDATIONS

Substance Use Disorders and Adults

Substance Abuse is a Key Driver of adverse outcomes across the spectrum of health and human services delivery systems. In the areas of medical service utilization and potentially avoidable medical costs, research has shown that substance abuse 1) increases the risk of injuries, accidents, and overdoses requiring hospitalization[1], 2) increases the risk of acquiring infectious diseases such as HIV/AIDS or hepatitis[2], and 3) causes drug-seeking behavior associated with extreme Emergency Department (ED) utilization[3]. Prior research has also shown that providing treatment to persons with substance use disorders reduces inpatient admissions, ED utilization, and medical costs[4]. Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain - they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs. Addiction is a treatable disease. Discoveries in the science of addiction have led to advances in drug abuse treatment that help people stop abusing drugs and resume their productive lives[5].

2011 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) Highlights[6]:

- In 2011, an estimated 22.5 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.7% of the population aged 12 or older.
- The rate of current illicit drug use among persons aged 12 or older in 2011 (8.7%) was similar to the rate in 2010 (8.9%).
- Marijuana was the most commonly used illicit drug. In 2011, there were 18.1 million past month users. Between 2007 and 2011, the rate of use increased from 5.8% to 7.0%, and the number of users increased from 14.5 million to 18.1 million.
- The number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000).

In Kitsap County[7]:

- Alcohol has remained the drug of choice for individuals admitted to publically funded treatment from 41% in 2007 to 37% in 2012.

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[1] World Health Organization (2011). Global status report on alcohol and health. WHO Press: Geneva, Switzerland.
[2] Milloy, MJS, et al. (2010). Inability to access addiction treatment and risk of HIV infection among injection drug users recruited from a supervised injection facility. Journal of Public Health, vol. 32:342-349.
[3] Nordlund, D., Mancuso, D., and Felver, B. (2004). Chemical Dependency Treatment Reduces Emergency Room Costs and Visits. Olympia, WA: DSHS Research and Data Analysis Division, http://publications.rda.dshs.wa.gov/887/.
[4] For example, see Mancuso, D. and Felver, B. (2010). Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment. Olympia, WA: DSHS Research and Data Analysis Division, http://publications.rda.dshs.wa.gov/1417/.
[5] National Institute on Drug Abuse (2013)
[6] 2011 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, 2012
[7] SCOPE-WA Kitsap County Data January 1, 2012 – December 31, 2012

- Methamphetamine as a drug of choice has been relatively stable for individuals admitted to publically funded treatment from 26% in 2007 to 22% in 2012.
- Marijuana as a drug of choice has also been relatively stable for individuals admitted to publically funded treatment from 20% in 2007 to 17% in 2012.
- Increase in homelessness for individuals admitted to publically funded treatment from 4% in 2007 to 12% in 2013.
- Methamphetamine use has stayed consistent for individuals admitted to publically funded treatment from 27% in 2007 to 26% in 2013.
- Increase in heroin as drug of choice for individuals admitted to publically funded treatment from 4% in 2007 to 9% in 2013.

PREVALENCE In Kitsap County[8]

Definition: The number of individuals (at or below 200% federal poverty level) in need of Chemical Dependency treatment. The prevalence estimates were developed by the Department of Social and Health Services Research and Data Analysis Division (RDA) using data from the National Survey on Drug Use and Health, adjusted using Washington State Office of Financial Management (OFM) population estimates.

Past Year Need for Alcohol or Illicit Drug Treatment (2011)

	Youth Ages 12-17			Adults Ages 18+		
	Prevalence Rate	Population in Need	Population in need as % of state total	Prevalence Rate	Population in Need	Population in need as % of state total
Statewide Total	**8.7%**	**15,285**	**100.0%**	**11.9%**	**159,621**	**100.0%**
Kitsap	9.4%	486	**3.2%**	12.4%	4,712	**3.0%**

PENETRATION In Kitsap County

Definition: This calculation was done using the number of individuals (at or below 200% federal poverty level) receiving Chemical Dependency treatment relative to the number in need. This includes admissions, intensive outpatient, outpatient, group care enhancement, and Opiate Substitution Treatment data. Detox is not included. The second table includes admission, IOP, OP, OST, group care enhancement, and adds in residential treatment.

Past Year Population Receiving Outpatient (OP) or Opiate Substitution Treatment (OST) Penetration (2011)

	Youth				Adult			
	Need	OP/OST Served*	Penetration Rate	Admission as % of State Total	Need	OP/OST Served*	Penetration Rate	Admission as % of State Total
State Total	**15,285**	**6,203**	**41%**	**100.0%**	**159,261**	**40,398**	25%	**100.0%**
Kitsap	486	214	44%	**3.4%**	4,712	1,215	26%	**3.0%**

[8] Department of Social and Health Services Research and Data Analysis Division (RDA) using data from the National Survey on Drug Use and Health

Past Year Population Receiving Residential, Outpatient, or Opiate Substitution Treatment Penetration (2011)

	Youth				Adult			
	Need	AOD Tx Served*	Penetration Rate	Admission as % of State Total	Need	AOD Tx Served*	Penetration Rate	Admission as % of State Total
State Total	**15,285**	**7,370**	**48%**	**100.0%**	**159,261**	**47,209**	**30%**	**100.0%**
Kitsap	486	218	45%	**3.0%**	4,712	1,512	32%	**3.2%**

RATES OF CO-OCCURRING SERIOUS PHYSICAL HEALTH CONDITIONS AND ALCOHOL AND OTHER DRUG TREATMENT NEEDS (2011)

This data was compiled by RDA. High health risk is determined using a PRISM risk score that indicates an individual is eligible for health home care.

	Youth				Adult			
		High Cost Clients				High Cost Clients		
	OP/IOP Admits	# in county	% of county	% of statewide	OP/IOP Admits	# in county	% of county	% of statewide
Statewide	5,156	1,287	25%	100.0%	27,758	6,938	25%	100.0%
Kitsap	158	21	13%	1.6%	922	241	26%	3.5%

Assessment of Capacity and Distribution of Pain and Addiction Medicine Providers for Kitsap County

In May of 2013, the Kitsap Public Health District conducted a survey of pain and addiction medicine providers in the Kitsap County Region. This survey was precipitated by the sudden closure of a single practice within Kitsap County resulting in 200 patients seeking services overnight. In addition, a phone interview was conducted with over a dozen pain and addiction clients seeking services during this survey period. The purpose of the provider survey was to assess the distribution and capacity of pain and addiction medicine providers. Summary of the findings include:

1. Only one provider on a limited basis was available to provide services in Kitsap County. All other providers (thirty-two) are from outside the county.
2. This creates transportation limitations for those who rely on public transportation.
3. The majority of providers are taking new patient referrals however; the majority do not take Medicaid or Medicare.
4. There are no Methadone replacement providers within Kitsap County.

Having the diagnosis of chronic pain and/or addiction coupled with the lack of insurance or the presence of Medicaid/Medicare creates a gap in service delivery in Kitsap County. When talking to patients looking for medical providers, there has been a high level of frustration trying to find services when a single provider within the county closed their doors. Many of these clients have turned to the Emergency Department (ED) or to street drugs in an effort to treat their pain and/or addiction.

Key Recommendations to Address Local Gaps in Service for Adult Substance Use Disorders:

Gap #1: Behavioral Health Prevention, Early Intervention and Training
Recommendations:

- Support shared plan through ongoing collaboration and increased care coordination among mental health, substance abuse, health and justice stakeholders through joint projects, blended funding, information sharing, and cross-training.
- Train all systems on community resources and substance abuse treatment options including inpatient, outpatient, medication assisted, detoxification services and crisis triage.
- Educate local substance abuse treatment providers on Veteran's issues and available resources.
- Provide substance use disorder education and training to providers working with the aging population.
- Provide consistent substance use disorder consultation to providers working with the aging population.
- Embed strategies for working with individuals with substance use disorders within the existing local CNA/ LPN/ nursing curriculum
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

Gap #2: Crisis Intervention/Triage Services
Recommendations:

- Establish specialized homeless outreach services, including specialized outreach to Veterans.
- Establish specialized geriatric outreach team to assist providers working with the aging population.
- Provide substance abuse disorder screening, brief intervention, and referral for treatment for youth, adults and older adults in primary care.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Recommendations:

- Increase substance abuse treatment funding for individuals who are not eligible for Medicaid, including individuals on Medicare, Veterans and do not have private insurance.
- Increase access and options for medication assisted treatment.
- Increase efforts to attract more providers within Kitsap County to provide pain and addiction consultations.
- Expand family education, involvement and support activities for individuals in outpatient substance use disorder treatment.
- Increase dual-certification among mental health and substance abuse treatment providers for addressing all of the individuals behavioral health needs.

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:

- Dedicate funds for out of county medical detoxification services and explore options for a local medical detoxification provider.

- Explore local options for a local medical detoxification provider.

Gap #5: Acute Inpatient Care Services
Recommendations:
- Increase number of local residential substance abuse treatment beds.
- Expand family education, involvement and support activities for individuals in residential substance use disorder treatment.

Gap #6: Recovery Support Services
Recommendations:
- Address barriers to accessing treatment by increasing treatment options and locations in Bainbridge Island, North and South Kitsap.
- Identify transportation barriers to getting to treatment and increase transportation options
- Provide funding for recovery supportive services for individuals with a Substance Use Disorder while in treatment including child care, transportation, and employment.

Mental Illness and Adults

Mental health plays an important role in our overall well-being. An estimated 19.6 percent of Americans ages 18 and older—about one in five adults—will experience a mental health problem this year. But studies show that most people with mental problems get better, and many recover completely. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[9]

Mental illnesses are caused by a combination of biological, social, and psychological factors. Environmental stressors experienced in childhood increase the likelihood that a child will later have a diagnosable mental illness[10]. Every one of us experiences the effects of mental illness. Some of us know the consequences of this disorder personally or in the lives of our loved ones. Others may have friends or co-workers who suffer from this disease. On a societal level mental illness results in higher costs to tax payers from increased arrests, lower rates of high school completion and employment, and higher health care costs.

Nationally:
- Half of Americans will have a diagnosable mental illness at some point in their lifetime[11].
- During any given year, 19% of adults experience a mental illness[12].

[9] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2013). Community Conversations About Mental Health

[10] . Perry, B., Pollard, R., Blakley, T., Baker, W., & Vigilante, D. (1995). Childhood Trauma: The Neurobiology of Adaptation and 'Use-Dependent' Development of the Brain. Infant Mental Health Journal

[11] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication. Arch Gen Psych 2005;62:617-27.

[12] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (NSDUH Series, H-45, HHS Publication No. (SMA) 12-4725).

- A 2005 Department of Justice report indicated that 56% of state prisoners and 64% of jail inmates experienced mental health problems[13].
- It is estimated that almost 70% of youth in the justice system have a diagnosable mental disorder[14].

In Kitsap County:

- The Peninsula RSN, including Kitsap County, has the highest rate of youth psychiatric inpatient hospitalizations in the State.
- The Peninsula RSN, including Kitsap County, had the highest number of boarded individuals in October 2013 ever recorded.

Providing for and supporting good mental health is a public health issue just like assuring the quality of drinking water or preventing and managing infectious diseases. Communities prosper when the mental health needs of community members are met. Unaddressed mental health issues can have a negative influence on homelessness, poverty, employment, safety, and the local economy[15].

- Approximately one in five Americans will have a mental health problem in any given year, yet only a little over one in three people with a mental health problem will receive mental health services.
- Over 38,000 Americans died by suicide in 2010, making the number of Americans who die by suicide more than double the number who died by homicide.
- One-third of individuals with severe mental illnesses who receive community mental health services after lengthy stays in a state hospital achieve full recovery in psychiatric status and social function, and another third improve significantly in both areas.
- Of the more than six million people served by state mental health authorities across the nation, only 21 percent are employed.

Prevention-focused interventions have been shown to reduce the likelihood that problems evolve into diagnosable mental illness or substance abuse disorders. These interventions can also reduce the impact of existing disorders[16]. Despite the effectiveness of mental health prevention and treatment, not all individuals are getting the help they need. Lack of insurance, physical limitations, stigma, and strict access to care standards are some reasons individuals might not be accessing services. In some cases, the resources aren't available.

- As the rate of mental illness increases, the amount of state funded resources continues to decrease. For example, between 2000 and 2010, the number of involuntary treatment act-certified beds in Washington State decreased by 36%.
- Washington State ranks 47th in the nation in number of psychiatric beds per capita[17].

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[13] U.S. Department of Justice, Office of Justice Programs. (2006). Bureau of Justice Statistics special report: mental health problems and jail inmates (NCJ213600).

[14] Skowyra, K., & Cocozza, J. (2006). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. Delmar, NY: The National Center for Mental Health and Juvenile Justice and Policy Research Associates, Inc.

[15] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2013). Community Conversations About Mental Health

[16] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2013). Community Conversations About Mental Health

[17] M. Burley. (2011). Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts (Document No. 11-10-3401). Olympia: Washington State Institute for Public Policy.

- The Centers for Disease Control reports that only half of children with mental disorders received treatment for the disorder in the past year.[18]

Key Recommendations to Address Local Gaps in Service for Adult Mental Illness:

Gap #1: Behavioral Health Prevention, Early Intervention and Training
Recommendations:

- Support shared plan through ongoing collaboration and increased care coordination among mental health, substance abuse, health and justice stakeholders through joint projects, blended funding, information sharing, and cross-training.
- Educate the community on Healthy Option Services and Medicaid Expansion.
- Educate local mental health treatment providers on Veteran's issues and available resources.
- Provide mental health education and training to providers working with the aging population.
- Provide consistent mental health consultation to providers working with the aging population.
- Embed strategies for working with individuals with mental illness within the existing local CNA/ LPN/ nursing curriculum.

Gap #2: Crisis Intervention/Triage Services
Recommendations:

- Establish specialized homeless outreach services, including specialized outreach to Veterans.
- Establish specialized geriatric outreach team to assist providers working with the aging population.
- Provide mental health screening, brief intervention, and referral for treatment for adults and older adults in primary care.
- Provide Crisis Triage/Respite and/or Drop Off Center alternative for individuals with Behavioral Health needs not eligible for acute hospital or Evaluation and Treatment Services but are in need of short term 24 hour services, including assessment and referral.
- Explore advance beds for dementia patients who are not currently accepted by Western State or Kitsap Mental Health Services.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Recommendations:

- Increase mental health treatment funding for individuals who are not eligible for Medicaid, the uninsured, and Veterans not eligible for benefits.
- Increase dual-certification among mental health and substance abuse treatment providers for addressing all of the individuals behavioral health needs.
- Expand Community Mental Health Center services to include individuals who are not eligible for Medicaid.
- Explore geriatric population needs.

[18] Center for Disease Control, National Health and Nutrition Examination Survey. http://www.cdc.gov/nchs/nhanes/about_nhanes.htm#data

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:

- Educate mental health providers on available Emergency Housing, Detoxification and Crisis Triage beds at Kitsap Recovery Center.

Gap #5: Acute Inpatient Care Services
Recommendations:

- Increase number of local mental health inpatient beds for adults, including gero-psychiatric beds.
- Increase capacity for Program for Assertive Community Treatment (targeting 18-40 years olds with Axis 2 diagnosis).
- Increase number of local co-occurring disorder residential mental health/substance abuse treatment beds.

Gap #6: Recovery Support Services
Recommendations:

- Explore local reimbursement options implemented in Pierce and Clallam Counties.
- Explore local cursory competency evaluation for out of custody, low risk offenders.
- Address barriers to accessing treatment by increasing treatment options and locations in Bainbridge Island, North and South Kitsap.
- Identify transportation barriers to getting to treatment and increase transportation options
- Assess the mental health service needs of an aging population.
- Recruit existing organizations/individuals to develop a mental health support group similar to AA/NA.
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

Mental Illness and Substance Use Disorders in Youth

The research supports the need for prevention and early intervention strategies to address the mental, emotional and behavioral problems that can occur throughout a young person's life. Young people experience some of the highest prevalence rates of mental illness and yet have some of the lowest help seeking rates of any group. Additionally, childhood emotional and behavioral disorders are the most costly of all illnesses in children and youth.

Nationally:

- Half of adult mental health problems begin before age 14, and three-quarters begin before age 24.[19]
- In 2007, 8.2 percent of adolescents, an estimated 2.0 million youths aged 12 to 17, experienced at least one major depressive episode.[20]
- Binge drinking and heavy alcohol use peaks between those aged 18-25, with nearly 40 percent of people in that age group reporting binge drinking and 12 percent reporting heavy alcohol use.[21]

[19] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (2012)
[20] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Data Spotlight: Major Depressive Episode among Adolescents Living in Poverty (2012)

- Suicide is the third leading cause of death among youth ages 15-24.[22]
- One survey found that in a 12-month period, almost 13.8 percent of high school students had seriously considered suicide, 10.9 percent of high school students had made a suicide plan, and 6.3 percent of high school students attempted suicide at least once.[23]

In Kitsap County:

- Rates of major depression in Washington State are among the highest in the nation for youth aged 12 to 17[24] .
- Depression is closely linked to suicide, and 18% of tenth graders in Washington reported having serious thoughts about suicide in the past year[25] .
- The number of youth treated in publically funded outpatient treatment fell slightly from 177 in 2007 to 148 in 2012[26].
- Youth age 14 and under admitted to treatment rose from 8% in 2007 to 20% in 2012.
- The primary drug of choice remained marijuana, with 62% in 2007 rising to 78% in 2012.
- Alcohol remained the secondary drug of choice, with 27% in 2007 decreasing to 14% in 2012.
- Methamphetamines were the tertiary drug of choice with 9% in 2007 decreasing to 3% in 2012.
- Youth in treatment who identified their age of first use at age 11 or under increased from 23% in 2007 to 33% in 2012.

In the Fall of 2012 more than 200,000 students in grades 6, 8, 10 and 12 took the Washington State Healthy Youth Survey. The following charts document prevalence of substance use, mental health concerns and perceptions of harm for students in Kitsap County.

[21] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings (2012)

[22] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Vital Statistics System, National Center for Health Statistics (2010)

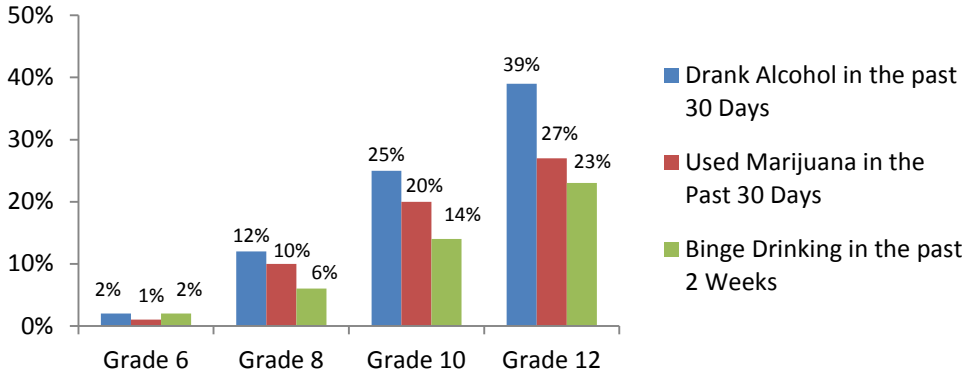
[23] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2010) Youth risk behavior surveillance—United States, 2009

[24] DOH 2010 Washington Healthy Youth Survey

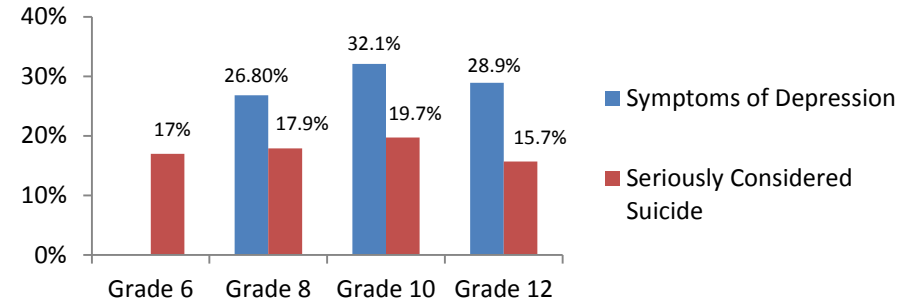
[25] Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and cause of death among public mental health clients in eight states. PrevChronic Dis [serial online] 2006 Apr [July 30, 2013].

[26] SCOPE-WA Kitsap County Data January 1, 2012 – December 31, 2012

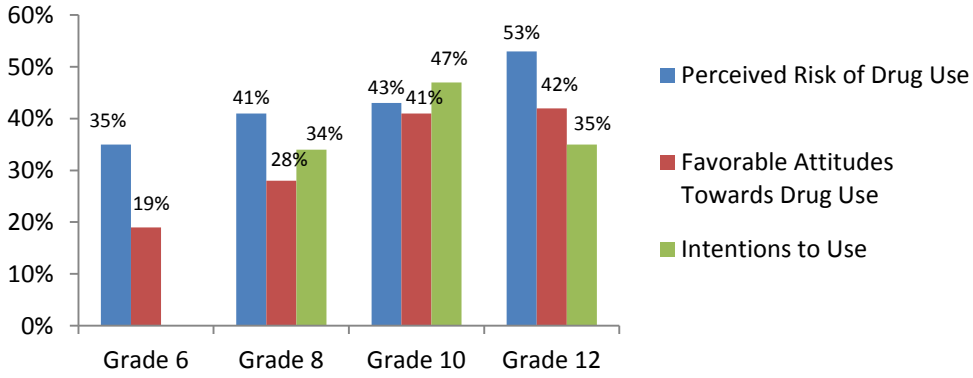
Kitsap County Healthy Youth Report 2012 – Prevalence of Drug and Alcohol Use[27]



Kitsap County Healthy Youth Report 2012 – Prevalence of Mental Health Concerns[28]



Kitsap County Healthy Youth Report 2012 – Perceptions of Drug Use[29]



Youth with mental health and substance abuse service needs often experience a number of additional family, school and life stressors that can make high school participation and success difficult. One Washington State study found[30]:

- Youth with behavioral health needs were less likely to graduate from and more likely to drop-out of high school than youth without behavioral health needs. Youth with co-occurring needs were the least likely to graduate on time (12 percent) and most likely to drop-out (80 percent).

[27] Kitsap County Healthy Youth Report (2012)
[28] Kitsap County Healthy Youth Report (2012)
[29] Kitsap County Healthy Youth Report (2012)
[30] Behavioral Health Needs and School Success, Washington State Department of Social and Health Services, Research and Data Analysis Division (2013)

- Youth with behavioral health needs had poor test outcomes, suggesting that school difficulties began early. Youth with co-occurring behavioral health needs were least likely to meet standard on 10th grade reading (34 percent) or math (9 percent) tests.
- Graduation rates varied by diagnostic category, with the lowest graduation rates found among youth with substance abuse, psychotic disorders, bipolar disorder and/or ADHD.
- Youth with behavioral health needs were more likely to experience an array of challenges and risk factors that are also associated with educational failure, including juvenile justice involvement, homelessness, early childbirth, school mobility and emergency room use.

Prevention is a step or set of steps along a continuum to promote individual, family, and community health; prevent mental and substance use disorders; support resilience and recovery; and prevent relapse. Prevention interventions help to reduce the likelihood of developing a mental illness or a substance use disorder and can help delay the onset or reduce the severity of a mental illness. Some important ways that we can promote mental health and prevent mental illness and substance use disorders is to increase protective factors and use promising strategies that address the needs of children, adults, and families in the community.[31] The research supports the need for prevention and early intervention strategies to address the mental, emotional and behavioral problems that can occur throughout a young person's life[32].

- By preventing a child from becoming dependent on alcohol, we can save approximately $700,000 over the course of the child's lifetime[33].
- By helping a child graduate from high school that would otherwise have dropped out, we can save as much as $388,000 over the course of the child's lifetime[34].
- When juvenile drug courts utilize a wide range of non-detentionbased sanctions, they can exerience cost-savings as high as $5,000 per participant[35].

Schools play a critical role in ensuring that behavioral problems are identified early so that young people can grow and thrive in a healthy environment. Schools can lead coordination efforts in bringing youth-serving agencies together to guarantee that children, youth, and families can easily access services that are community based, child centered, family focused, and culturally and linguistically competent. A Substance Abuse and Mental Health Services Administration (SAMHSA) study indicated that most youths age 12-17 receiving mental health services in the last year received them at school (11.5%)[36].

- Only 2.3% of adolescents receiving mental health services for emotional or behavioral problems received that care at a mental health clinic or center.
- Another 9.4% received counseling from a private therapist.
- The most common reason adolescents sought counseling was for depression.

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[31] Community Conversations About Mental Health Information Brief, Substance Abuse and Mental Health Services Administration (2013)

[32] Community Conversations About Mental Health Information Brief, Substance Abuse and Mental Health Services Administration (2013)

[33] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Promoting Recovery and Resilience for Children and Youth Involved in the Juvenile Justice and Child Welfare Systems (2012)

[34] Ibid

[35] Van Warmer and Lutz, Exploring the Value of Juvenile Drug Courts (2011)

[36] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (February 19, 2009). The NSDUH Report: Adolescent Mental Health: Service Settings and Reasons for Receiving Care. Rockville, MD.

Many high risk students do not have access to private counseling or might not meet the stringent access to care standards of the community mental health system. Offering prevention and treatment services where children are most likely to seek help (educational settings, for example) increases the likelihood that they will follow through on treatment.

Key Recommendations to Address Local Gaps in Service for Youth with Mental Illness and/or Substance Use Disorders:

Gap #1: Behavioral Health Prevention, Early Intervention and Training
Recommendations:

- Support shared plan through collaboration and increased care coordination among mental health, substance abuse, positive youth development programs, and schools through joint projects, blended funding, information sharing, and cross-training to prevent and reduce youth behavioral health issues.
- Expand mental health and substance abuse prevention coalitions countywide.
- Expand evidence based mental health and substance abuse early prevention and intervention parent programs (Example: Nurse-Family Partnership Program and Strengthening Families).
- Provide school-based mental health and substance use prevention education for students to include intervention, assessment, referral and treatment support.
- Conduct professional development for educators, youth development and community agencies on youth mental health and substance abuse issues, concerns and supportive intervention strategies.

Gap #2: Crisis Intervention/Triage Services
Recommendations:

- Expand school-based mental health and substance use prevention, outreach, assessment, intervention, referral and treatment.
- Establish Suicide Prevention, Screening and Referral options in schools and the community.
- Provide mental health and substance abuse screening, brief intervention and referral for youth in primary care.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services

Recommendations:

- Increase access to community mental health and substance use disorder outpatient treatment for non-Medicaid and uninsured youth.

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:

- Dedicate funds for out of county medical detoxification services for youth and explore options for a local medical detoxification provider.

Gap #5: Acute Inpatient Care Services
Recommendations:

- Increase the number of local inpatient beds for youth with mental illness and substance use disorders.

Gap #6: Recovery Support Services
Recommendations:

- Address barriers to accessing treatment by increasing treatment options and locations in Bainbridge Island, North and South Kitsap for youth.
- Identify transportation barriers to getting to treatment and increase transportation options
- Expand parent education, involvement and support activities for youth with mental health and substance use disorders.
- Increase wrap-around services for serious emotionally disturbed youth.
- Recruit existing organizations/individuals to develop a mental health support group similar to AA/NA for youth.
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

Mental Illness and Substance Use Disorders in the Homeless

The Impact of Mental Health and Substance Use Disorders on Homelessness:
Nationally it is estimated that 20 to 25% of the homeless population in the United States suffers from some form of severe Mental Illness. In comparison, only 6% of Americans are severely Mentally Ill. In a 2008 survey performed by the U.S. Conference of Mayors, 25 cities were asked for the three largest causes of homelessness in their communities. Mental Illness was the third largest cause of homelessness for single adults (mentioned by 48% of cities). For homeless families, Mental Illness was mentioned by 12% of cities as one of the top 3 causes of homelessness[37].

Substance use problems are both a consequence of and a leading factor in the continuance of homelessness among individuals. It is estimated that nearly half of all individuals experiencing homelessness, and 70 percent of Veterans experiencing homelessness, suffer from substance use disorders. A majority of those with Substance Use Disorders also suffer from moderate to severe Mental Illness. Substance use is also a prevalent characteristic among unaccompanied youth[38]. Data from research conducted in the past five years indicates that:

- About 30% of people who are chronically homeless have mental health conditions.
- About 50% have co-occurring substance use problems[39].

Homelessness in Kitsap County: On any given day there are estimated to be more than 500 people living on the streets, in vehicles, and in the woods of Kitsap County, in shelters, in transitional housing, or with friends and family in temporary situations[40]. Homelessness costs our community. Each year, Kitsap County residents' tax dollars are spent caring for homeless people through our emergency services – 911, emergency rooms and clinics, law

[37] Mental Illness and Homelessness, National Coalition for the Homeless (2009)
[38] United States Interagency Council on Homelessness (2013)
[39] Current Statistics on the Prevalence and Characteristics of People Experiencing Homeless in the United States, Substance Abuse and Mental Health Services Administration (2011)
[40] Heading Home: Kitsap Homeless Housing Plan 2012, Kitsap Regional Coordinating Council (2012)

enforcement, fire and rescue units, jails, detoxification programs, the judiciary system and more[41]. The Point In Time Count is an annual count (a single 24 hour period, not reflective of total number homeless over the year) of sheltered and unsheltered homeless person's in Washington. Of the 523 individuals counted in 2012, participants gave many and varied reasons for becoming homeless. Combining overarching themes the following emerge as reasons contributing to homelessness:

- Economic factors and job loss top the list - 279 or 53%
- Family break-up, domestic violence - 196 or 37%
- Re-entering the community from jail, prison, or mental institution - 154 or 30%
- Eviction or the ending of a temporary living situation – 142 or 27%
- Medical or mental health issues – 95 or 18%
- Alcohol or drug use – 95 or 18%

Prevalence of Housing for Individuals discharged from behavioral health treatment facilities in the 12 months following a client's last discharge month in State Fiscal Year (SFY) 2010[42]:

- Nearly half of the 9,909 clients discharged from residential chemical dependency (CD) treatment facilities had an indication of housing need, yet only 18 percent of those in need received housing assistance.
- Approximately 30 percent of the 1,792 clients discharged from state mental health hospitals had an indication of housing need, yet only 17 percent of those in need received housing assistance.
- Housing need was identified through multiple service systems. Of particular note, 32 percent of residential CD treatment facility leavers and 39 percent of state mental hospital leavers had housing need identified through the chemical dependency and mental health systems, respectively.

Institutional discharge can be a particularly vulnerable time in terms of housing stability[43]. Washington State Department of Commerce's Ten-Year Homeless Plan therefore aims to reduce the proportion of individuals experiencing homelessness following release from institutions[44]. Kitsap Homeless Housing Plan 2012 update has established it a priority to reduce the proportion of individuals experiencing homelessness following release from institutions as well.

Key Recommendations to Address Local Gaps in Service for Housing for Individuals with Mental Illness and Substance Use Disorders:

Gap #1: Behavioral Health Prevention, Early Intervention and Training Recommendations:

- Support shared plan through collaboration increased care coordination among mental health, substance abuse, and housing stakeholders through joint projects, blended funding,

[41] Heading Home: Kitsap Homeless Housing Plan 2012, Kitsap Regional Coordinating Council (2012)
[42] Department of Social and Health Services Research and Data Analysis Division (RDA), The Status of Individuals Discharged from Behavioral Health Treatment Facilities (2012)
[43]See, for example: Metraux, Stephan, Thomas Byrne, and Dennis Culhane (2010). "Institutional Discharges and Subsequent Shelter Use Among Unaccompanied Adults in New York City," *Journal of Community Psychology*, Vol. 38(1): 28-38.
[44]Ten-Year Homeless Plan: 2008 Annual Report, http://www.commerce.wa.gov/site/823/default.aspx

information sharing, and cross-training to assist and support persons with behavioral health disorders in finding permanent housing.
- Train the homeless/housing system on community resources and behavioral health treatment options including inpatient, outpatient, medication assisted, detoxification services and crisis triage.

Gap #2: Crisis Intervention/Triage Services
Recommendations:
- Establish mental health and substance use outreach to individuals who live on the street, the woods or in their cars.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Recommendations:
- Develop shelter-based mental health and substance use prevention, withy interlocking referrals among agencies, outreach, assessment, intervention, referral and treatment.

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:
- Enhance linkage at intake and discharge to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, and mental health & substance abuse treatment.

Gap #5: Acute Inpatient Care Services
Recommendations:
- Enhance linkage at intake and discharge to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, and mental health & substance abuse treatment.

Gap #6: Recovery Support Services
Recommendations:
- Increase case management and discharge planning to increase linkages to Mental Health and Substance Use Disorders Treatment.
- Increase project based subsidized housing vouchers for individuals in Behavioral Health treatment.
- Provide appropriate tailored subsidized housing and support services for homeless individuals or persons at risk of homelessness with Behavioral Health issues.
- Establish stabilization transition housing for individuals with Behavioral Health issues moving from jail to treatment.
- Establish flexible rental assistance funds for individuals with Behavioral Health needs.
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

Mental Illness and Substance Use Disorders and the Adult Criminal Justice System

The over-representation of persons with serious mental illnesses in the criminal justice system has been a concern for several decades[45]. Nationally there are high rates of mental illnesses and substance abuse problems among people in the criminal justice system.

- The prevalence of persons with serious mental illness among people entering jails is 16.9%[46].
- In 2005, individuals who experienced mental health problems accounted for 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates[47].
- 80% of adult jail and prison inmates have at least one substance use problem[48].
- Almost two-thirds (64.5 percent) of the inmate population in the U.S. (1.5 million) meet medical criteria for an alcohol or other drug use disorder[49].
- Approximately one quarter of people held in US prisons or jails have been convicted of a drug offense[50].

In Kitsap County:

- Based on national trends, approximately 6,400 individuals in the Kitsap County jail annually experience a mental health problem.
- Based on national trends, approximately 8,000 individuals in the Kitsap County jail annually experience a substance use problem.
- In 2011, 873 individuals (ages 18+) in Kitsap County were arrested for alcohol violations[51].
- In 2011, 514 individuals (ages 18+) in Kitsap County were arrested for drug violations[52].
- Over 140 individuals in Kitsap County participate in Adult Drug Court annually.
- Over 17 – 20 individuals in Kitsap County participate in the new Veteran's Treatment Court.

Treatment shows evidence of reducing crime and increasing public safety:

- Increases in admissions to substance abuse treatment are associated with reductions in crime rates.
- Increased admissions to drug treatment are associated with lower incarceration rates.
- Substance abuse treatment helps in the transition from the criminal justice system to the community.
- Substance abuse treatment is more cost effective than prison or other punitive measures[53].

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[45] The Next Generation of Behavioral Health and Criminal Justice Intervention: Improving Outcomes by Improving Interventions, Center for Behavioral health Services and Criminal Justice Research (2011)

[46] Steadman (2009)

[47] U.S. Department of Justice, Office of Justice Programs. (2006). Bureau of Justice Statistics special report: mental health problems and jail inmates (NCJ213600). Retrieved from http://bjs.ojp.usdoj.gov/ content/pub/pdf/mhppji.pdf

[48] Sabol and Couture (2008)

[49] Behind Bars II: Substance Abuse and America's Prison Population, National Center on Addiction and Substance Abuse, (2010)

[50] Community Conversations About Mental Health Information Brief, Substance Abuse and Mental Health Services Administration (2013)

[51] Risk and Protection Profile for Substance Abuse in Kitsap County, Washington State Department of Social and Health Services, Research and Data Analysis Division (2013)

[52] Risk and Protection Profile for Substance Abuse in Kitsap County, Washington State Department of Social and Health Services, Research and Data Analysis Division (2013)

[53] Community Conversations About Mental Health Information Brief, Substance Abuse and Mental Health Services Administration (2013)

- If all inmates with substance use disorders who are not receiving treatment were provided evidence-based treatment and aftercare, we would break even on this investment in one year if just over 10 percent of those receiving such services remained substance and crime free and employed[54].

Key Recommendations to Address Local Gaps in Service for Individuals with Mental Illness and Substance Use Disorders in the Adult Criminal Justice System:

Gap #1: Behavioral Health Prevention, Early Intervention and Training
Recommendations:

- Support shared plan through collaboration and increased care coordination among mental health, substance abuse, and adult criminal justice stakeholders through joint projects, blended funding, information sharing, and cross-training to prevent and reduce inappropriate involvement of persons with behavioral health disorders from involvement in the adult criminal justice system.
- Train the Adult Criminal Justice System on community resources and behavioral health treatment options including inpatient, outpatient, medication assisted, detoxification services and crisis triage.

Gap #2: Crisis Intervention/Triage Services
Recommendations:

- Develop county wide protocols for first responders responding to a call where mental illness or substance use may be a factor.
- Conduct crisis intervention training for all first responders countywide to respond to calls where mental illness or substance use may be a factor.
- Establish a Mobile Crisis Team and infrastructure to handle attempts by law enforcement mental health, substance abuse, EMS or other providers to preempt entry into legal system, jail hospital, or to "the street".
- Provide Criminal Justice System alternative through Crisis Respite/Triage Center/Drop Off Center with dedicated beds for short term 24/7 service.
- Sustain an adult diversion program for low level offenders with mental illness or substance abuse disorders.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Recommendations:

- Provide on-site behavioral health screening and referral to Superior, Municipal and District Courts.
- Expand mental health and substance abuse outreach, assessment, intervention, referral and treatment in the jail.
- Expand mental health and substance abuse outreach, assessment, intervention, referral and treatment in existing adult therapeutic courts.
- Enhance linkage at discharge to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, housing with/without supportive services, and mental health & substance abuse treatment.
- Encourage gathering of local statistics.

[54] Behind Bars II: Substance Abuse and America's Prison Population, National Center on Addiction and Substance Abuse, (2010)

- Explore local reimbursement options for local mental health competency evaluations.
- Explore local cursory competency evaluation for out of custody, low risk offenders.

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:
- Educate first responders on available Emergency Housing, Detoxification and Crisis Triage beds at Kitsap Recovery Center.

Gap #5: Acute Inpatient Care Services
Recommendations:
- Educate first responders on available inpatient substance abuse treatment beds at Kitsap Recovery Center.

Gap #6: Recovery Support Services
Recommendations:
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

Mental Illness and Substance Use Disorders and the Juvenile Justice System

Youth who are involved with the juvenile justice system have substantially higher rates of mental health disorders than children in the general population, and they may have rates of disorder comparable to those among youth being treated in the mental health system.

Nationally:
- The prevalence of mental disorders among youth in the general population is estimated to be about 22 percent; the prevalence rate for youth in the juvenile justice system is as high as 60 percent[55].
- In 2006, half (52.4 percent) of juvenile or youthful offender inmates in state prisons and local jails met clinical criteria for substance use disorders.
- The problem is particularly severe among youth incarcerated in local jails where 54.3 percent met such clinical criteria compared with 36.7 percent of juvenile inmates in state prison. Without timely and adequate interventions, youthful offenders are at increased risk of developing persistent criminal careers[56].

In Kitsap County:
- In 2011, 71 youth (ages 10 - 17) in Kitsap County were arrested for alcohol violations[57].
- In 2011, 64 youth (ages 10 - 17) in Kitsap County were arrested for drug violations[58].

[55] Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices, National Mental Health Association (2004)
[56] Behind Bars II: Substance Abuse and America's Prison Population, National Center on Addiction and Substance Abuse, (2010)
[57] Risk and Protection Profile for Substance Abuse in Kitsap County, Washington State Department of Social and Health Services, Research and Data Analysis Division (2013)
[58] Risk and Protection Profile for Substance Abuse in Kitsap County, Washington State Department of Social and Health Services, Research and Data Analysis Division (2013)

- In 2012, 35 youth participated in the Juvenile Drug Court Program.
- In the first six months of 2013, the number of youth who entered Juvenile Drug Court increased by 64% from the number of youth who entered the program in the first six months of 2012.
- In 2012, the number of youth on probation who received outpatient drug/alcohol services increased by 29% from 2010.
- In 2012, 23% of youth admitted to Juvenile Detention were taking mental health medication.
- Between July 2009 and June 2013, 477 youth in Juvenile Detention were seen by a mental health professional.
- In 2012, 9 youth participated in the Individualized Treatment Court Program for co-occurring disorders; a 125% increase in participants from the program's inception in 2006.

Treatment Works: The research supports the need for prevention and early intervention strategies to address the mental, emotional and behavioral problems that can occur throughout a young person's life[59]. Recidivism rates among those within the juvenile court system who received treatment are as much as 25 percent lower than the rates of those children and teens in untreated control groups. The best, research-based treatment programs, however, can reduce recidivism rates even more-from 25 to 80 percent[60]. When juvenile drug courts utilize a wide range of non-detention based sanctions, they can experience cost-savings as high as $5,000 per participant[61].

Key Recommendations to Address Local Gaps in Service for Individuals with Mental Illness and Substance Use Disorders in the Juvenile Justice System:

Gap #1: Behavioral Health Prevention, Early Intervention and Training
Recommendations:

- Support shared plan through collaboration and increased care coordination among mental health, substance abuse, and juvenile justice stakeholders through joint projects, blended funding, information sharing, and cross-training to prevent and reduce inappropriate involvement of persons with behavioral health disorders from involvement in the juvenile justice system.

Gap #2: Crisis Intervention/Triage Services
Recommendations:

- Expand capacity for 24 hour crisis response for youth through law enforcement training, mobile crisis team, emergency housing and crisis triage.
- Expand youth Involuntary Treatment Act/Crisis Response services.

[59] Community Conversations About Mental Health Information Brief, Substance Abuse and Mental Health Services Administration (2013)
[60] Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices, National Mental Health Association (2004)
[61] Van Warmer and Lutz, Exploring the Value of Juvenile Drug Courts (2011)

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services
Recommendations:

- Expand mental health and substance use prevention, outreach, assessment, intervention, referral and treatment within the juvenile justice system.
- Increase access to community mental health and substance use disorder treatment for non-Medicaid youth involved in the Juvenile Justice System.
- Expand parent involvement and support activities for youth with mental health and substance use disorders.
- Expand the use of evidence and research based programs found to decrease depression, suicidal behavior and substance abuse among juvenile justice involved youth.
- Increase wrap-around services for serious emotionally disturbed youth.
- Establish a dedicated behavioral health specialist to serve the juvenile detention facility, Individualized Treatment Court and be available for consultation to Probation Counselors dealing with the general probation population Expand capacity for therapeutic courts within the juvenile justice system.
- Enhance linkage at discharge from Detention to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, housing and mental health & substance abuse treatment.
- Encourage gathering of local statistics.

Gap #4: Medical and Sub-Acute Detoxification Services
Recommendations:

- Educate Juvenile Justice Staff on available Emergency Housing and Detoxification beds available in the State.
- Dedicate funds for out of county medical detoxification services for Juvenile Justice involved youth and explore options for a local medical detoxification provider.
- Enhance linkage at intake and discharge to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, and mental health & substance abuse treatment.

Gap #5: Acute Inpatient Care Services
Recommendations:

- Educate Juvenile Justice Staff on available Inpatient Mental health and Substance Abuse Treatment beds locally and in the State.
- Enhance linkage at intake and discharge to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, and mental health & substance abuse treatment.

Gap #6: Recovery Support Services
Recommendations:

- Increase supportive services, case monitors, UA collection, incentives and pro-social activities in all Juvenile Therapeutic Courts.
- Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement.

KEY INFORMANT INTERVIEW SUMMARY

KITSAP COUNTY CONTINUUM OF CARE GAP ANALYSIS

Behavioral Health Prevention, Early Intervention and Training

Gaps:

- **Insufficient Behavioral Health Prevention**
  - Reinstitute Nurse-Family Partnership Program (post-partum depression, et al)
- **Insufficient Behavioral Health Early Intervention**
  - Build an adult diversion program for low level offenders
- **Insufficient Behavioral Health Training**
  - Educate homeless/housing staff on behavioral health issues
  - Train all systems on community resources and referral options
  - Develop cross training opportunities for hospital, law enforcement schools and local behavioral health providers
  - Educate local behavioral health providers on Veteran's issues and available resources
- **Lack of education, training and behavioral health expertise with aging and long-term care providers**
  - Provide behavioral health education and training to providers working with the aging population
  - Provide consistent behavioral health consultation to providers
  - Embed behavioral health strategies within the existing CNA/ LPN/ nursing curriculum

Crisis Intervention/Triage

Gaps:

- **Lack of pre-crisis outreach for compromised people who are hard to engage to prevent hospital or law enforcement involvement**
  - Establish assertive outreach/mobile crisis and engagement team

- Establish specialized homeless outreach services, including Veterans
- Establish specialized geriatric outreach team

- **Lack First Responder training in Behavioral Health issues**
  - Provide 40 hour Crisis Intervention Training to all first responders
- **Lack of consistent county-wide guidelines for law enforcement to intervene in Behavioral Health situations**
  - Develop county-wide protocols specific to patrol
- **Lack of crisis triage beds in the community**
  - Establish Crisis Triage Beds in the emergency room
  - Increase number of local Crisis Triage Beds at Kitsap Recovery Center
- **Lack of "drop off center" or stabilization housing in lieu of jail or the emergency room**
  - Explore options for voluntary drop off center or similar models
- **Lack of on-site Behavioral Health screening, assessment and referral services**
  - Provide on-site Behavioral Health screening at the following locations:
    - Housing Solutions Center and/or housing sites
    - Superior, Municipal, and District Court
    - Juvenile Department and in Detention
    - Kitsap County Jail
    - Local schools

Outpatient Care – Psychiatry, Medical and Medication Management, Counseling

Gaps:

- **Lack of integrated Behavioral Health treatment**
  - Increase care coordination between systems, including Veterans
  - Increase bi-directional care coordination between primary care and behavioral health
  - Increase dual-certification as Behavioral Health providers (agencies)
- **Lack of medication assisted opiate treatment**
  - Increase access and options for medication assisted treatment
- **Medicaid Access to Care Standards make it difficult to access treatment at the local Community Mental Health Center**
  - Educate the community about the alternative Healthy Option Providers
  - Increase Behavioral Health treatment funding for non Medicaid, Medicare, the uninsured and Veterans not eligible for benefits

- Expand Community Mental Health Center services to include individuals who are not eligible for Medicaid

- **Fragmented Behavioral Health services and provider participation in the Juvenile Individualized Treatment Court (ITC)**
  - Establish a dedicated Behavioral Health Therapist for ITC
- **Insufficient funds to support Adult and Juvenile Therapeutic Courts**
  - Provide funding for increased capacity and supportive services, case monitors, UA collection, incentives and pro-social activities
- **Lack of Geriatrics specific assessment, outpatient and inpatient treatment**
  - Explore geriatric population treatment needs
- **Lack of Behavioral Health treatment options in the jail**
  - Establish on site jail treatment services

Medical and Sub-Acute Detox

Gaps:

- **Lack of medical detox (inpatient and outpatient)**
  - Dedicate funds for out of county medical detox
  - Explore options for a local medical detox provider

Acute Inpatient Care

Gaps:

- **Reduce use of acute inpatient care through community-based stabilization and intervention**
  - Increase capacity for Program for Assertive Community Treatment (targeting 18-40 years olds with Axis 2 diagnosis)
- **Insufficient number of local Behavioral Health treatment beds**
  - Increase number of local Behavioral Health Inpatient Beds, including gero-psychiatric beds

Recovery Support Services

Gaps:

- **Lack of community awareness of current Behavioral Health Medicaid Services/Providers**
  - Educate the community on Healthy Option Services and Medicaid Expansion

- **Insufficient subsidized housing for individuals with Behavioral Health Issues**
    - Increase project based subsidized housing vouchers for individuals in Behavioral Health treatment
    - Provide appropriate tailored subsidized housing and support services for homeless individuals and persons at risk of homelessness with Behavioral Health issues
    - Establish stabilization transition housing for individuals with Behavioral Health issues moving from jail to treatment
    - Establish flexible rental assistance funds for individuals with Behavioral Health needs
- **Geographic barriers to accessing services locally**
    - Increased outstations in the north, south and Bainbridge Island
    - Identify transportation barriers and increase transportation options
- **Lack of mental health peer support group(s)**
    - Recruit existing organizations/individuals to develop a mental health support group similar to AA/NA for youth, young adults and adults.
- **Long wait times for court ordered mental health competency evaluations**
    - Explore local reimbursement options implemented in Pierce and Clallam Counties
    - Explore local cursory competency evaluation for out of custody, low risk offenders

BEHAVIORAL HEALTH SYSTEM MAP

Key: Service Availability for Publicly Funded Mental Health and Substance Abuse Prevention, Intervention and Treatment Services Effective 8/01/13

Service is available through our organization:

- No (N)
- Yes (Y) [for bed-based services, please use Comments to note number of beds available]
- Yes But (YB) with comments below

Location of services (note all that apply):

- North (N)
- Central (C)
- South (S)
- Countywide Outreach (CO)

Ages groups provided this service (note all that apply):

- Children and youth (to age 18) (C)
- Transition age youth (18-21) (TA) [note that in CA, transition age youth are now defined in law as 16-25]
- Adults (22-59) (A)
- Older Adults (60+) (OA)

Comments, possibilities include:

- Service availability limited by space, resources, other constraints (please describe)
- Services limited to specific population (please describe)
- Services to be/recently terminated/reduced due to (please describe)
- **GREEN SHADING INDICATES GAP IN SERVICE**

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Behavioral Health Prevention, Early Intervention and Training					
Support shared plan through collaboration	KCPS	YB	C,N	All	Bremerton Substance Abuse Prevention Coalition – limited to Bremerton & North Kitsap
Information Dissemination	OESD	Y	N, Bremerton	Youth 13-18	School based CD/MH training
Information Dissemination	PCHS	Y	CO	All	Community based education, training and awareness events

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Information Dissemination	KMHS	Y	CO	All	Community based education, training and awareness events
Information Dissemination	KCPS	Y	CO	All	Community based education, training and awareness events through Bremerton Substance Abuse Prevention Coalition
Information Dissemination	KPHD	Y	CO	All	Community based education, training and awareness events
Education	KMHS	Y	CO	A	Mental Health First Aid Course for Youth and Adult
Education	OESD	Y	CO	A	Mental Health First Aid Course for Youth, Compassionate Schools, ACEs Training. Working with Children from Substance Abusing Homes, Working with Substance Abusing Youth
Education	Various	Y	CO	All	Education and training on Adverse Childhood Experiences
General consultation for MDs and hospitals	KMHS	YB			As requested. KMHS Psych ARNP available to all PCP's in county, clinical consultation for hospital, behavioral health professional for HHP clinics.
General consultation for MDS	PCHS/KMHS	Y	C	All	Psych ARNP available to PCHS PCPs
Consultation to childcare settings	KPHD	Y	CO	0-3 yrs.	Various child care settings
Parent-Child Assistance Program	Agape	Y	CO	A	Assistance to pregnant women receiving treatment
Parent Education	OESD	Y	CO	Prenatal -3	0-5 outreach program including newborn home visiting
Parent Education	WSU Ext	YB	CO	C	Strengthening Families Program funding limited
Parent Education	KCR	Y	C	A	Through the Parenting Place
Environmental Approaches	KCPS/OESD	Y	C	A	Parent and Student Social Norms Campaign

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Suicide prevention curriculum	BSD	YB	C	K - 12	Riding the Waves Suicide Prevention Look, Listen, Link HELP
Suicide substance abuse prevention curriculum	KMHS	YB	C	C	CAST 6 week evidence based suicide and Substance Abuse prevention curriculum – limited to BSD
Suicide/substance abuse prevention curriculum	BSD	YB	C	C	RCY evidence based suicide and Substance Abuse prevention curriculum – limited to BSD
Cross Systems Training		YB	CO	All	Increase cross system training opportunities for law enforcement, education, primary care, service providers
Suicide/substance abuse prevention curriculum		YB	CO	K-12	Establish Behavioral Health Prevention Curriculum county Wide
Nurse Family Partnership Program	KPHD	YB	CO	0-5 yrs.	0-5 outreach program including newborn home visiting limited
Consultation to childcare settings	KMHS	N		0-5 yrs.	KMHS consultation to ECAEP and Headstart program, ended 2/2013 due to sequester.
Adult Diversion Program		N		A	Establish Adult Diversion for low level offenders
Behavioral Health Provider Education		N		A	Educate local behavioral health providers on Veteran's issues and available resources.
Behavioral Health Provider Education		N		OA	Providing behavioral health education and training to providers working with aging population
Behavioral Health Curriculum		N		A	Embed behavioral health strategies within existing CNA/LPN/nursing curriculum
Crisis Intervention/Triage					
1-8OO crisis line (24/7) and including suicide screening	KMHS	Y	CO	All	Primarily volunteer staffed – access DMHPs as necessary

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Crisis team (24/7)	KMHS	Y	CO	All	DMHP staffed 24/7– Will do community outreach
Mobile crisis team	OESD	Y	N, C, S	K-12	ESD Student Services Center supports a regional crisis support team for schools, provided when the district requests support after a traumatic incident/death of a student
Emergency Room	HMC	YB	CO Bremerton	All	4 beds- insufficient for current need
Urgent care/Walk in clinic	HMC	Y	S-Port Orchard	All	Primarily medical, not intended for BH
Crisis residential (un-locked) beds	KMHS	Y	CO - Bremerton	All	11 30-day beds located at Keller House Residential Unit
Crisis stabilization beds - Youth	KMHS	YB	CO - Bremerton	8 - 18	1 bed only
Crisis triage beds (MH/SA)	KRC	YB	CO - Bremerton	18 and up	Limited to 4 triage beds, shared with Harrison and KMHS- insufficient for current need
Crisis Response Training	Various	YB	CO	All	Law Enforcement/Frist Responder Training limited and intermittent
Crisis Respite and/or Crisis Triage Center		N	CO	A	Establish voluntary Drop Off Center
County Wide Protocols for Crisis Response		N	CO	All	Develop county wide protocols
Mobile crisis team (24/7)		N	CO	All	Establish Outreach/Engagement Team
Mobile crisis team		N	CO	All	Establish specialized geriatric outreach team
On Site Behavioral Health Screening		N	Housing Programs	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Screening		N	Jail/Corrections	18 and up	Have on site Behavioral Health Therapist

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
On Site Behavioral Health Screening		N	Juvenile Detention	C	Have on site Behavioral Health Therapist
On Site Behavioral Health Screening		N	Superior Court	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Screening		N	Municipal Court	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Screening		N	District Court	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Screening		N	Public Schools	C	Have on site Student Assistance Behavioral Health Professional/Therapist
On Site Behavioral Health Screening		N	Primary Care	All	Have on site Behavioral Health Therapist
Homeless Outreach		N			Establish specialized homeless outreach services, including Veterans
Outpatient Care – Psychiatry, Medical and Medication Management, Counseling					
1-800 Information &Referral line	KMHS	Y	CO	All	
1-800 access line	KMHS	Y	CO	All	Not 1-800 – but free access countywide
Inpatient Assister Medicaid Enrollment Program	KPHD Various	Y	CO	All	KMHS PCHS KCR
MH/CD Outreach to special populations	KMHS	YB	CO	All	Older adult, schools on limited basis
MH services to jail/corrections	KMHS	YB	CO	18 and up	Determination of services coordination and discharge planning for clients of KMHS only
MH services to jail/corrections	ConMed	YB	CO	18 and up	Limited to medication management, brief behavioral health screening and crisis intervention.
Offender Reentry Services (ORSCAP)	DOC/KMHS	Y	CO	Adults	

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
MH/SA services to Juvenile Detention	KMHS	YB	CO	8 - 18	Limited to 3 days a week for treatment and discharge planning. SA for KMHS clients only.
SA services to Superior Court	KRC Cascade	Y	CO	18 and up	Adult Felony Drug Court Veterans Court
MH Services to Juvenile Court	KMHS	YB	CO	8 - 18	Limited support to Juvenile Drug Court
SA services to Juvenile Court	KARS	Y	CO	C	Intensive and outpatient treatment Juvenile Drug Court Individualized Treatment Court
Western State Liaison	KMHS	Y	CO	All	Discharge planning
MH/SA Services at primary care facilities	PCHS	Y	Port Orchard Bremerton (2 sites) Poulsbo	All	Integrated behavioral health with primary care. PCPs provide medication services. PHQ2 and PHQ9 screening for depression.
MH/SA Services at primary care facilities	HHP/KMHS	Y	Port Orchard Bremerton Silverdale Poulsbo	All	MH and CD screens. PCPs provide medication services. Brief BH services provided by KMHS on HHP sites; grant funded through 2015
Nursing Home Liaison Team	KMHS	YB	CO - Bremerton	A, OA	In need of psychiatric consultative and Nursing BH Services.
MH/SA Services at primary care facilities	KMHS	Y	CO	C	Psychiatric consultant available to all Kitsap PCPs for behavioral health; grant funded through 2013
MH and Co-occurring SA Outpatient Treatment Services	KMHS	Y	CO	All	Active KMHS client *note that required Access to Care Standards & recent reductions in state funding for non-Medicaid services result in clinical and financial eligibility requirements to access RSN funded services provided by KMHS

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Adult SA Intensive/Outpatient Treatment Services	Various	Y	C, S, N	18 and up	Agape Unlimited Cascadia Addiction Treatment Services Cascade Recovery Center Kitsap Mental Health Services Kitsap Recovery Center Port Gamble S'Klallam Program Recovery Center West Sound Treatment Center
Adolescent SA Intensive/Outpatient Treatment Services	Various	Y	C	10 - 17	Cascade Recovery Center Kitsap Mental Health Services Co-occurring disorders only
Family tx/counseling	KMHS	Y	CO	All	Active KMHS clients*
Medication Assisted Treatment	KMHS	YB	C	All	Limited to KMHS clients
Psychiatric evaluation and/or consultation	KMHS	Y	C, CO	All	Active KMHS clients*, CO to nursing homes only
Psychiatric prescribing/meds management (routine and urgent)	KMHS	Y	C, CO	All	Active KMHS clients*, CO to nursing homes only
Provide Pharmaceutical Services MH Campus	KMHS	Y	Bremerton	All	KMHS clients
Clinical Pharmacy Program	PCHS	Y	All four sites	All	PCHS patients only.
Psychological testing	KMHS	Y		All	Contracted as needed Not available "in house"
Care coordination and case management including linkage with primary care provider	KMHS	Y	CO	All	Active KMHS clients*
24/7 intensive home /community -based case management (WRAP or PACT level)	KMHS	Y	S, C, CO	C, TA, A.	WRAP, as needed, for youth. PACT for 45 adult clients, recently awarded DBHR expanded ITA funds for 45 additional PACT slots.

Attachment B

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Adult Day Treatment	KMHS	Y	C	TA, A	Day treatment and community integration activities
Case aide/coach for children/adolescents	KMHS	Y	CO	C	As needed –active KMHS clients
Day treatment (school) services/adolescent (intensive)	KMHS	Y	C	C	Madrona Day Treatment at KMHS Armin Jahr Elementary and Mountain View Middle School have on site KMHS programs
Peer partners	KMHS	Y	CO	TA, A	"Life coaches" and peer counselors in adult services
Parent peer partners	KMHS	In development	CO	Youth	
Intensive Therapeutic Foster Care Services	KMHS	Y	Bremerton	6 - 18	Includes Multi-dimensional Treatment Foster Care program
Targeted transitional services for young adults	KMHS	In development	CO	18 - 25	
Individual skill building/coaching	KMHS	Y	C, CO	All	Active KMHS clients* as needed
12 Step Programs	AA, NA,Other	Y	CO	A	
Care Coordination		N	CO	All	Increase coordination and dual-certified providers
Veterans System Care Coordination		YB- sporadic			Increase coordination between local services and Veteran system services
Behavioral Health Treatment options for uninsured		YB	CO	All	Increase funding to cover uninsured individuals, including Medicare and Veterans. Expand providers to treat uninsured
On Site Behavioral Health Treatment		N	Jail/Corrections	A	Provide opportunity for incarcerated individuals to complete court ordered treatment program
On Site Behavioral Health Treatment		N	Juvenile Detention	C	Establish dedicated Therapist for ITC Increase Drug Court Capacity

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
On Site Behavioral Health Treatment		N	Superior Court	A	Increase existing Therapeutic Courts capacity Have on site Behavioral Health Therapist
On Site Behavioral Health Treatment		N	Municipal Court	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Treatment		N	District Court	A	Have on site Behavioral Health Therapist
On Site Behavioral Health Treatment		N	Public Schools	K – 12	Have on site Behavioral Health Therapist
On Site Behavioral Health Treatment		N	Primary Care	All	Have on site Behavioral Health Therapist
Geriatric Behavioral Health Services		N		OA	Some, for individuals qualifying for KMHS level of services.
Methadone Maintenance Program		N		A	Increase access and options for MAT
Acute Inpatient Care					
Acute MH inpatient/E&T (involuntary, voluntary)	KMHS	YB	CO - Bremerton	All	10 beds – Youth Inpatient Unit 15 beds – Adult Inpatient Unit. Insufficient for current need.
Acute MH inpatient single bed certification	HMC	Y	C) - Bremerton	A	4 Beds
SA Inpatient Treatment Beds	KRC	Y	CO - Bremerton	18 and up	42 adult beds
Acute MH community hospital inpatient Unit		N	CO	A	Increase number of beds
Gero Psychiatric Beds		N	CO	OA	For MH/SA involved
Co-occurring dx inpatient beds		N	CO	A	

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Mental Health Diversion, Medical and Sub-Acute Detoxification					
Detox/residential beds	KRC	Y	CO - Bremerton	18 and up	8 beds at KRC
Outpatient medical detox		N	CO	A	
Inpatient medical detox beds		N	CO	A	
Recovery Supportive Services					
Single Resident Occupancy Units for MH Clients	KMHS	Y	CO	A, OA	52 units – Project Based Housing Vouchers
Staff supportive living housing	KHMS	Y	CO	A,OA	33 units - Project Based Housing Vouchers
Apartments/homes/ access managed for MH consumers	KMHS	Y	N, C, S	A, OA and	Combination of apartments and shared housing – agency clients. Project Based Housing Vouchers
Permanent beds for severe and chronic MH consumers, unable to reside in alternative community-based housing options	KMHS	Y	CO	A,OA	4 beds- permanent beds located at Keller House residential program
Private Landlord and public housing development for MH Clients	KMHS	Y	C, CO	A, OA	Work with landlords, housing authorities
Emergency Homeless Housing	KRC	YB	C	A	Limited to 3 male beds and 3 female beds
SA Transitional Housing	Agape	YB	C	A	Koinonia Inn – 6 beds for pregnant/parenting

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
SA Permanent Housing	Agape	YB	C	A	Sisyphus II Housing - 2 - 5 bedroom homes and 22 Units
SA Permanent Housing	West Sound	YB	S	A	O'Hana House – 13 beds for Women in Treatment, supportive services, WRAP
SA Supportive Housing	West Sound	YB	C S	A	The Lighthouse – 8 beds for Men in Treatment - supportive services, WRAP
Housing First Programs	West Sound	YB	C	A	Forward Bound – Limited to 14 units in Bremerton, Project Based Housing Vouchers
Recovery Housing Programs	Oxford Housing	Y	CO	A	Oxford Houses – 4 Women, 1 Women with Children, 11 Men
Financial management	KMHS	Y	C	TA, A, OA	Protective Payee – 2 FTE, other protective payees in the community
Referral and support for family members	KMHS	YB	C	TA, A, OA	On a limited basis – available through agency/advocate co-sponsored "Community Voice" meetings and through NAMI Kitsap
Supported employment	KMHS	Y	C, CO	TA, A	Active KMHS clients* Also includes DVR contract
Vocational Services	West Sound	Y	CO	A	Compass Vocational Services
Peer counselors/ community friends	KMHS	Y	CO	TA, A	"Life coaches" – as mentioned earlier
12 Step Programs	AA, NA,Other	Y	CO	A	
Court ordered mental health competency evaluations	WSH	YB	WSH (Steilacoom)	A	Long wait times in local jails awaiting WSH bed. Pierce and Clallam utilize SB 5551 for reimbursement for evaluations completed in local jail(s). Explore local cursory competency evaluation for out of custody, low risk offenders
Supportive Services		N	CO	All	Would include assistance for child care, transportation, employment, etc. to support individual while in treatment

	Provider Organization	Service Available?	Location of Services?	Age Groups Served?	Comments (include number of beds available for bed-based services)
Specialized Behavioral Health Housing Programs		N	CO	A	Increase Behavioral Health Housing options
Transitional Housing		N	CO	A	Establish transitional housing for individuals moving from jail to treatment
Harm Reduction Housing		N	CO	A	Increase project based subsidized housing vouchers for MH/SA involved or in recovery
Flexible rental assistance Fund		N	CO	A	For MH/SA involved
Address geographic barriers		N	CO	All	Increase outstations/onsite options Increase transportation options for treatment
Peer/self-help group support for MH		N	CO		Develop recovery support groups similar to AA/NA

ACRONYMS

AA	Alcoholics Anonymous
Agape	Agape Treatment Program- Substance Abuse Treatment Program
BSD	Bremerton School District
Cascade	Cascade Treatment Program- Substance Abuse Treatment Program
ConMed	Subcontractor of medical services and behavioral screening in Kitsap County Jail
DOC	Department of Corrections
HHP	Harrison Health Partners
HMC	Harrison Medical Center
KARS	Kitsap Adolescent Recovery Services
KCPS	Kitsap County Prevention Services
KCR	Kitsap Community Resources
KMHS	Kitsap Mental Health Services
KPHD	Kitsap Public Health District
KRC	Kitsap Recovery Center
NA	Narcotics Anonymous
OESD	Olympic Educational School District #114
Oxford House	Oxford House- Recovery Housing Program
PCHS	Peninsula Community Health Services
West Sound	West Sound Treatment Program- Substance Abuse
WSH	Western State Hospital
WSU Ext	Washington State University Extension office