

*Whatcom County*  
**Comprehensive  
Behavioral Health Plan**



***Preventive and recovery-oriented approaches to  
community-based treatment and supportive services***

July 2008



Whatcom County Health Department

**PUBLIC HEALTH**  
ALWAYS WORKING FOR A SAFER AND  
HEALTHIER WASHINGTON

## Table of Contents

<b>Executive Summary .....</b>	<b>2</b>
Purpose of the Plan .....	2
Findings .....	3
<b>Introduction .....</b>	<b>7</b>
Purpose of the Plan .....	8
Overall Goal and Objectives .....	8
Information Sources.....	9
<b>Dimensions of the Problem .....</b>	<b>10</b>
Budgets and Public Costs.....	10
Criminal Justice and Public Safety .....	12
Mental Illness .....	14
Substance Abuse.....	15
Homelessness .....	18
Health.....	20
Productivity: Education, Employment and Income .....	22
Older adults .....	23
<b>Work That Needs to be Done: Cross-system behavioral health services strategies .....</b>	<b>24</b>
<b>Behavioral Health Solutions.....</b>	<b>30</b>
<b>Appendix A: Community Health and Public Safety Committee Recommendations .....</b>	<b>39</b>

# Executive Summary

Untreated, serious mental illness and chemical dependency disorders overwhelm our criminal justice system and other public services, including the hospital emergency department. Many adults and juveniles end up in our courts and jails due to these disorders, resulting in substantial spending that could otherwise be better targeted to the offenders who pose a greater public safety risk.

As a result of recent community service planning processes, local experts in the fields of criminal justice, mental health, chemical dependency, health care, housing, and others have recommended strategies to prevent, intervene, treat, and divert behavioral health cases away from continual cycles of recidivism due to inadequate local resources. The substantial public and tragic personal costs of inadequate community-based treatment are very real. The costs are expressed as unnecessary criminal justice encounters and expense, endless cycles of dependence on local public services and facilities, reduced productivity and unemployment, homelessness, child abuse and neglect, disease and mortality.

Furthermore, the limited amount of funding for community-based treatment relative to the need forces every community to ration services. This necessarily results in many disorders going untreated, or sacrificing important components of the recovery continuum. Some have compared this resource scarcity and attempts to address it as squeezing a balloon: redistributing funding to address service shortages in one part of the continuum tends to distort and render less effective, the other parts.

Whatcom County residents are fortunate that there are so many dedicated individuals and organizations providing a continuum of services from prevention to post-treatment support services. And our communities have made great strides in addressing some of our most serious service gaps. But there are still many gaps remaining, including the simple reality that we do not have the capacity to meet the demand for community-based treatment and the necessary supportive services to support people in their recovery.

## Purpose of the Plan

Whatcom County behavioral health and criminal justice professionals recognize the need to closely examine the linkages and opportunities for synergy that may accrue from more comprehensive planning across traditional systems or “silos.” This plan represents a significant step toward this type of linked planning. It relies on synthesizing the results of several recently completed local and regional plans and reviewing the literature and local assessment data to describe behavioral health-related problems and solutions. The purpose of this analysis was to identify strategies that maximize return on criminal justice and behavioral health investments, and provide behavioral health consumers opportunities to participate in services that support a preventive and recovery-oriented continuum of care.

For the purpose of this plan, we refer to chemical dependency and mental illness, collectively, as *behavioral health* disorders; hence, we refer to this plan as a ***comprehensive behavioral health plan***.

## Findings

### **Behavioral health disorders create a multi-dimensional community problem.**

Persons with behavioral health disorders who receive inadequate or no community-based treatment and supportive services are costly to the community. They typically experience escalating problems as their conditions continue untreated. These problems and the lack of adequate resources to address them, in turn, are associated with the following dimensions of a very complex problem:

- **Criminal justice costs and public safety:** Per capita law and justice costs in Whatcom County have increased 46% since 1999. This trend is associated with increased bookings (34% from 2001 to 2008) and increased jail population (70% from 2001 to 2008). Most jail inmates have a behavioral health disorder and 20% have a serious mental illness. The average number of inmates per month that use psychotropic medication has increased 170% over the past decade (from 19 in 1997 to 52 in 2007). The dozen most frequent offenders in Whatcom County all have a behavioral health disorder, they have been arrested an average of 32 times per offender and had 93 and 79 contacts with the County Sheriff and Bellingham Police, respectively. Just these twelve individuals have cost taxpayers \$722,611 in jail costs alone. Persons with behavioral health disorders are much more likely to be arrested than other individuals, and once in jail, they are likely to be incarcerated longer. Furthermore, incarceration impedes treatment and recovery by limiting access to services.
- **Hospital costs:** People with behavioral health disorders visited St. Joseph Hospital emergency department 7,992 times in 2005, and only 297 people accounted for 24% of those visits. Persons with co-occurring disorders tend to be the most frequent emergency department visitors, and fewer than one in six of the most frequent emergency department visitors in need of substance abuse treatment actually receive it.
- **Mental illness:** A conservative estimate of the number of County residents who need publicly subsidized mental health treatment, but are not receiving it – primarily because they do not qualify for Medicaid – is 2,776 persons. That means that local treatment providers are forced to ration treatment to only those that qualify for Medicaid or meet other narrowly defined criteria. A real tragedy of these inadequacies is the individual and societal opportunities lost. Persons who would otherwise not escalate to a severe need status or who would not end up in a crisis that results in hospitalization or incarceration end up in those situations unnecessarily. This is particularly true, and troublesome, for children with mental illness, 75-80% of whom do not receive adequate mental health services. From a public cost viewpoint, this amounts to poor or negative returns on investment.
- **Substance abuse:** DSHS estimates that 76% of the 4,249 low-income households in Whatcom County that need subsidized substance abuse treatment are not getting it. In the most recent statewide assessment of Washington residents, Whatcom County ranked 3<sup>rd</sup> out of 39 counties for substance abuse need, and 32<sup>nd</sup> for providing treatment. Even the most needy – those incapacitated from employment – and who are actively seeking substance abuse treatment have a difficult time accessing it. The waiting list for treatment assistance for this group of individuals has more than quadrupled since 1991, but

most of that growth has occurred in the last decade. Alarming, Whatcom County's youth methamphetamine addiction rate is rising much faster than the statewide rate. As measured by treatment admission rates per 100,000 population, Whatcom County has seen a 430% increase, compared to a statewide increase of 47%.

- **Homelessness:** Behavioral health disorders are often precursors to homelessness. This is especially true among the chronically homeless and people with multiple homeless episodes. In 2008, 42% of Whatcom County's homeless households said that substance abuse was a primary reason for their homelessness. Similarly, mental illness is also an important precursor to homelessness. In 2008, 30% of Whatcom County's homeless households said that mental illness was a primary reason for their homelessness. Additionally, homeless persons counted in 2008 who reported a mental illness disability were nearly three times as likely (49%) to have also reported a substance abuse disorder compared to those with no reported mental illness (18%). Homelessness is twice as likely among jail inmates with mental illness: According to a national study of jail inmates, those with a mental illness were twice as likely (17%) to have been homeless in the year prior to their incarceration compared to inmates without a mental illness (9%). Lack of secure housing exacerbates behavioral health problems directly and indirectly through disrupting treatment plans, prohibiting employment, straining family ties, and negatively impacting physical health.
- **Physical health:** Behavioral health disorders are associated with increased morbidity, disabilities, and reduced life spans. Suicide is the most devastating and far-reaching effect of untreated mental illness. It is the world's leading cause of violent death, exceeding both homicide and war. Whatcom County's suicide rate exceeds that of Washington State. Between 2000 and 2005 (the last year for which we have data), Whatcom County's annual age-adjusted suicide rate has exceeded the Washington State's rate in five out of six years. Substance abuse also claims lives. In recent years, Whatcom County's drug- and alcohol-induced death rates have been comparable or higher than the state rates.
- **Productivity:** One of the costs of untreated chemical dependency and mental illness is lost productivity. Society loses some or all of the productive ability of those with untreated behavioral health disorders. These costs are difficult to measure, but there is good evidence to suggest that treatment reduces these costs. More than half (56%) of students with a mental health disorder age 14 and older drop out of high school; this is the highest dropout rate for any disability group. Mental illness is also associated with low employment rates and low wages. Though many people with mental illness would like to work, lack of supportive structures and employee incentives means that only 1 in 3 are employed. Individuals are often faced with the choice of employment or treatment; yet without treatment their mental illness is likely to interfere with their capacity to acquire and maintain adequate employment. The average hourly wage for an employed person with mental illness is \$3 less than the general population; even among those who have a college degree.

**Six recommended behavioral health strategies emerge from an array of community planning processes.** The Substance Abuse, Mental Health Region, Law and Justice, and other strategic plans were examined for commonly recommended strategies to address the problems associated with inadequate behavioral health services in Whatcom County. These strategies include:

1. *Increase access to community mental health and substance abuse treatment services*
2. *Expand prevention, early intervention and outreach services for adolescents and adults*
3. *Expand access to diversion options and therapeutic courts*
4. *Create and expand access to services that support people in recovery and people reintegrating upon release from jail or prison*
5. *Increase integration and coordination between behavioral health service systems*
6. *Develop stable source of local funding*

Expected outcomes of these six strategies are shown in the chart on the following page.

**Cost-effective, evidence-based and emerging best practices are available to address many of the problems associated with inadequate community-based treatment and supportive services.** Local, state and national-level evaluation data have demonstrated positive returns on community investment for behavioral health treatment expansion and related programs and services designed to treat persons with mental illness and chemical dependency. Whatcom County currently lacks many of these programs or has very limited capacity to meet demand. A detailed list of specific recommended actions and programs within each of the six general strategies are presented. Appendix A presents an example of one mix of services that could be funded with enhanced local funds such as that that could be generated by a sales tax increase authorized by the Washington State Legislature in 2005.

## Whatcom County Behavioral Health Plan Strategies and Expected Outcomes

### #1: Increase access to community mental health and substance abuse treatment services

- ☑ Non-Medicaid eligible
- ☑ Treatment is cost-effective
- ☑ Treatment reduces recidivism, hospitalization, and homelessness

### #4: Create and expand access to services that support people in recovery

- ☑ Provide stable housing
- ☑ Increase education and employment
- ☑ Decrease relapse and recidivism

### #2: Expand prevention, early intervention and outreach services for adolescents and adults

- ☑ Early intervention decreases harmful effects, future costs
- ☑ Reduce emergency room and law-enforcement costs
- ☑ Enhance family involvement

### #5: Increase integration and coordination between behavioral health service systems

- ☑ Eliminate redundancies, unnecessary costs
- ☑ Highlight service gaps
- ☑ Acknowledge interrelatedness of public safety, housing, productivity, and behavioral health

### #3: Expand access to diversion options and therapeutic courts

- ☑ Divert from jail
- ☑ Reduce recidivism
- ☑ Increase educational attainment and employment
- ☑ Reunite families

### #6: Develop stable source of local funding

- ☑ Reduce service gaps
- ☑ Realize future pay-offs for present investments
- ☑ Leverage other funding with local funds

## Introduction

*Persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders are disproportionately more likely to be confined in a correctional institution, become homeless, become involved with child protective services or involved in a dependency proceeding, or lose those state and federal benefits to which they may be entitled as a result of their disorders.*

*-- 2005 Omnibus Treatment of Mental and Substance Abuse Disorders Act.<sup>1</sup>*

Criminalization of mental illness and chemical dependency is recognized as a problem throughout the United States. Untreated, serious mental illness and chemical dependency disorders overwhelm our criminal justice system and other public services, including the hospital emergency department. Many adults and juveniles end up in our courts and jails due to these disorders, resulting in substantial spending that could otherwise be better targeted to the offenders who pose a greater public safety risk.

As a result of recent community service planning processes, local experts in the fields of criminal justice, mental health, chemical dependency, health care, housing, and others have recommended strategies to prevent, intervene, treat, and divert behavioral health cases away from continual cycles of recidivism due to inadequate local resources. The substantial public and tragic personal costs of inadequate community-based treatment are very real. The costs are expressed as unnecessary criminal justice encounters and expense, endless cycles of dependence on local public services and facilities, reduced productivity and unemployment, homelessness, child abuse and neglect, disease and mortality.

Fortunately, as a society, we have developed cost-effective models of prevention, intervention and diversion, and scientifically proven treatments for our citizens who struggle with either or both of these debilitating disorders. However, as the Washington State Legislature found in 2005, state policies that control and limit most of the resources available to local communities has not kept pace with the development of these evidence-based treatment practices:

*Prior state policy of addressing mental health and chemical dependency in isolation from each other has not been cost-effective and has often resulted in longer-term, more costly treatment that may be less effective over time.<sup>2</sup>*

Because the funding and policy development is isolated, it should come as no surprise that our local planning processes also tend to follow that pattern. Unfortunately, simplifying these interrelated problems by treating them as isolated problems forestalls real solutions.

Furthermore, the limited amount of funding for community-based treatment relative to the need forces every community to ration services. This necessarily results in many disorders going untreated, or sacrificing important components of the recovery continuum. Some have compared this resource scarcity and attempts to address it as

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<sup>1</sup> E2SSB 5763, Chapter 504, Laws of 2005, Section 101.

<sup>2</sup> E2SSB 5763, Chapter 504, Laws of 2005, Section 101.

squeezing a balloon: redistributing funding to address service shortages in one part of the continuum tends to distort and render less effective, the other parts.

Whatcom County residents are fortunate that there are so many dedicated individuals and organizations providing a continuum of services from prevention to post-treatment support services. And our communities have made great strides in addressing some of our most serious service gaps. But there are still many gaps remaining, including the simple reality that we do not have the capacity to meet the demand for community-based treatment and the necessary supportive services to support people in their recovery.

### **Purpose of the Plan**

We in Whatcom County are also fortunate that these same dedicated individuals and organizations regularly re-examine how our community works together to address emergent criminal justice and behavioral health issues, and to support people in their recovery. They do this within numerous planning and assessment processes. These participants increasingly recognize the need to more closely examine the linkages and opportunities for synergy that may accrue from more comprehensive planning across traditional systems or “silos.”

This plan represents a significant step toward this type of linked planning. It relies primarily on synthesizing the results of several recently completed local and regional plans and reviewing the literature and local assessment data to describe behavioral health-related problems and solutions. The objective of this analysis was to identify high priority strategies that hold the promise of significant contribution to a community that:

- maximizes its return on criminal justice and behavioral health investments, and
- provides behavioral health consumers opportunities to participate in services that support a preventive and recovery-oriented continuum of care.

For the purpose of this plan, we refer to chemical dependency and mental illness, collectively, as *behavioral health* disorders; hence, we refer to this plan as a ***comprehensive behavioral health plan***.

### **Overall Goal and Objectives**

**Behavioral Health Plan Goal:** *All Whatcom County behavioral health consumers have the opportunity to participate in services that support a preventive and recovery-oriented continuum of care.*

#### **Behavioral Health Plan Objectives**

- Seek linkages between community-based service systems, including criminal justice, mental health, substance abuse, housing, employment, domestic violence, child and family, and other service systems.

- Determine the gaps in community services for people with mental illness and chemical dependency.
- Synthesize the most current community priorities for action expressed in existing plans.
- Highlight existing recommended actions common to multiple community service plans.
- Recommend actions that promise a high return on community investments

### **Information Sources**

This behavioral health plan relied primarily on existing, recently completed local and regional strategic plans and assessments across a wide variety of community service systems. Local, regional and state-level databases and technical reports were also used to describe the effects of community-based treatment and the gaps in treatment and supportive services.

## Dimensions of the Problem

Mental illness and chemical dependency are just two of the many dimensions of the behavioral health phenomenon that affects our community’s resiliency. Crime, public safety, public expenditures, housing, physical health, employment and education are all negatively affected by inadequate levels of community-based treatment. Each of these dimensions is described below with demonstrative indicators of the need for treatment and supportive services.

## Budgets and Public Costs

*The financial impact to the County of continuing to build court and jail capacity for many of our citizens that don't belong in the criminal justice system is enormous. The ongoing impact of this failed policy is to bleed off vital resources necessary for the proper implementation of the criminal justice system. The public safety risk is that this continued misuse of public funding results in truly dangerous individuals not being processed in the criminal justice system and left in the community or released early because of lack of jail capacity. We also can't build our selves out of this misguided process which incarcerates behavioral health consumers rather than providing appropriate interventions and treatment.*

*-Gary Williams, Whatcom County Human Services Division Supervisor, retired*

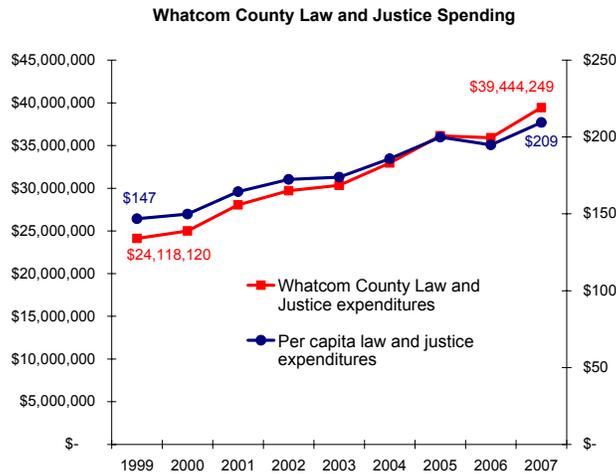
## Criminal justice costs

- Frequent offenders with behavioral health disorders cost taxpayers plenty:**  
 The 12 people most frequently booked into Whatcom County jail have cost taxpayers over \$720,000. The County estimates that 75% of jail inmates have a mental health disorder and/or a co-occurring chemical dependency disorder. And that’s just the jail costs associated with individual inmates.<sup>3</sup> Other costs include court costs, and the cost for repeated emergency room visits, hospitalization, and detoxification. Insurance plans rarely offer comprehensive mental health coverage, leaving Medicaid to pick up the slack in financing mental health and substance abuse services.

<b>\$722,611</b>	<b>Cost to incarcerate Whatcom County Jail’s 12 most frequent inmates</b>
<b>32</b>	<b>Average number of times these 12 were arrested since 1993</b>
<b>93</b>	<b>Average number of times these 12 had a County Sheriff’s Office contact since 1993</b>
<b>79</b>	<b>Average number of times these 12 had a Bellingham Police contact since 1993</b>
<b>100%</b>	<b>Percent of these 12 with a behavioral health disorder</b>

<sup>3</sup> These include medication, hospitalization, food, clothing, indigent supplies, nursing services and overtime pay.

- **Whatcom County law and justice expenditures comprise 50% of general fund spending.** These expenditures increased 64% from 1999 to 2007. Per capita spending increased 46%, from \$147 to \$209 per year for every person in the County.<sup>4</sup>



**Hospital emergency department costs**

- **Persons with co-occurring disorders dominate frequent emergency room visitors:** 56% of persons who visited the emergency room 31 times or more had diagnoses of *both a substance abuse and mental health disorders*.<sup>5</sup> In King County, 94% of persons who visited the emergency room 21 times or more had diagnoses of substance abuse, mental health disorders, or both.<sup>6</sup>

**7,992**

**Number of St. Joseph Hospital emergency room visits by people with behavioral health disorders**

**297**

**Number of behavioral health patients that accounted for 24% of visits.<sup>7</sup>**

- **Frequent emergency room visitors are not accessing treatment:** Most aged and disabled Medicaid clients who are frequent emergency room visitors have an alcohol or other drug use disorder or both; however, fewer than one in six of the most frequent ER visitors in need of substance abuse treatment actually receive it.<sup>8</sup>

<sup>4</sup> Whatcom County Budgets

<sup>5</sup> Mancuso, D., Nordlund, D., and B. Felver. 2002. *Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness*. DSHS Research and Data Analysis Division.

<sup>6</sup> King County Department of Community and Human Services: *Mental Illness and Drug Dependency Action Plan, Population Data and Service Needs* (cover page).

<sup>7</sup> St. Joseph Hospital/PeaceHealth and Whatcom Alliance for Healthcare Access. 2005. *Collaborating to Reduce the use of SJH Emergency Department Services for Non-emergent Care*. Bellingham, WA

<sup>8</sup> Mancuso, D., Nordlund, D., and B. Felver. 2004. *Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness*. DSHS Research and Data Analysis Division. Updated June 2004.

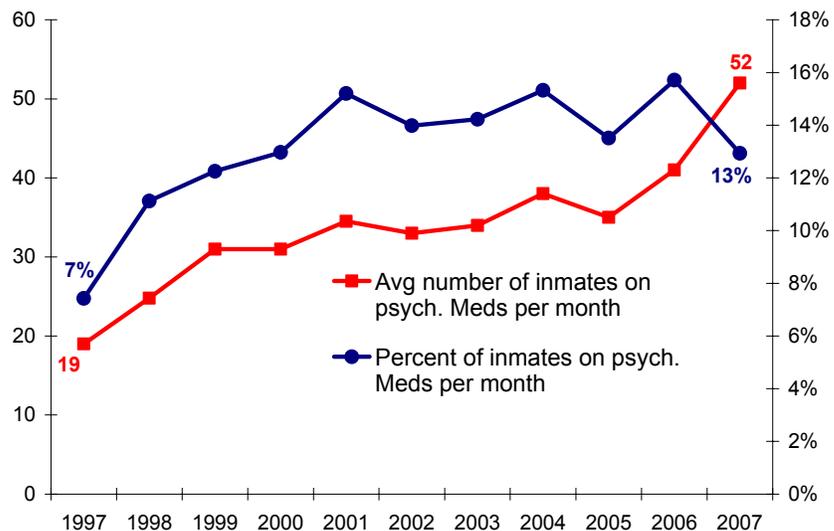
### Criminal Justice and Public Safety

*It's not uncommon for a single person to be responsible for 20 or 30 property crimes, usually to finance an addiction to drugs such as methamphetamine or heroin.*

*-Spencer Kope, Whatcom County Sheriff's Office crime analyst<sup>9</sup>*

- Whatcom County's jail population is increasing rapidly**, and a substantial percentage of inmates have behavioral health disorders, especially those that cycle repeatedly through the jail and other parts of the criminal justice system. From 2001 to 2007, average monthly jail bookings increased 34% (from 455 to 686). Between 2006 and 2007, total bookings increased 47% (from 5,608 to 8,234). The average daily jail population has increased 70% between 2001 and 2008 (from 227 to 741).
- High prevalence of behavioral health disorders among jail inmates:** Approximately 20% of Whatcom County jail inmates have a serious mental illness, including schizophrenia, bi-polar disorder, or clinical depression, and 85-90% come into the jail under the influence of drugs and/or alcohol.<sup>10</sup> Nationally, nearly two-thirds (64%) of all jail inmates have a mental health problem, and three in four of them also met criteria for substance dependency or abuse.<sup>11,12</sup> One measure of the prevalence of mental health disorders among inmates is the proportion who are prescribed psychotropic drugs. The average number of inmates per month that use psychotropic medication has increased 170% over the past decade (from 19 in 1997 to 52 in 2007).

**Whatcom County Jail Inmates Using Psychotropic Medication**



<sup>9</sup> As reported in: Heringa, C. 2008. Violent crime rises slightly in county. Bellingham Herald, June 20, A1.

<sup>10</sup> Personal communication with Lt. Wendy Jones, Whatcom County Chief of Corrections.

<sup>11</sup> James, D. and L. Glaze. 2006. *Mental Health Problems of Prison and Jail Inmates*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

<sup>12</sup> Braddock, D. 2004. *On Drugs, Crime and Dollars: Closing the Alcohol and Drug Treatment Gap*. DSHS, Olympia, WA.

- **High prevalence of behavioral health disorders among children in the juvenile justice system:** Rates for children in the juvenile justice system are similar to those for adults. A Chicago-based study reports that psychiatric disorders are present in 66% of boys and 75% of girls in juvenile detention, while substance abuse affects 50% of these youth.<sup>13</sup>
- **Persons with alcohol or drug-related disorders are much more likely to be arrested and/or convicted of crimes than other individuals.** This is particularly true among low-income individuals. A recent study found that the odds ratio of arrest or conviction for Medicaid clients with chemical dependency disorders (versus Medicaid clients with no chemical dependency disorder) is about 5 to 1.<sup>14</sup>
- **Once in jail, persons with mental illness are likely to have a longer length of stay than other offenders.**<sup>15</sup> Lacking access to mental health services, many consumers receive their first contact with mental health services upon incarceration.<sup>16</sup> Prior access to treatment might have helped these individuals avoid criminal activity altogether. This pattern holds true with youth offenders as well. Without intervention, 50% of children who exhibit behavior disorders will ultimately engage in criminal activity.<sup>17</sup>
- **Incarceration often impedes treatment and recovery** by limiting access to services and creating further barriers to reintegration (e.g. criminal record that limits employment opportunities). “When they are put in jail, people with mental illnesses frequently do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they are discharged.”<sup>18</sup>

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<sup>13</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.32.

<sup>14</sup> Mancuso, D., and S. Estee. 2003. *Washington State Mental Health Services: Cost Offsets and Client Outcomes*. DSHS Research and Data Analysis Division.

<sup>15</sup> King County Department of Community and Human Services: Mental Illness and Drug Dependency Action Plan, Population Data and Service Needs p.3.

<sup>16</sup> Snohomish County Blue Ribbon Commission on Criminal Justice Priorities, Conclusions and Recommendations (2008:9).

<sup>17</sup> Snohomish County Blue Ribbon Commission on Criminal Justice Priorities, Conclusions and Recommendations (2008:10).

<sup>18</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.32.

## Mental Illness

*One out of seventeen Whatcom County residents experience debilitating mental health disorders. One in five families is affected. - Betty Scott, NAMI Whatcom County Chapter, First Vice President*

Mental illnesses are disorders of the brain that can profoundly disrupt a person's thinking, feeling, mood, and ability to relate to others. Mental illnesses include such disorders as bipolar disorder, schizophrenia, major depression, obsessive-compulsive disorder, anxiety disorders including post-traumatic stress disorder (PTSD), and other severe and persistent mental illnesses. Mental illnesses can affect persons of any age, race, religion, or socioeconomic status, and are not the result of personal weakness, lack of character, or poor upbringing.

The unmet need and significant barriers to mental health care, especially for those who do not qualify for Medicaid, leave many of our residents with no where to turn, especially children, when early intervention would have the largest return on investment.

- **There is a high, unmet need:** Based on service utilization and census data, North Sound Mental Health Administration estimates, conservatively, that 2,776 persons in the general population are not receiving mental health services because of their Medicaid status. And 345 people who required inpatient or crisis services are not being authorized for follow-up outpatient services.<sup>19</sup>
- **Funding constraints and state and federal laws force local providers to ration treatment:** According to a recently completed Washington State report, "Given funding constraints and the statutory responsibility of the system to focus exclusively on individuals with the most serious and chronic diagnosable illnesses, any vestige of capacity to participate in the delivery of expanded services or early intervention no longer exists through the Medicaid financing system. Where capacity has been built, it has depended on alternative solutions developed at the local level."<sup>20</sup>
- **Prevention and early identification and intervention are needed, but not occurring often enough:** According to a recent study of ways to better coordinate services between public schools and publicly funded mental health providers: "The scope of need is great, few children receive organized services and schools are a primary vehicle for identifying people who may face a lifetime of emotional and economic loss without effective treatment."<sup>21</sup>
- **Mental illness is common among children:** Annually, 21% of children experience are diagnosed with mental illness; 9-15% experience a condition that causes substantial functional impairment, and 5-9% experience severe emotional disturbances that result in extreme functional impairment.
- **Most children that need treatment don't get it:** 75-80% of children with serious emotional disturbances fail to receive the specialty services they need, and according to family members the majority of these children fail to receive any services at all. Research also shows that adults with disabling mental health conditions experienced onset in early adolescence.<sup>22</sup>

<sup>19</sup> North Sound Mental Health Administration (NSMHA) Utilization/Financial Model based on data covering service dates April 2005 through March 2006; and personal communication May 27, 2008: Dennis Regan, Data Support Analyst, NSMHA.

<sup>20</sup> Harrington, H., Bldoggett, C., Hertel, R. and M. Johnson. 2008. *Publicly Funded Mental Health and School Coordination Resource Manual*. State Superintendent of Public Instruction, Olympia, Washington.

<sup>21</sup> Harrington et al.

<sup>22</sup> Harrington et al.

## Substance Abuse

Only 24% of the 4,249 lower-income households that would benefit from community-based substance abuse treatment are accessing it. Current policies force us to ration these services to the indigent. There are not enough funds to help provide these services to the working poor and other poorly served subgroups. – Jackie Mitchell, Whatcom County Substance Abuse Programs Coordinator

Nearly 8 percent of adults in the United States between the ages of 18 and 54 have a clinically significant alcohol or drug disorder. A majority (61%) of these people have an alcohol-only disorder, 22% have a drug-only disorder, and 17% have both.<sup>23</sup>

In the most recent statewide assessment of Washington State residents, 18.4% of adults living at or below 200% of the poverty level in Whatcom County exhibited a need for substance abuse treatment, but treatment was provided to only 24% of people who need it.

**3<sup>rd</sup>**

**Whatcom County's rank of 39 counties for need for substance abuse services**

**32<sup>nd</sup>**

**Whatcom County's rank for providing treatment to people who need it.**

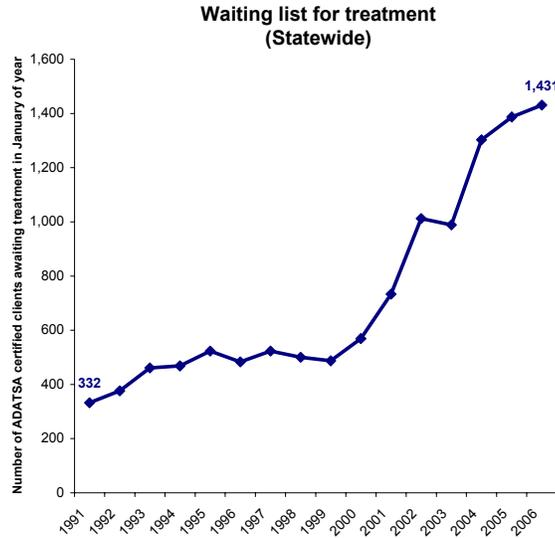
- **Very high unmet need:** Compared to statewide rates, Whatcom County has substantially higher need for treatment and significantly lower rates of treatment access: 7,389 adults need treatment and only 1,360 access treatment.<sup>24</sup> A 2003 study showed that only 20% of Washington youth in need of chemical dependency treatment received needed services.<sup>25</sup>
- **Treatment services for the indigent is inadequate:** Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals whose chemical dependency disabilities prevent them from gaining employment. The waiting list for ADATSA treatment services has more than quadrupled since 1991, and its growth is accelerating. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. However, in 2006, 30% of ADATSA clients already assessed as needing treatment were never admitted to treatment at all.<sup>26</sup>

<sup>23</sup> Steve Aos, Jim Mayfield, Marna Miller, and Wei Yen. (2006). *Evidence-based treatment of alcohol, drug, and mental health disorders: Potential benefits, costs, and fiscal impacts for Washington State*. Olympia: Washington State Institute for Public Policy.

<sup>24</sup> DSHS Research and Data Analysis Division. 2005. *County Profile of Substance Use and Need for Treatment Services: Whatcom County*.

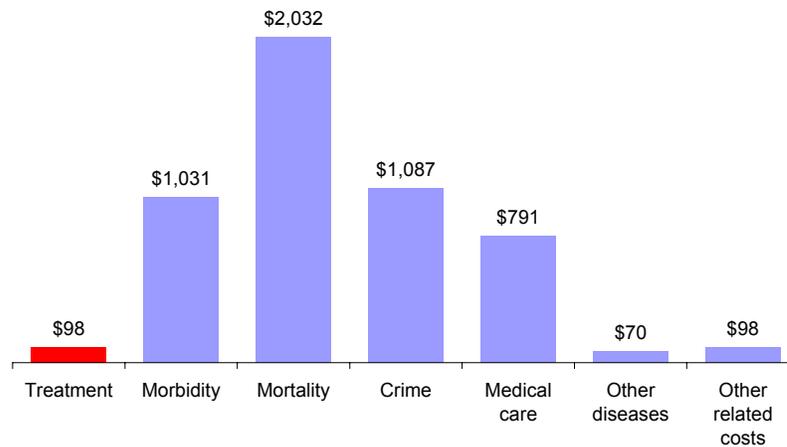
<sup>25</sup> King County Department of Community and Human Services: Mental Illness and Drug Dependency Action Plan, Population Data and Service Needs p.3.

<sup>26</sup> DSHS, Division of Alcohol and Substance Abuse. 2007. *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*.



- The costs of substance abuse are substantial:** mortality, crime, and morbidity-related costs represented the largest economic costs of substance abuse in 2005. The estimated cost per death measured in terms of lost income was \$630,000. Medical care costs (\$791 million) - including hospital, outpatient medical care, prescription drugs, nursing homes, and other professional costs – were almost four times what they were in 1996 (\$211 million).<sup>27</sup>

**Economic Costs of Drug and Alcohol Abuse in Washington, 2005**  
in millions of dollars

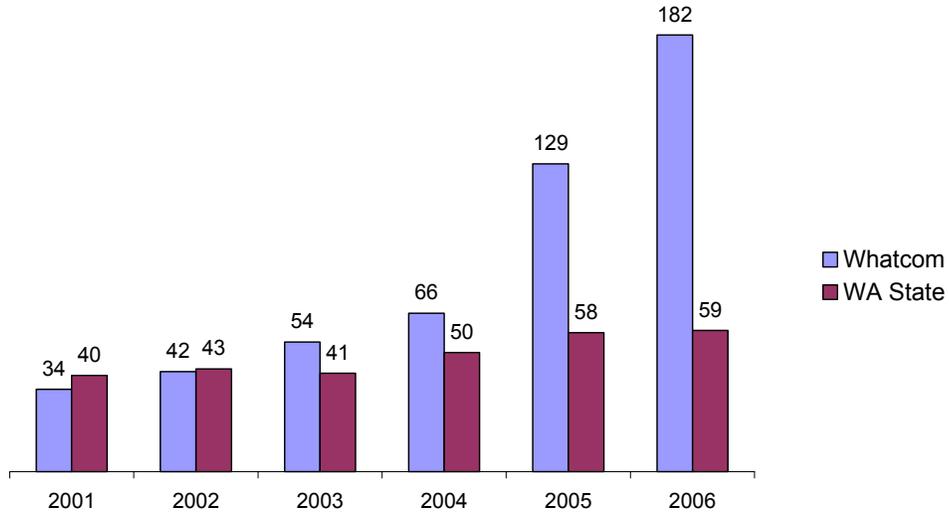


<sup>27</sup> Wickizer, T. 2007. The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse.

- **Methamphetamine addiction is a fast growing problem:**  
Methamphetamine detoxification admissions in the County increased 50% from 2004 to 2006. Youth meth treatment admission rates are rising statewide, but Whatcom County's rate is rising very rapidly, increasing from 34 per 100,000 in 2001 to 182 in 2006, an increase of 430%.

### Youth Methamphetamine Admission Rate

Admissions per 100,000 population



## Homelessness

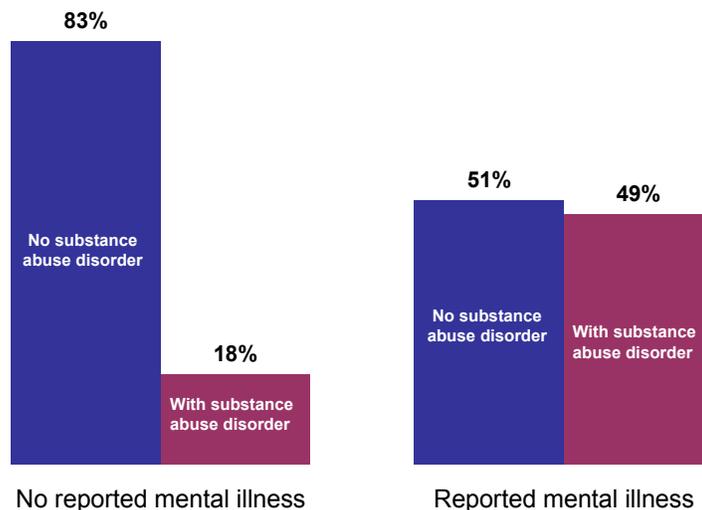
*Serious mental illness and chemical dependency are disproportionately prevalent among homeless persons in Whatcom County. 42% of the 891 homeless persons who responded to the 2008 Whatcom County homeless census reported chemical dependency, and 30% reported mental illness as primary reasons for their homelessness.*

*2008 Whatcom County Point-in-Time Homeless Count*

Behavioral health disorders are often precursors to homelessness. This is especially true among the chronically homeless and people with multiple homeless episodes.

- Substance abuse is strongly associated with homelessness:** Substance abuse is an important precursor to homelessness. In 2008, 42% of Whatcom County’s homeless households said that substance abuse was a primary reason for their homelessness.<sup>28</sup>
- Mental illness is also associated with homelessness:** Similarly, mental illness is also an important precursor to homelessness. In 2008, 30% of Whatcom County’s homeless households said that mental illness was a primary reason for their homelessness.<sup>29</sup>
- Many of Whatcom County’s homeless persons face the challenges of co-occurring disorders:** Homeless persons counted in 2008 who reported a mental illness disability were nearly three times as likely (49%) to have also reported a substance abuse disorder compared to those with no reported mental illness (18%).<sup>30</sup>

**Homeless persons with mental illness are highly likely to have a co-occurring substance abuse disorder**



<sup>28</sup> Whatcom County Health Department (WCHD). 2008. *Everyone Counts: 2008 Whatcom County Point-in-Time Homeless Count.*

<sup>29</sup> WCHD. 2008.

<sup>30</sup> WCHD. 2008.

- **Homelessness is twice as likely among jail inmates with mental illness:** According to a national study of jail inmates, those with a mental illness were twice as likely (17%) to have been homeless in the year prior to their incarceration compared to inmates without a mental illness (9%).<sup>31</sup>
- **Lack of secure housing exacerbates behavioral health disorders:** HUD reports indicate that 1.4 million SSI beneficiaries are paying more than 50% of their income on housing.<sup>3233</sup> Landlords often discriminate against potential tenants based on income sources (Section 8; SSI, etc.) and mental illness itself. Lack of secure housing exacerbates behavioral health problems directly and indirectly through disrupting treatment plans, prohibiting employment, straining family ties, and negatively impacting physical health.

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<sup>31</sup> James, D. and L. Glaze. 2006. *Mental Health Problems of Prison and Jail Inmates*. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

<sup>32</sup> July 2003 report from The President's New Freedom Commission On Mental Health p.31.

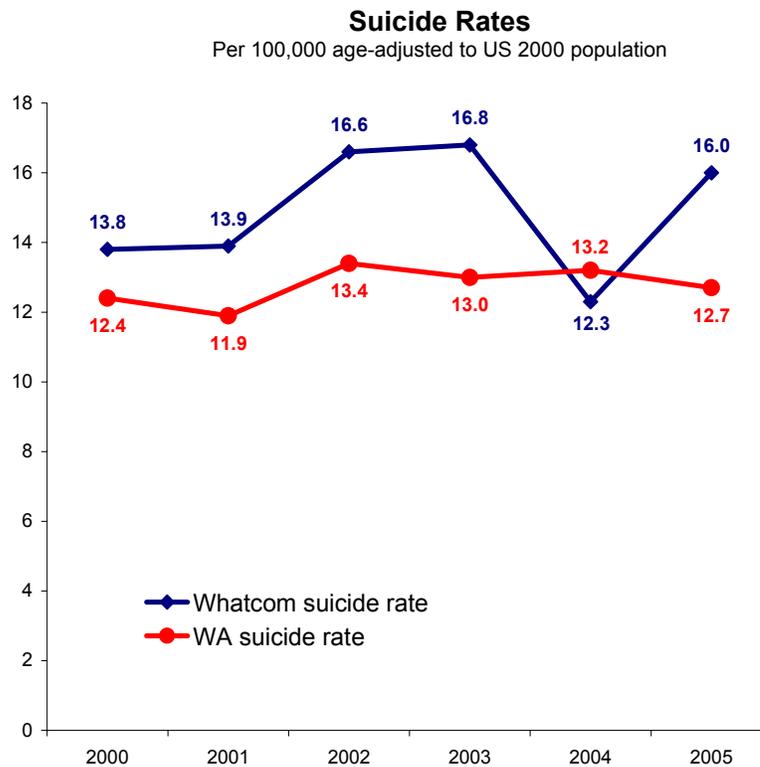
<sup>33</sup> Housing is generally considered "affordable" when residents spend no more than 30% of their income on housing costs.

**Health**

*Our Community Care Crisis Officers responded to 28 completed suicides and 90 reported attempts in 2007. Between this January and March alone, 14 more people committed suicide. More than 130 children were present in these homes.*  
 - Betty Scott, NAMI Whatcom County Chapter, First Vice President

Behavioral health disorders are associated with increased morbidity, disabilities, and reduced life spans. The tragedy of drug and alcohol-induced death and suicide, often a result of chronic mental illness, is all too common in Whatcom County.

- **Whatcom County’s suicide rate exceeds that of Washington State.** Between 2000 and 2005 (the last year for which we have data), Whatcom County’s annual age-adjusted suicide rate has exceeded the Washington State’s rate in five out of six years.<sup>34</sup>



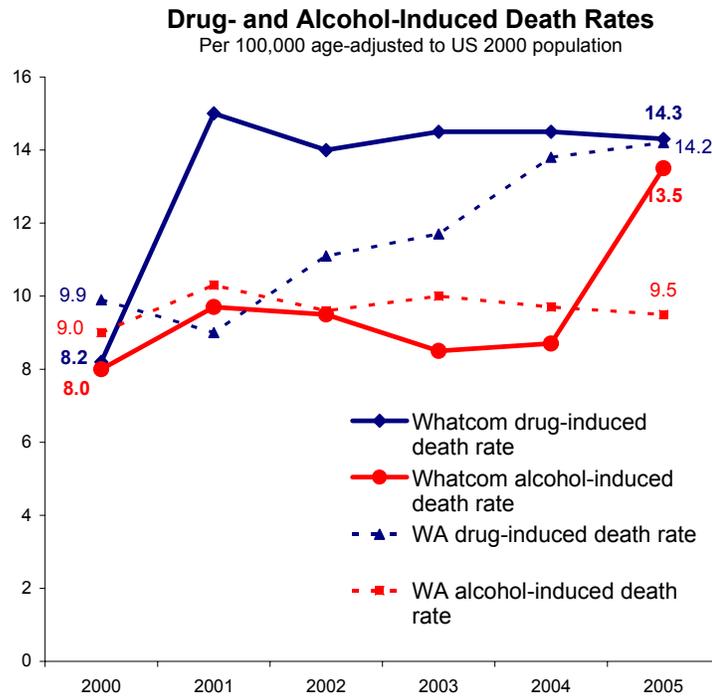
- **Suicide is the most devastating and far-reaching effect of untreated mental illness.** It is the world’s leading cause of violent death, exceeding both homicide and war<sup>35</sup>. Resulting in the deaths of about 30,000 Americans each year, suicide was the 11<sup>th</sup> leading cause of death in 2000. Mental illness is among the leading causes of disability in the United States<sup>36</sup>.

<sup>34</sup> Washington State Health Dept. (various years). Washington State Vital Statistics Reports. Olympia.

<sup>35</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.3.

<sup>36</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.21.

- Substance abuse claims lives:** In recent years, Whatcom County's drug- and alcohol-induced death rates have been comparable or higher than the state rates.<sup>37</sup>



<sup>37</sup> Washington State Health Dept. (various years). Washington State Vital Statistics Reports. Olympia.

## Productivity: Education, Employment and Income

*Though living in poverty, SSI recipients paradoxically find that returning to work makes them even poorer, primarily because employment results in losing Medicaid coverage, which is vital in covering the cost of medications and other treatments. – Report from the President’s New Freedom Commission on Mental Health (2003:29).*

One of the costs of untreated chemical dependency and mental illness is lost productivity. Society loses some or all of the productive ability of those with untreated behavioral health disorders. These costs are difficult to measure, but there is good evidence to suggest that treatment reduces these costs.

- **Mental illness is associated with high school dropout rates:** 56% of students with a mental health disorder age 14 and older drop out of high school; this is the highest dropout rate for any disability group. Students in this category are also the least likely of any disability group to graduate with a regular high school diploma.<sup>38</sup>
- **Mental illness is associated with low employment rates:** Though many people with mental illness would like to work, lack of supportive structures and employee incentives means that only 1 in 3 are employed<sup>39</sup>. Individuals are often faced with the choice of employment or treatment; yet without treatment their mental illness is likely to interfere with their capacity to acquire and maintain adequate employment. A DSHS study revealed, “for over half of adult consumers interviewed, mental health services did not help them get basic resources such as employment, work training, and safe housing.”<sup>40</sup>
- **Mental illness is associated with low wages:** The average hourly wage for an employed person with mental illness is \$3 less than the general population; even with a college degree, a 2003 report revealed that 70% of these workers made less than \$10 per hour.<sup>41</sup>

<sup>38</sup> US Dept. of Education. 2005. *Twenty-seventh Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act – 2005, Volume 1*. Washington, DC.

<sup>39</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.29.

<sup>40</sup> “The Voices: 2006 Washington State Mental Health Resource and Needs Assessment Study.” Washington State Department of Social and Health Services.

<sup>41</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.34.

## Older adults

*Substance abuse services for older adults are extremely limited. Senior-specific programs for substance abuse are virtually non-existent. Older adults face huge barriers when seeking assistance for mental health problems. It is estimated that 97% of older individuals with depression do not receive any treatment for their disease.*

*-2008 Northwest Regional Council Strategic Plan*

- **Physical health and mental health are strongly linked, especially for older adults, the group most affected by chronic illnesses.** Depression, for example, affects one in four older adults with a chronic illness<sup>42</sup>. While physical health problems may lead to mental health problems, the reverse is also true. Depression slows recovery from illness and injury, and increases mortality rates.<sup>43</sup>
- **While the rate of mental illness among older adults is increasing, the social stigma attached to mental illness is persistent, presenting barriers to treatment and recovery.** People are increasingly likely to fear and avoid those with mental illness, discouraging sufferers from seeking help for fear of exposure.<sup>44</sup>
- **Despite increased contact with medical personnel including primary care physicians, older adults have the highest suicide rate of any other age group.** The lack of screening and intervention through these contact points is evident, considering 1 in 3 older men had met with their primary care provider within a week of committing suicide, and nearly 3 in 4 had met within a month.<sup>45</sup> “Nine out of ten aged and disabled clients who visited the emergency room 31 or more times in FY 2002 had a substance abuse disorder, a mental illness, or both.”<sup>46</sup>
- **Literature shows that traditional substance abuse services are not meeting the needs of older adults, yet senior-centered services are very limited.** Prescription drug abuse is a particular problem with older adults, linked with inconsistent primary health care and “doctor hopping.”<sup>47</sup>
- **Older adults face additional barriers to mental health care, and are often misdiagnosed and untreated.** An estimated 97% of older individuals with depression do not receive treatment. 75% of those who do receive treatment do not receive adequate treatment.<sup>48</sup> In other words, less than 1% (3%/25%) of depressed older adults are receiving adequate treatment.

<sup>42</sup> July 2003 report from The President’s New Freedom Commission On Mental Health p.26.

<sup>43</sup> “Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans.” SAMHSA’s National Mental Health Information Center (2005:2).

<sup>44</sup> “Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans.” SAMHSA’s National Mental Health Information Center (2005:executive summary).

<sup>45</sup> “Mentally Healthy Aging: A Report on Overcoming Stigma for Older Americans.” SAMHSA’s National Mental Health Information Center (2005:3).

<sup>46</sup> “Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness: Washington State’s Aged, Blind and Disabled Clients.” Washington State Department of Social and Health Services.

<sup>47</sup> Area Plan 2008-2011 Section C-3.

<sup>48</sup> Area Plan 2008-2011 Section C-3.

**WORK THAT NEEDS TO BE DONE: CROSS-SYSTEM BEHAVIORAL HEALTH SERVICES STRATEGIES**

The following table presents a cross-systems matrix of recently completed community plans and needs assessments that included recommendations related to behavioral health services. Six general strategies emerged from the detailed recommendations (see chart below). Expected outcomes of these six strategies are shown in the chart on the following page.

Recommended Strategies based on community plans and needs assessments	Community Service Plans and Needs Assessments					
	A. NSMHA Strategic Plan	B. Substance Abuse Strategic Plan	C. Law and Justice Plan	D. 10-Year Homeless Plan	E. PeaceHealth Behavioral Health Stakeholder Assessment	F. Whatcom Prosperity Project
1. Increase access to community mental health and substance abuse treatment services	✓	✓	✓	✓	✓	✓
2. Expand prevention, early intervention and outreach services for adolescents and adults	✓	✓	✓	✓	✓	
3. Expand access to diversion options and therapeutic courts		✓	✓			
4. Create and expand access to services that support people in recovery and people reintegrating upon release from jail or prison	✓	✓	✓	✓		
5. Increase integration and coordination between behavioral health service systems	✓	✓	✓	✓		✓
6. Develop stable source of local funding	✓	✓	✓			✓

## Whatcom County Behavioral Health Plan Strategies and Expected Outcomes

### #1: Increase access to community mental health and substance abuse treatment services

- Non-Medicaid eligible
- Treatment is cost-effective
- Treatment reduces recidivism, hospitalization, and homelessness

### #4: Create and expand access to services that support people in recovery

- Provide stable housing
- Increase education and employment
- Decrease relapse and recidivism

### #2: Expand prevention, early intervention and outreach services for adolescents and adults

- Early intervention decreases harmful effects, future costs
- Reduce emergency room and law-enforcement costs
- Enhance family involvement

### #5: Increase integration and coordination between behavioral health service systems

- Eliminate redundancies, unnecessary costs
- Highlight service gaps
- Acknowledge interrelatedness of public safety, housing, productivity, and behavioral health

### #3: Expand access to diversion options and therapeutic courts

- Divert from jail
- Reduce recidivism
- Increase educational attainment and employment
- Reunite families

### #6: Develop stable source of local funding

- Reduce service gaps
- Realize future pay-offs for present investments
- Leverage other funding with local funds

The following tables present the detailed activities and programmatic changes recommended, but not yet adequately implemented, by each of several community service plans. Letter notations denote the specific strategic plan or community needs assessment that recommended each action.

**Table 1 Cross-system matrix of recommended strategies to improve the behavioral health system in Whatcom County**

Recommended Strategies	Recommended Action
<p><b>1. Increase access to community mental health and substance abuse treatment services</b></p> <p><b>Plans: A, B, C, D, E, F, G, H, I</b></p>	<ul style="list-style-type: none"> <li>• Increase inpatient, outpatient, and co-occurring services to low-income people who do not qualify for Medicaid (A), (B), (E)</li> <li>• Support training for Whatcom County chemical dependency professionals (B)</li> <li>• Substance abuse treatment services designed for older adults (B),(H)</li> <li>• Implement Designated Crisis Responder and involuntary detoxification services (A), (C)</li> <li>• Expand discharge and related jail behavioral health services, including the recovery house treatment model; continue to develop the funding to support treatment for the criminal justice population. (A),(B), (I)</li> <li>• Expand the local Program of Assertive Community Treatment. (I)</li> <li>• Explore and develop outcomes in conjunction with evidence-based practices, which focus on improving treatment completion rates. (B)</li> <li>• Develop blended or collaborative services with the medical community to treat addicts, including those with chronic pain. (B)</li> <li>• Increase the availability of mental health treatment and domestic violence treatment in the community, adapting behavioral health services to meet the needs of domestic violence perpetrators and victims. (C),(G)</li> <li>• Develop transportation and staffing for both group therapy and individual services to be provided in the new Triage Center for offenders who are housed in the existing main jail. (C)</li> <li>• Provide for adequate space and staffing for long-term mental health, alcohol and substance abuse treatment in plans for the new main jail. (C)</li> <li>• Medicaid eligibility advocacy (A)</li> <li>• Address the need for local behavioral health services for children and adolescents (E)</li> </ul>
<p><b>Plan Key: A=NSMHA Strategic and Housing Plans, B=Substance Abuse Strategic Plan, C=Law and Justice Plan, D=10-Year Homeless Plan, E PeaceHealth Behavioral Health Stakeholder Assessment F=Whatcom Prosperity Project; G Bellingham-Whatcom County Commission Against Domestic Violence Strategic Plan; H=Northwest Regional Council Strategic Plan</b></p>	

Recommended Strategies	Recommended Action
<p><b>2. Expand prevention, early intervention and outreach services for adolescents and adults</b></p> <p><b>Plans: A, B, C, D, H, I</b></p>	<ul style="list-style-type: none"> <li>• Implement services that target multiple systems, including children in schools and homeless youth (A),(B),(D)</li> <li>• Explore development of additional outreach projects targeted at such populations as homeless youth, youth in schools, seniors, and the emergency department. (B)</li> <li>• Implement prevention services that reduce priority risk factors and increase priority protective. (B)</li> <li>• Implement prevention services that target multiple systems, including youth and their families. (B)</li> <li>• Increase outreach and behavioral health services for seniors that are adapted to their unique needs. (A),(B)</li> <li>• Develop medical screening component at the Triage Center and increase integration with the hospital emergency department. (B),(E), (I)</li> <li>• Enhance hospital emergency department services for behavioral health patients. (B),(E), (I)</li> <li>• Develop coordinated utilization of the Children’s Mental Health Crisis Emergency Team to work with Juvenile Court, probation and Detention Center. (C)</li> <li>• Implement the Whatcom County Homeless Services Center to provide a coordinated point of exit from homelessness for individuals and families with both moderate and severe housing barriers (D)</li> </ul>
<p><b>3. Expand access to diversion options and therapeutic courts</b></p> <p><b>Plans: B, C, I</b></p>	<ul style="list-style-type: none"> <li>• Develop a behavioral health specialty court to divert from jail offenders whose offenses are caused by mental health problems, and to better utilize mental health treatment resources in the community. (C), (I)</li> <li>• Maintain and expand Drug Court, Juvenile Drug Court and Family Treatment Court by hiring a court coordinator for each program. (C)</li> <li>• Reduce the inappropriate use and need for additional jail capacity with the provision of treatment and supports for offenders with treatable behavioral health disabilities. Increase treatment funding for behavioral health offenders. (B)</li> <li>• Identify and reduce barriers to jail diversion. Utilize funding from the state Hargrove legislation to develop diversion alternatives for ex-offenders. (C)</li> <li>• Identify and develop services to assure case management activities. (B)</li> <li>• Research funding alternatives for Court Programs and back door treatment services. (B)</li> </ul>
<p><b>Plan Key: A=NSMHA Strategic and Housing Plans, B=Substance Abuse Strategic Plan, C=Law and Justice Plan, D=10-Year Homeless Plan, E PeaceHealth Behavioral Health Stakeholder Assessment; F=Whatcom Prosperity Project; G Bellingham-Whatcom County Commission Against Domestic Violence Strategic Plan; H=Northwest Regional Council Strategic Plan, I=NAMI Whatcom County Recommendations for Behavioral Health Plan</b></p>	

Recommended Strategies	Recommended Action
<p><b>4. Create and expand access to services that support people in recovery and community re-entry</b></p> <p><b>Plans: A, B, C, D, I</b></p>	<ul style="list-style-type: none"> <li>• Expand housing and residential services and options, especially to chronic substance abusing populations, and with co-occurring disorders. (A),(B), (I)</li> <li>• Permanent housing with supportive services for re-entering youth with mental health issues or developmental disabilities that preclude family re-unification or self-sufficiency. (D)</li> <li>• Increase community housing access for ex-offenders released from prison and jail, as well as those with criminal or violent histories. (A),(C), (I)</li> <li>• Advocate that Washington State’s Housing Trust Fund make a priority of funding housing projects that serve people re-entering the community from in-patient hospitalization and residential care facilities, assuring smooth transitions between triage and inpatient treatment to housing and outpatient treatment. (A),(B)</li> <li>• Research the feasibility for startup of a self-supporting Alano club or Drop-in Center with space for adult and youth. (B)</li> <li>• Promote the development of 70 new slots of supportive housing services are developed (A)</li> <li>• Seek to double the number of adult residential treatment facility beds in the region from 16 to 32. (A)</li> <li>• The County Coordinator and substance abuse providers should work closely with the new Homeless Services Center and Community Oriented Re-Entry (CORE) Team to develop new housing solutions. (B)</li> <li>• Determine possible methods for implementing Family Support Services in a longer-term program for the next biennium. (B)</li> <li>• Find ways to support landlords so that they will be more willing to rent to [mental health treatment] consumers. (A)</li> <li>• Expand employment and vocational services during and after treatment and for offenders released from treatment. Recruit job sites, organizations, and employers to provide volunteer training or employment to people in recovery. (A),(B),(C)</li> <li>• Continue support and development of clubhouses. (A), (I)</li> <li>• Develop the resources to allow community mental health providers to offer Wellness Recovery Action Plan (WRAP) programs and Peer Connections support groups. (I)</li> <li>• Establish a local transition network to which newly released ex-offenders may be evaluated and access services including health care. (C)</li> <li>• Provide access to medications for low-income persons as needed for long-term stabilization. (I)</li> </ul>

**Plan Key:** A=NSMHA Strategic and Housing Plans, B=Substance Abuse Strategic Plan, C=Law and Justice Plan, D=10-Year Homeless Plan, E PeaceHealth Behavioral Health Stakeholder Assessment F=Whatcom Prosperity Project; G Bellingham-Whatcom County Commission Against Domestic Violence Strategic Plan; H=Northwest Regional Council Strategic Plan, I=NAMI Whatcom County Recommendations for Behavioral Health Plan

Recommended Strategies	Recommended Action
<p><b>5. Increase integration and coordination between behavioral health service systems</b></p> <p><b>Plans: A, B, C, D, F, G, I</b></p>	<ul style="list-style-type: none"> <li>• Cooperate with statewide effort to establish electronic health records technology to coordinate health records between jails and community mental health and substance abuse treatment agencies. (C)</li> <li>• Track intermediate results and long term results; and increase the community's ability to collect and analyze data that addresses variances between smaller geographies within Whatcom County. (B)</li> <li>• Identify and develop services to assure case management activities. (B)</li> <li>• Increase cross system coordination of pre and post booking diversion utilizing the new Whatcom County Behavioral Health Triage Center. (C)</li> <li>• Create more linkages across community service systems (e.g. domestic violence, mental health, substance abuse, law and justice, and employment services). (D)</li> <li>• Begin implementing a countywide homeless management information system (HMIS) to provide better accountability for public investments in homeless services. (D)</li> <li>• Service providers and policy makers must coordinate and collaborate across sectors (F)</li> <li>• Convene a summit of service providers (mental health, drug &amp; alcohol, CPS, domestic violence and housing) to discuss coordination and integration of services across all disciplines and to set the foundation for a more coordinated and integrated service delivery model. (G)</li> <li>• Integrate mental health and medical care at all medical and mental health centers. (I)</li> <li>• Provide CIT training for law enforcement personnel. (I)</li> </ul>
<p><b>6. Develop stable source of local funding</b></p> <p><b>Plans: A, B, C, F, I</b></p>	<ul style="list-style-type: none"> <li>• Explore additional funding such as that authorized by RCW 82.14.460 (sales tax increment) and RCW 70.96A.325 (state matching funds for methamphetamine treatment). (A), (B), (C), (F), (I)</li> <li>• Research funding opportunities to recruit for opiate substitution service capacity. (B)</li> <li>• Secure dependable funding sources for both adult and juvenile Drug Court. (C)</li> <li>• Develop a dependable funding stream for an adult Behavioral Health Court. (C)</li> <li>• Provide blended funding for clients with co-occurring disorders (I)</li> </ul>
<p><b>Plan Key:</b> A=NSMHA Strategic and Housing Plans, B=Substance Abuse Strategic Plan, C=Law and Justice Plan, D=10-Year Homeless Plan, E PeaceHealth Behavioral Health Stakeholder Assessment F=Whatcom Prosperity Project; G Bellingham-Whatcom County Commission Against Domestic Violence Strategic Plan; H=Northwest Regional Council Strategic Plan, I=NAMI Whatcom County Recommendations for Behavioral Health Plan</p>	

## Behavioral Health Solutions

This section of the plan presents example evaluation findings of community-based behavioral health strategies that emerged from the examination of local community service plans. Most of the findings in this section are based on state-level evaluation and cost-benefit studies. Where available, local evaluation data are also presented. In some cases, national level data or recommendations are used.

### Strategy #1: Increase access to community mental health and substance abuse treatment services

- **Treatment prevents first offenses and recidivism:** In Whatcom County, between 2002 and 2004, for those with no pre-admission arrest, adults who received and completed treatment were 4.5 times less likely than non-completers to have a post-discharge felony arrest. For those with a pre-admission felony arrest, completers were 2.3 times less likely to have a post-discharge arrest.<sup>49</sup>
- **Treatment reduces publicly funded inpatient hospital admissions:** In the year following discharge from substance abuse treatment, treatment completers were 21% less likely to require an inpatient hospital admission.<sup>50</sup> Completing treatment has an even greater effect on emergency room visits for Washington State SSI recipients. Those who received no treatment average 13.3 visits per year, those who begin treatment average 11.0 visits, while those who complete treatment average only 6.8 visits.<sup>51</sup>
- **Good return on community investment:** Using a very thorough cost-benefit analysis, the Washington State Institute for Public Policy found that “evidence-based treatment of these disorders can achieve about \$3.77 in benefits per dollar of treatment cost. This is equivalent to a 56% rate of return on investment. From a narrower taxpayer’s-only perspective, the ratio is roughly \$2.05 in benefits per dollar of cost.”<sup>52</sup>
- **Substance abuse treatment reduces emergency department costs and visits:** The average monthly emergency room cost is \$442 for SSI clients who need substance abuse treatment but do not receive it. These costs are reduced to \$288 per month for SSI clients who receive treatment.<sup>53</sup> 15% of all visits to the local hospital emergency department are by people with behavioral health disorders. In 2004 there were 7,992 emergency department visits by people with behavioral health disorders. Within that group there were 297 frequent ED users (4 or

<sup>49</sup> DSHS, Division of Alcohol and Substance Abuse, TARGET Database

<sup>50</sup> DSHS Research and Data Analysis Division. 2002. *Substance Abuse Treatment and Hospital Admission: Analyses from Washington State*.

<sup>51</sup> DSHS Research and Data Analysis Division. “Reducing Emergency Room Visits Through Chemical Dependency Treatment: Focus on Frequent Emergency Room Visitors.” (2004)

<sup>52</sup> Steve Aos, Jim Mayfield, Marna Miller, and Wei Yen. 2006. *Evidence-based treatment of alcohol, drug, and mental health disorders: Potential benefits, costs, and fiscal impacts for Washington State*. Olympia: Washington State Institute for Public Policy.

<sup>53</sup> Mancuso, D., Nordlund, D., and B. Felver. 2004. *Chemical Dependency Treatment Reduces Emergency Room Costs and Visits*. DSHS Research and Data Analysis Division.

more visits during the year) who accounted for just 6% of behavioral health patients, but 24% of the ED visits.

- **Treatment works for most people living with mental illness, and an array of services and supports are necessary to ensure recovery.** Early identification and treatment is of vital importance. By getting people the treatment they need early, recovery is possible. The unintended consequence of untreated mental illness results in a negative financial and social impact to police, educators, emergency rooms, and businesses. Cost-effective, proven treatment and services exist that not only support recovery for people living with mental illness, but also ensure the health of our communities and families.
- **Treatment outcomes for mental illness are effective, with success rates ranging from 60-80%.<sup>54</sup>** The Assertive Community Treatment program (ACT) is a cost-effective and life-saving alternative to traditional care. In one year, hospital inpatient days decreased 63% and jail days decreased 70% for Oklahoma ACT clients.<sup>55</sup>
- **Outpatient mental health treatment reduces mortality:** Over a two-year period, the odds of dying are 23% lower for mentally ill Medicaid clients who receive outpatient mental health treatment than the odds for Medicaid clients with similar mental illness who did not get treatment. For persons on General Assistance (GA-U), the odds of dying are 29% lower.<sup>56</sup>
- **Substance abuse treatment reduces mortality:** A study by DSHS found that among persons who need substance abuse treatment, the risk of death is 57% lower for persons who receive treatment compared to those who do not.<sup>57</sup>
- **Substance abuse treatment results in higher rates of employment and earnings:** Among substance abuse clients who were not employed prior to treatment, those who completed treatment were 1.3 times more likely than non-completers to be employed in the year after discharge, and had three times higher annual median wages.<sup>58</sup>
- **Medical costs are reduced significantly for Medicaid clients who receive mental health treatment.** Subsequent medical costs for clients receiving outpatient mental health treatment are reduced by about \$105 per person per month in the first follow-up year and \$126 per month in the second year, compared to clients with similar mental illness who did not receive treatment. These savings offset 41-50% of the cost of providing the outpatient treatment.<sup>59</sup>

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<sup>54</sup> National Alliance on Mental Illness Fact Sheet (2007:2).

<sup>55</sup> National Alliance on Mental Illness Fact Sheet (2007:2).

<sup>56</sup> Mancuso, D. and S. Estee. 2003. Washington State Mental Health Services: Cost Offsets and Client Outcomes. Technical Report. DSHS Research and Data Analysis Division.

<sup>57</sup> Braddock, D. 2004. *On Drugs, Crime and Dollars: Closing the Alcohol and Drug Treatment Gap*. DSHS, Olympia, WA.

<sup>58</sup> Whatcom County Health Department. 2008. DSHS DASA TARGET data analysis by Cornerstone Strategies, Inc.

<sup>59</sup> Mancuso, D., and S. Estee. 2003. *Washington State Mental Health Services: Cost Offsets and Client Outcomes*. DSHS Research and Data Analysis Division.

## **Strategy #2: Expand prevention, early intervention and outreach services for adolescents and adults**

- **Screening, brief intervention, referral and treatment (SBIRT) is a promising new practice:** SBIRT is an emerging best practice being used successfully in Washington State. It provides brief interventions, brief therapy, and, in some cases, chemical dependency treatment to emergency department patients who screen positive for substance use disorders. Findings from a recent pilot study of SBIRT in Washington State (WASBIRT) are encouraging, showing significant reductions in average days of alcohol use, binge drinking, and illegal drug use in a six month follow-up.<sup>60</sup> In addition to being effective, this program is also cost-efficient. Pilot study results suggest that up to \$2.7 million could be saved a year if brief interventions were routinely given to Medicaid clients. The major source of savings is reduced hospitalizations resulting from emergency room visits, at -\$238 per member per month.<sup>61</sup>
- **School-based mental health programs, such as TeenScreen®, are in a unique position to provide early intervention to children and teens, saving them a lifetime of suffering and hardships.** This program administers students an initial screening questionnaire identifying youth who may be at-risk for suicide. These youth are then further assessed through a one-on-one interview with a mental health professional, through which appropriate referrals are made.<sup>62</sup> Studies have shown this screening program is very effective at identifying teens at-risk for suicide, enabling early intervention and treatment.<sup>63,64</sup>

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<sup>60</sup> Estee, Sharon, Nella Lee, and Lijian He. 2006. *Six-Month Follow-up Survey of WASBIRT Clients April 2004 – January 2005*. DSHS Research and Data Analysis Division.

<sup>61</sup> Estee, Sharon, Lijian He, David Mancuso, and Barbara E.M. Felver. 2007. *Medicaid Costs Decline Among Emergency Department Patients who Received Brief Interventions for Substance Use Disorders through WASBIRT*. DSHS Research and Data Analysis Division.

<sup>62</sup> <http://www.teenscreen.org/program-overview>

<sup>63</sup> Shaffer D., Scott M, Wilcox H., Maslow C., Hicks R., Lucas C., Garfinkel R., Greenwald S. 2004. *The Columbia Suicide Screen: Validity and Reliability of a Screen for Youth Suicide and Depression*. *Journal of the American Academy of Child and Adolescent Psychiatry*; 43(1):71-79.

<sup>64</sup> July 2003 report from The President's New Freedom Commission On Mental Health p.25.

### Strategy #3: Expand access to diversion options and therapeutic courts

- **Diversion programs place offenders with behavioral health needs in treatment programs for mental health and substance abuse rather than in jail.** Behavioral courts, also known as therapeutic courts, or drug courts, are a popular means of diversion supported by many mental health practitioners in our community. These courts address the many factors in an offender's life that are prohibiting their successful functioning in society, while a jail sentence often creates further barriers to success without addressing the root causes of criminal behavior.
- **The Washington State Institute for Public Policy found that drug court reduced recidivism by 13% for five out of six counties studied.** The cost effectiveness of drug courts in six counties (King, Pierce, Spokane, Skagit, Thurston, and Kitsap) was evaluated, with positive results in all but King County.<sup>65</sup> These patterns are especially strong in Whatcom County, where the recidivism rate for drug court graduates is even lower than the statewide average, (29% versus 35%).<sup>66</sup> The effect of drug courts is promising when compared to the average recidivism rate of 54% for offenders who do not go through drug court<sup>67</sup>.
- **Though drug courts are more expensive to operate, in the long-run they are more cost-effective than traditional courts for offenders with chemical dependency issues.** This study found that for those five counties, there was \$1.74 in benefits for every dollar spent on drug courts, due primarily for the reduction in recidivism.<sup>68</sup> These findings were corroborated in an extensive literature review of 56 studies of Washington drug courts carried out by the Institute. This report showed that on average drug courts reduced recidivism by 10.7%.<sup>69</sup>
- **Court-required treatment boosts completion rates:** Based on Whatcom County data from 2000-2006, the annual treatment completion rate among publicly-funded adults was 28% higher for those in Court-required outpatient treatment programs.<sup>70</sup> In Whatcom County, drug court is making a particular impact on methamphetamine addiction and related criminal activity. About one in three drug court participants are methamphetamine users and one in three drug court graduates were treated primarily for methamphetamine addiction.<sup>71</sup> It is important to consider these results in the face of the growing problem of methamphetamine addiction and its negative impact on the community.

<sup>65</sup> Washington State Institute for Public Policy. 1999. *Can Drug Courts Save Money for Washington State Taxpayers?*

<sup>66</sup> Whatcom County Drug Court Fact Sheet. 2008.

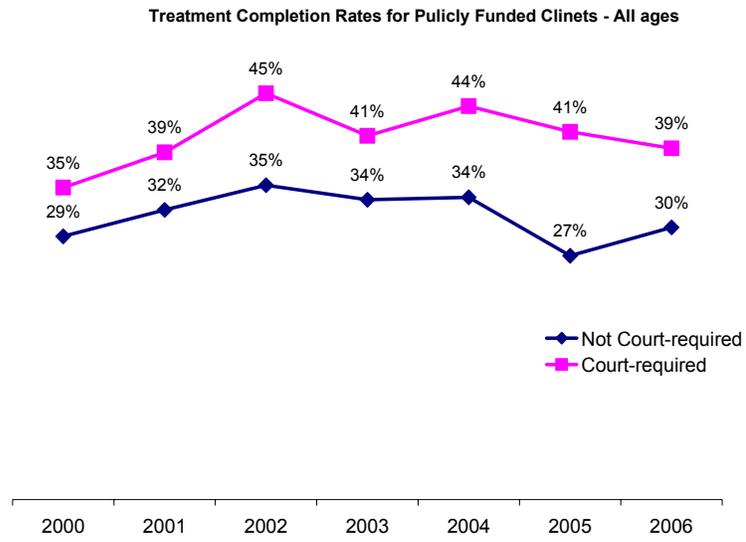
<sup>67</sup> Whatcom County Drug Court Fact Sheet. 2008.

<sup>68</sup> Washington State Institute for Public Policy. 1999. *Can Drug Courts Save Money for Washington State Taxpayers?*

<sup>69</sup> Washington State Institute for Public Policy. 2006. *Evidence-Based Adult Corrections Programs: What Works and What Does Not.*

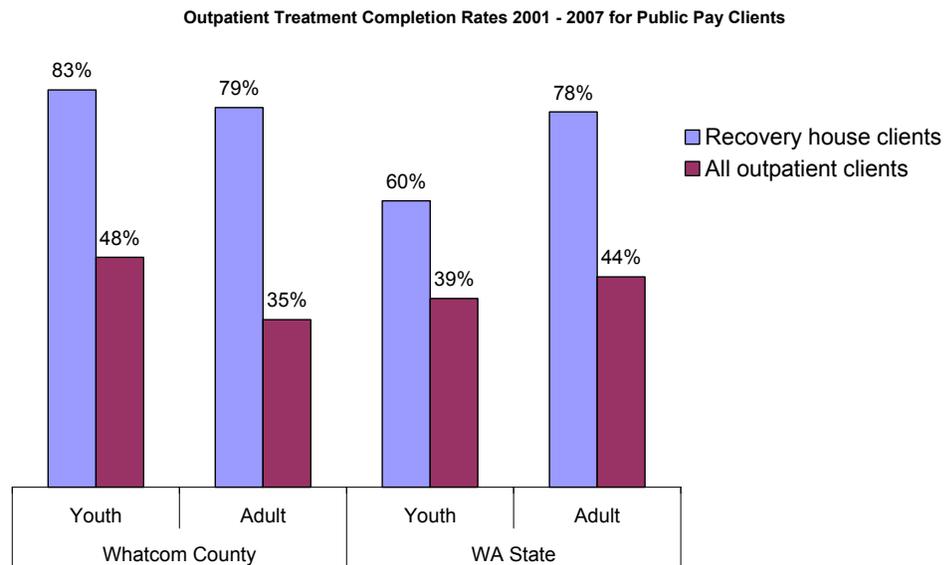
<sup>70</sup> Whatcom County Health Department. 2008. DSHS DASA TARGET data analysis by Cornerstone Strategies, Inc.

<sup>71</sup> Whatcom County Drug Court Fact Sheet. 2008.



#### Strategy #4: Create and expand access to services that support people in recovery and people reintegrating upon release from jail or prison

- Recovery houses boost treatment completion rates.** Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment. There is ample evidence that recovery houses are essential elements in a community's recovery continuum. They are associated with substantial increases in treatment completion for adults and youth.<sup>72</sup>



- Supportive housing programs for the mentally ill have proven cost-effective solutions for homelessness:** Findings from a study of homeless persons with severe mental illness in New York City show reduced shelter use, hospitalizations, length of hospital stays, and incarceration for supported housing clients. The cost of running the supportive housing program is offset by the cost savings from these reduced service needs.<sup>73</sup>
- Supported employment programs go beyond basic vocational training or job search services:** People with mental illness need help finding suitable employment, negotiating their needs with employers, and maintaining ongoing successful employment. One study found, even when controlling for demographics, work history, and clinical conditions, clients participating in supported employment programs

<sup>72</sup> Whatcom County Health Department. 2008. DSHS DASA TARGET data analysis by Cornerstone Strategies, Inc.

<sup>73</sup> Culhane, D., S. Metraux, and T. Hadley. 2001. *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of Public Health, Corrections and Emergency Shelter Systems: The New York-New York Initiative*. Fannie Mae Foundation.

faired better than their peers. They were more likely to have a competitive job (55% compared to 35% of the control group), worked more hours per month and earn higher wages.<sup>74</sup> Employment can also be a positive and stabilizing factor for those with co-occurring disorders. One report identifies key elements of successful supported employment programs, including “incorporating information about the person’s substance use in a vocational profile and individualized employment plan, identifying a job that promotes recovery, learning coping mechanisms for managing stress at work, developing a money management plan, and using a team approach.”<sup>75</sup>

- **Employment resource center decreases recidivism for clients re-entering from incarceration:** A study of The Kintock Group, Inc. found that clients of a reintegration program had a greater success rate of not being recommitted (72% Kintock group; 65% control group), even when controlling for age, race, type of crime, and other common predictors of recidivism. In addition to case management and substance abuse treatment, the Kintock program includes “employment referral, placements, employment counseling and employment support and retention.”<sup>76</sup>
- **Community-based models for vocational rehabilitation reduce hospitalization of behavioral health clients:** The Nassau Day Training Program (NDTP) supports training and employment of schizophrenic patients. An evaluation of this program revealed that one year after enrollment mental health costs were reduced by 70% for program participants, mainly through reductions in hospitalization and day treatment programs. The authors hypothesize that the positive effects of this program is due to clients having meaningful, structured activities related to the client’s own goals, increased social contact leading to early detection of mental illness symptoms, and the therapeutic properties of the work itself: by engaging one’s mind one strengthens it.<sup>77</sup> Another study of the Assertive Community Treatment program also found positive results for vocational rehabilitation for the severely mentally ill. Clients of the ACT program who received vocational support services were more likely to start new jobs, report job upgrades, work more days, and make higher wages than clients of the ACT program that did not receive vocational support.<sup>78</sup>

<sup>74</sup> Cook, Judith. 2007. *Executive Summary of Findings from the Employment Intervention Demonstration Program*. Center on Mental Health Services Research & Policy.

<sup>75</sup> Becker, Deborah R., Robert E. Drake, and William J. Naughton, Jr. 2005. *Supported Employment for People with Co-Occurring Disorders*. *Psychiatric Rehabilitation Journal*, 28(4):332-338.

<sup>76</sup> Jengeleski, James L. and Michael S. Gordon. 2003. *The Kintock Group, Inc. – Employment Resource Center: A Two-Year Post-Release Evaluation Study*. *The Journal of Correctional Education*, 54(1):27-30.

<sup>77</sup> Jaeger, Judith, Stefanie Berns, Estelle Douglas, Bonnie Creech, Bruce Glick, and John Kane. 2006. *Community-based vocational rehabilitation: effectiveness and cost impact of a proposed program model*. The Royal Australian and New Zealand College of Psychiatrists.

<sup>78</sup> Furlong, Mark, Marion L. (Taffy) McCoy, Jerry Dincin, Roy Clay, Kelly McClory and Debra Pavick. 2002. *Jobs for People with the Most Severe Psychiatric Disorders: Thresholds Bridge North Pilot*. *Psychiatric Rehabilitation Journal*, 26(1):13-22.

### **Strategy #5: Increase integration and coordination between behavioral health and other service systems**

- **Behavioral health service providers and public school collaboration.** Across the country, progressive growth of school mental health programs and services has been spurred by increased recognition of the benefits to schools of attention to student mental health and by the potential of mental health services in schools for improving access to diagnosis and treatment, for achieving improved coordination of services (especially coordination with educational programs), and for increased prevention efforts.<sup>79</sup>
- **Behavioral health crisis triage requires continued and further collaboration** between behavioral health providers, the criminal justice system, and medical care providers. To realize the most cost-effective outcomes, a crisis triage system integrates jail, emergency department and psychiatric hospital diversion with law enforcement, and it integrates mental health and chemical dependency assessment and treatment. Whatcom County's Crisis Triage Center represents a significant step toward this fully integrated model; however, recent needs assessments have highlighted some activities that would further enhance the cost-effectiveness of this system. Examples include enhanced medical and behavioral health services, and crisis intervention training for law enforcement personnel.
- **Boundary Spanners encourage smooth transitions between incarceration, treatment, and other services by maintaining strong ties with criminal justice and mental health providers.**<sup>80,81</sup> This emerging practice helps individuals move through complex service systems by "identifying gaps, reducing barriers to services, and conserving institutional resources." A key component of system-wide coordination, boundary spanners increase collaboration between diverse entities through "expression of the needs, expectations, and demands of one system using the terms and concepts of another."<sup>82</sup>

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<sup>79</sup> Center for School-Based Mental Health Programs, Miami University

<sup>80</sup> Taxman, Faye S., Douglas Young, James M. Byrne, Alexander Holsinger, and Donald Anspach. 2002. *From Prison Safety to Public Safety: Innovations in Offender Reentry*. National Institute of Justice.

<sup>81</sup> Gruzinkas, Albert J., Jonathan C. Clayfield, Kristen Roy-Bujnowski, William H. Fisher, and the Hon. Maurice H. Richardson. 2005. *Integrating the Criminal Justice System into Mental Health Service Delivery: The Worcester Diversion Experience*. Behavioral Sciences and the Law 23:277-293.

<sup>82</sup> Pettus, Carrie A. and Margaret Severson. 2006. *Paving the Way for Effective Reentry Practice: The Critical Role and Function of the Boundary Spanner*. The Prison Journal, 86:206-229. See also Steadman, Henry J. *Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems*. Law and Human Behavior, 16(1):75-87.

**Strategy #6: Develop stable source of local funding**

Engrossed Second Substitute Senate Bill 5763 – known also as the “Hargrove Bill” – was passed in 2005. The bill authorized counties to impose a 1/10 of one percent sales tax to fund new mental health, chemical dependency or therapeutic court services. As of November 2007, eight counties had passed the sales tax option and five more counties were considering or planning to implement the tax. Counties with the new tax include: Clallam, Clark, Island, Jefferson, King, Okanogan, Skagit and Spokane. Counties considering passing the tax include: Lewis, San Juan, Snohomish, Whatcom and Yakima.<sup>83</sup> Projected revenues for those planning to or who have implemented the sales tax option ranged from \$ 250,000 in Okanogan County to \$48 million in King County. Services to be provided include alternative courts and an array of mental health and substance abuse treatment options.

In Whatcom County, three community service plans include recommendations to implement the sales tax increment option to fund behavioral health services. In 2008, a committee of behavioral health advocates developed a proposed set of specific activities that could address many of the needs and implement the strategies that have been recommended by local plans. This list of activities is included in Appendix A. It should be noted that these specific activities are not necessarily those that would be implemented with new funds generated by a sales tax increase, should the County decide to exercise that option. In that event, it is likely that these and other recommendations would be reviewed by an advisory committee created by a local ordinance, as most of the other “Hargrove Bill” counties have done.

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<sup>83</sup> Strode, A.D. 2008. Final Report: Implementing E2SSB-5763 In Washington State Counties. Washington Institute for Mental Health Research and Training, Washington State University, Spokane.

**Appendix A: Community Health and Public Safety Committee Recommendations**

## Community Public Safety and Health Committee Recommendations

A local group of behavioral health advocates recommends the following actions that respond to the strategies that emerged from multiple community service plans. This list is presented as an example of the mix of services that could be procured with additional funding generated by a 0.1% sales tax increment and that meet the legislative intent of E2SSB 5763. Descriptions of each item appear on the following pages.

Strategy	Activity	Estimated Cost
1. Increase access to behavioral health treatment	1.1: Mental Health and Substance Abuse Treatment (Non-Medicaid)	\$399,975
	1.2: Professional workforce development and training	\$50,000
2. Expand prevention, early intervention and outreach services	2.1: High School Screening, Brief Intervention, Referral and Treatment	\$194,000
	2.2: Children's Behavioral Health Crisis Team (youth CJ system)	\$45,000
	2.3: Behavioral Health Crisis Triage Center - Medical Staffing	\$211,000
	2.4: Drop-In Center for youth with co-occurring disorders	\$232,208
	2.5: Emergency Dept. Screening, Brief Intervention, Referral and Treatment	\$94,498
	2.6: Older Adult Intervention & Referral	\$85,000
	2.7: Children's psychological evaluation for juvenile system	\$20,000
	2.8: Whatcom Prevention – Mentoring/ Challenge Day	\$100,000
3. Expand access to diversion options and therapeutic courts	3.1: Mental Health Court Treatment Team	\$168,804
	3.2: Juvenile Drug Court Treatment Enhancement	\$81,723
	3.3: Family Treatment Court Enhancement-Staffing	\$253,647
	3.4: Adult Drug Court Treatment Enhancement	\$94,823
	3.5: Pre-Post Booking Diversion	\$100,000
	3.6: Crisis Intervention Training (CIT)	\$50,000
	3.7: Offender Re-Entry Follow-up	\$20,000
	3.8: Mental Health Case Mgmt (Juvenile Detention, Dist. Court Probation, Jail)	\$201,862
4. Create and expand access to services that support people in recovery and re-entry	4.1: Re-employment Coordination and Job Coaching, Mentoring.	\$212,150
	4.2: Drop-In Center for adults	\$80,000
	4.3: Re-Entry Transition Network	\$22,500
	4.4: Re-Entry/Recovery Housing	\$525,300
	4.5: Delancey Street Foundation (planning)	\$20,000
	4.6: Family and Parenting Peer Support	\$20,000
5. Increase integration and coordination between systems	5.1: Boundary Spanner	\$61,634
	5.2: Program Coordination & Evaluation (10%)	\$334,412
<b>Total</b>		<b>\$3,678,536</b>

The following table shows how the priorities recommended by the Community Public Safety and Health Committee correspond to recommendations from previous planning processes that are presented in the table that begins on page 26.

Strategy	Committee Recommended Activity	Corresponding Recommendations from Other Plans
1. Increase access to behavioral health treatment	1.1: Mental Health and Substance Abuse Treatment (Non-Medicaid)	Increase inpatient, outpatient, and co-occurring services to low-income people who do not qualify for Medicaid (A), (B), (E)
	1.2: Professional workforce development and training	Support training for Whatcom County chemical dependency professionals (B)
2. Expand prevention, early intervention and outreach services	2.1: High School Screening, Brief Intervention, Referral and Treatment	Implement services that target multiple systems, including children in schools and homeless youth (A),(B),(D)
	2.2: Children’s Behavioral Health Crisis Team (youth CJ system)	Develop coordinated utilization of the Children’s Mental Health Crisis Emergency Team to work with Juvenile Court, probation and Detention Center. (C)
	2.3: Behavioral Health Crisis Triage Center - Medical Staffing	Develop medical screening component at the Triage Center and increase integration with the hospital emergency department. (B),(E), (I)
	2.4: Drop-In Center for youth with co-occurring disorders	Research the feasibility for startup of a self-supporting Alano club or Drop-in Center with space for adult and youth. (B)
	2.5: Emergency Dept. Screening, Brief Intervention, Referral and Treatment	Enhance hospital emergency department services for behavioral health patients. (B),(E), (I)
	2.6: Older Adult Intervention & Referral	Substance abuse treatment services designed for older adults (B),(H)
	2.7: Children’s psychological evaluation for juvenile system	Emerging need identified by the Community Public Safety and Health Committee
	2.8: Whatcom Prevention – Mentoring/ Challenge Day	<p>Implement prevention services that reduce priority risk factors and increase priority protective. (B)</p> <p>Implement prevention services that target multiple systems, including youth and their families. (B)</p>

Strategy	Committee Recommended Activity	Corresponding Recommendations from Other Plans
<p>3. Expand access to diversion options and therapeutic courts</p>	<p>3.1: Mental Health Court Treatment Team</p>	<p>Develop a behavioral health specialty court to divert from jail offenders whose offenses are caused by mental health problems, and to better utilize mental health treatment resources in the community. (C), (I)</p>
	<p>3.2: Juvenile Drug Court Treatment Enhancement</p>	<p>Maintain and expand Juvenile Drug Court and Family Treatment Court by hiring a court coordinator for each program. (C)</p>
	<p>3.3: Family Treatment Court Enhancement-Staffing</p>	<p>Research funding alternatives for Court Programs and back door treatment services. (B)</p>
	<p>3.4: Adult Drug Court Treatment Enhancement</p>	<p>Reduce the inappropriate use and need for additional jail capacity with the provision of treatment and supports for offenders with treatable behavioral health disabilities. Increase treatment funding for behavioral health offenders. (B)</p>
	<p>3.5: Pre-Post Booking Diversion</p>	<p>Identify and reduce barriers to jail diversion. (C)</p>
	<p>3.6: Crisis Intervention Training (CIT)</p>	<p>Increase cross system coordination of pre and post booking diversion utilizing the new Whatcom County Behavioral Health Triage Center. (C)</p>
	<p>3.7: Offender Re-Entry Follow-up</p>	<p>Expand discharge and related jail behavioral health services, including the recovery house treatment model; continue to develop the funding to support treatment for the criminal justice population. (A),(B), (I)</p>
	<p>3.8: Mental Health Case Management (Juvenile Detention, Dist. Court Probation, Jail)</p>	<p>Identify and develop services to assure case management activities. (B)</p>

Strategy	Committee Recommended Activity	Corresponding Recommendations from Other Plans
<p>4. Create and expand access to services that support people in recovery and re-entry</p>	<p>4.1: Re-employment Coordination and Job Coaching, Mentoring.</p>	<p>Expand employment and vocational services during and after treatment and for offenders released from treatment. Recruit job sites, organizations, and employers to provide volunteer training or employment to people in recovery. (A),(B),(C)</p>
	<p>4.2: Drop-In Center for adults</p>	<p>Research the feasibility for startup of a self-supporting Alano club or Drop-in Center with space for adult and youth. (B)</p>
	<p>4.3: Re-Entry Transition Network</p>	<p>Increase community housing access for ex-offenders released from prison and jail, as well as those with criminal or violent histories. (A),(C), (I)</p> <p>The County Coordinator and substance abuse providers should work closely with the new Homeless Services Center and Community Oriented Re-Entry (CORE) Team to develop new housing solutions. (B)</p> <p>Establish a local transition network to which newly released ex-offenders may be evaluated and access services including health care. (C)</p>
	<p>4.4: Re-Entry/Recovery Housing</p>	<p>Expand discharge and related jail behavioral health services, including the recovery house treatment model; continue to develop the funding to support treatment for the criminal justice population. (A),(B), (I)</p>
	<p>4.5: Delancey Street Foundation (planning)</p>	<p>Emerging need by the Community Public Safety and Health Committee</p>
	<p>4.6: Family and Parenting Peer Support</p>	<p>Determine possible methods for implementing Family Support Services in a longer-term program for the next biennium. (B)</p>

Strategy	Committee Recommended Activity	Corresponding Recommendations from Other Plans
<p>5. Increase integration and coordination between systems</p>	<p>5.1: Boundary Spanner</p>	<p>Emerging need identified by the Community Public Safety and Health Committee</p>
	<p>5.2: Program Coordination &amp; Evaluation (10%)</p>	<p>Cooperate with statewide effort to establish electronic health records technology to coordinate health records between jails and community mental health and substance abuse treatment agencies. (C)</p> <p>Track intermediate results and long term results; and increase the community's ability to collect and analyze data that addresses variances between smaller geographies within Whatcom County. (B)</p> <p>Increase cross system coordination of pre and post booking diversion utilizing the new Whatcom County Behavioral Health Triage Center. (C)</p> <p>Create more linkages across community service systems (e.g. domestic violence, mental health, substance abuse, law and justice, and employment services). (D)</p> <p>Service providers and policy makers must coordinate and collaborate across sectors (F)</p> <p>Convene a summit of service providers (mental health, drug &amp; alcohol, CPS, domestic violence and housing) to discuss coordination and integration of services across all disciplines and to set the foundation for a more coordinated and integrated service delivery model. (G)</p>
<p>6. Develop stable source of local funding</p>	<p>6.1: Enact the 0.1% sales tax increment to fund behavioral health programs</p>	<p>Explore additional funding such as that authorized by RCW 82.14.460 (sales tax increment) and RCW 70.96A.325 (state matching funds for methamphetamine treatment). (A), (B), (C), (F), (I)</p>

## **Community Public Safety and Health Committee Recommendation Descriptions**

### **Strategy #1: Increase access to community mental health and substance abuse treatment services**

#### **Activity 1.1: *Flexible funding for behavioral health services to underserved, underinsured County residents***

Non-“siloeed” funding for mental health and substance abuse outpatient services for non-Medicaid eligible people. This treatment funding would make next-day appointments available to the “working poor” and people with no or little insurance. Up to \$200,000 prioritized for people in the criminal justice system.

#### **Activity 1.2: *Professional Workforce Development & Training***

Funding to attract Chemical Dependency Professional (CDP’s) and other behavioral health professionals to Whatcom County. Funding for stipends during internships /scholarships and/or pay while working.

### **Strategy #2: Expand prevention, early intervention and outreach services for adolescents and adults**

#### **Activity 2.1: *Bellingham High School Screening- Brief Intervention Brief Therapy and Referral to Treatment- (S-BIRT) Best Practice Pilot Project***

Screening, brief intervention and brief therapy, treatment and referral for youth in high schools at risk. Attempt to halt substance abuse problems at high schools before kids end up in criminal justice system. Places three Behavioral Health Specialists in high schools and provides brief outpatient services (up to 10 sessions) for youth & families. Attempt to intervene before youth are placed on suspension or end up with criminal problems. This model is based on an evidence-based practice currently being used in hospital emergency rooms in several Washington State communities.

#### **Activity 2.2: *Children’s Crisis Team***

Set up a multi-disciplinary networking team to coordinate systems for kids and youth in crisis and their families.

#### **Activity 2.3: *Triage County Behavioral Health Crisis Triage Center - Medical Staffing***

Medical screening services on-site at triage to expand ability to take consumers who need a higher level of care and to certify Substance Abuse Protective Custody clearance. This allows law enforcement to bring more people in crisis directly to triage instead of the hospital or jail. (Also hospital diversion)

**Activity 2.4: *Drop-In Center for Youth with behavioral health disorders***

A drop-in facility with services to intervene on street kids with mental health and/or substance abuse symptoms to prevent problems with the criminal justice system.

**Activity 2.5: *Washington State Screening Brief Intervention (WASBIRT) – Best Practice prevention/intervention.***

Early Intervention for people who enter the Emergency Department (ED). Screens for risky behavior and other behavioral health conditions. Uses a highly successful evidence-based model already in existence in eight emergency departments in the state. This project screens many 18-25 year olds who arrive at the hospital injured as a result of risky behaviors while intoxicated.

**Activity 2.6: *Older Adult Intervention & Referral***

Intervention and Intensive case management for older adults with behavioral health problems, intervenes with chemical abuse, possible involuntary commitment to facilities, if necessary, engagement to nursing care services when appropriate. Services to be provided by a FTE mental health and substance abuse professional committed to the longer engagement time often needed to connect to older adults.

**Activity 2.7: *Children's psychological evaluation for juvenile system.***

Increase ability to secure timely psychological evaluations for low income families with children in juvenile system or in Family Dependency Court. This would allow these children to be referred to treatment, preventing future criminal activity.

**Activity 2.8: *Prevention – Mentoring/ Challenge Day***

Provides a combination of intervention to students who are alienated at at-risk from substance abuse, depression, and crime. This program breaks down barriers between cliques in schools and builds empathy so that disenfranchised kids feel more supported by others in the schools. It also builds leadership.

**Strategy #3: *Expand access to diversion options and therapeutic courts*****Activity 3.1: *Mental Health Court Treatment Team***

Develop a Mental Health Court Treatment Team to participate in pre-court staffing of mentally ill clients. Team consists of a full time Mental Health Coordinator, Attorney General time and Court Commissioner time.

**Activity 3.2: *Juvenile Drug Court Expansion***

Juvenile drug courts offer teens a chance to clear up their legal charge(s) and get away from the drugs and alcohol that have gotten them on the wrong track with school, their families, the law and other responsibilities. The program offers an intensive level of supervision, support, feedback and consequences that helps the individual move from a negative pattern to more pro-social responses. The proposed expansion includes employing a full-time coordinator for Juvenile Drug Court plus additional prosecuting attorney time and court commissioner time.

**Activity 3.3: *Family Treatment Court Expansion***

Family Treatment Court is a civil court designed to help reunify families who have been affected by substance abuse, getting parents needed treatment so they can safely care for their children. Most of the parents in this program have co-occurring chemical dependency and mental health disorders, and many are also adult survivors of abuse. Without treatment, the cycle of abuse is likely to continue. The proposed expansion includes the hiring of a full-time coordinator to work within the judicial system, preferably a CDP. This expansion also requires additional time from the attorney general and court commissioner, as well as funding for the court-ordered chemical dependency and mental health treatment.

**Activity 3.4: *Adult Drug Court Expansion***

Drug courts provide a cost-effective alternative to traditional courts when they deal with drug abuse and drug-related crime. Incarceration breaks up families and creates a cycle of recidivism for those suffering addiction. Drug courts divert these offenders into treatment programs that help break the cycle of addiction and crime. This expansion seeks an additional full-time case manager and additional time from the attorney general and court commissioner.

**Activity 3.5: *Pre- and post-booking diversion***

Develop innovative partnership between judges, prosecutors, criminal defenders, law enforcement, jail, and behavioral health agencies to identify strategies to divert people from court and/or jail. Includes planning and pilot-level implementation.

**Activity 3.6: *Crisis Intervention Training (CIT)***

Train law enforcement to respond to people with behavioral health problems. This is a model which helps to promote further jail diversion services and which has been proven to be effective in other cities in the U.S.

**Activity 3.7: *Offender Preparation for Treatment***

Next day follow-up medical appointments for people in jail (mostly drug court) who need to receive medication after discharge from jail in order to get into treatment.

**Activity 3.8: *Mental Health Case Management***

Case management in District Court Probation and juvenile detention, as well as additional case management in the jail.

**Strategy #4: Create and expand access to services that support people in recovery and people reintegrating upon release from jail or prison**

**Activity 4.1: *Recovery re-employment coordination and job coaching/mentoring***

Coordinates employment services for individuals with mental illness and chemical dependency. Develops network of employers willing to mentor. Build skills and advocates for resources for newly recovering clientele. Intensive case management and job coaching.

**Activity 4.2: *Around the Clock Meeting Space for Adults***

Meeting space available for around the clock self-help groups to be organized and run by volunteers. This recovery-oriented space would provide immediate engagement and peer support to help consumers resist temptations to use substances or engage in criminal behavior. Funding is for start-up only; the center would eventually be self-supporting through contributions and volunteer-run as in the AA model.

**Activity 4.3: *Re-Entry Transition Network***

Pay for multidisciplinary professional time to participate in meetings develop re-entry plans for people and resources.

**Activity 4.4: *Recovery/Re-Entry Housing***

There are approximately 8 DASA adult residential recovery house providers and approximately 68 statewide adult recovery house bed slots. Recovery House Treatment provides an abstinence-based environment, free from alcohol and drug use, personal care and treatment, up to 60 days, with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities. Phase I of Permanent Housing Model – 24hours per day, 7 days per week staff on site- 20 bed site, 60-90 day stay to help people coming back into the community from institutions where they went through a recovery program.

**Activity 4.5: *Self Supporting, Self Run Living Community (Like Delancey Street Foundation)***

Start-up funding for a self-run, self-supporting community living for people with behavioral health issues who come out of prisons/jail. This a grassroots housing model has proven success in other communities by supporting recovery in a cost-efficient manor. Flexible seed money would enable this program to secure a facility or and apply for matching grants. This money is Creates a public/private partnership.

**Activity 4.6: *Parenting/family peer support.***

Provide peer support, information & education to people whose families are newly entering the mental health and/or substance abuse systems contacting the systems and providing information to families on substance abuse, mental health, and/or criminal justice services. Develop and distribute educational materials which would help family members navigate the substance abuse, mental health, criminal justice, and medical systems.

**Strategy #5: Increase integration and coordination between systems****Activity 5.1: *Legal Case Manager Boundary Spanner***

Professional who provides an effective bridge between criminal justice system staff (court of jurisdiction) and community behavioral health treatment providers. Develops and maintains relationships with key staff in all court and treatment elements. Maintains ongoing oversight of the status of court-ordered treatment for select cases and facilitates modifications of community re-entry plans with court approval.

**Activity 5.2: *Program Coordination and Evaluation***

Coordinate new and expanded services across service systems and develop and implement an evaluation plan to measure program outcomes and returns on investment.

