SOUTHWEST WASHINGTON BEHAVIORAL HEALTH SERVICES

CURRENT STATE OF AND GAPS IN BEHAVIORAL HEALTH SERVICES IN SOUTHWEST WASHINGTON

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INTRODUCTION

Washington’s behavioral health system is transforming to better support individual’s mental health and substance use disorder needs, treating more adults and children at home, in their communities, and in smaller facilities. The behavioral health system changes began in 2016 with Fully Integrated Managed Care (FIMC) and continue to evolve, in part, as a result of a settlement from the Trueblood v DSHS lawsuit, Governor Inslee’s Behavioral Health Five-Year Plan and related legislative initiatives. These changes are collectively overhauling the state’s behavioral health system into a patient-centered system with increased capacity to treat people effectively in their communities.

This report provides information on the state’s and southwest region’s behavioral health systems to support decision-making. Specifically, the report provides additional statewide context, maps current behavioral health services in southwest Washington, identifies gaps in current behavioral health services, and prioritizes needs. This report is not a needs assessment or a comprehensive assessment of service contexts and gaps; rather it summarizes stakeholder input on context, gaps, and funding priorities provided through a facilitated process.

STATEWIDE CONTEXT

Washington’s behavioral health care system is undergoing significant change as it implements various initiatives associated with, but not limited to, Trueblood and the Governor’s Behavioral Health Plan. The state is implementing the following strategies in the first phase (2019-2021 biennium) of the Trueblood Settlement, which includes southwest Washington:¹

- **Competency evaluation** access through additional staff.
- **Competency restoration team** enhancement, including creation of residential support for outpatient competency restoration.
- **Crisis triage/crisis stabilization and mobile crisis team** enhancement.
- **Diversion support** for people with behavioral health needs arrested for misdemeanors.
- **Engagement and outreach** through intensive case management and case finding services focused on individuals identified as high (and potentially high) utilizers of the forensic mental health system.
- **Housing supports** including forensic Housing and Recovery through Peer Services (HARPS) teams, supportive housing services and transitional housing vouchers, and intensive case management.
- **Forensic navigators** to be hired.
- **Forensic bed capacity** increased.
- **Technical assistance** for jails.

¹ Washington State Health Care Authority, Department of Social and Health Services, 2019-2021 Biennial Budget Summary for Trueblood Agreed Settlement
• **Crisis Intervention Training (CIT)** to law enforcement agencies and increased funding for the Criminal Justice Training Center (CJTC) and the Washington Association of Sheriffs and Police Chiefs (WASP) co-responders.

• **Workforce development** to support settlement requirements.

• **Enhanced peer support** including continuing education curriculum for peer counselors in the criminal justice system and new peer respite centers.

The Governor’s five-year behavioral health plan aligns with and enhances Trueblood Settlement requirements through broader, systemic change to the state’s behavioral health system. The plan specifically:  

• **Expands behavioral health treatment options** ensuring a full continuum of care for individuals with behavioral health needs, including those who are diverted from and transitioning out of state hospitals and the criminal justice system.

• **Increases housing supports** through: pairing stable housing with community treatment options; providing rental assistance for permanent supportive housing; and increasing funding for the Housing Trust Fund for permanent supportive housing.

• **Enhances workforce development** including compensation increases and loan repayment for state hospital employees, new behavioral health scholarships, increased psychiatry residency positions, and training and support for behavioral health providers caring for people in the community.

• **Increases access to appropriate community-based facilities** by: moving all civil commitments into the community over time through community provider increases and new state owned and operated facilities in local/regional settings; expanding the capacity to divert and discharge people from state hospitals through increased community capacity; beginning work on state-operated behavioral health facilities in smaller, community-based settings; the pre-design of a behavioral health focused teaching hospital at the University of Washington; and two new secure withdrawal facilities, including an Enhanced Services Facility (ESF) which will provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting and a Behavioral Health Intensive Facility (BHIF) with limited egress for people coming from the state hospital.

• **Continues to invest in state hospitals** through critical infrastructure improvements.

This work has resulted in several administrative changes in Washington’s behavioral health system, including:

• The Division of Behavioral Health and Recovery (DBHR) was moved from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). DSHS was the respondent of the Trueblood lawsuit and still houses the forensic behavioral health division.

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2 2019-21 Budget & Policy Highlights, *Transforming Washington’s Behavioral Health Care System*
• The Department of Commerce manages most capital funds for new behavioral health facilities. The Washington State Department of Health is often also involved due to licensing issues. This means legislative, regulatory, and policy changes can involve up to four departments (DSHS, HCA, Commerce, and Health). Department stakeholders are in the process of developing tools to coordinate and collaborate effectively within the new administrative structure.

As the state implements Trueblood requirements, clarity is needed about the two types of funding (fines and settlements) and the three resultant initiatives (Trueblood Grants, Trueblood Settlement, and Prosecutorial Diversion). Additionally, sustainability of behavioral health system development occurring under Trueblood is reliant on ongoing state leadership and funding, which is not fully guaranteed or secured.

SOUTHWEST WASHINGTON BEHAVIORAL HEALTH SERVICES AND GAPS

OVERVIEW

The southwest region of Washington is comprised of three counties – Clark, Klickitat, and Skamania.

Figure 1. Southwest Washington map

Clark County is the largest of the three counties, with demographics most closely resembling those of the state. Klickitat and Skamania counties are geographically larger and more rural, with less racial/ethnic diversity and higher disability and poverty levels.

Figure 2. Southwest Washington county demographic information

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3 US Census Bureau, QuickFacts Clark County, Washington; Klickitat County, Washington; Skamania County, Washington; Washington, https://www.census.gov/quickfacts
Washington has one of the highest rates of mental illness nationally, with 24 percent of adults statewide experiencing a diagnosable mental health condition and seven percent meeting criteria for a serious mental illness.\(^4\) Available behavioral health data show the southwest Washington region to generally be in line with statewide trends. Klickitat and Skamania counties have higher reported suicide rates; however, their small population size means small numbers can have an outsized impact on population percentages. Among adults statewide, self-reported poor mental health was more prevalent among females, those under 24 years of age, and American Indian or Alaskan Natives. People with less education and less income generally reported poorer mental health.\(^5\)

Figure 3. Southwest Washington population behavioral health status

<table>
<thead>
<tr>
<th></th>
<th>Clark County</th>
<th>Klickitat County</th>
<th>Skamania County</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult poor mental health days (per 30 days)(^6)</td>
<td>3.8</td>
<td>4.1</td>
<td>4.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Adult population reporting 14 or more poor mental health days per month, %(^7)</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Suicide crude rate per 100,000(^8)</td>
<td>15.2</td>
<td>18.3</td>
<td>25.5</td>
<td>14.2</td>
</tr>
<tr>
<td>Adult binge drinking, %(^9)</td>
<td>18%</td>
<td>16%</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Patients with any opioid prescription, rate per 1,000, all ages(^10)</td>
<td>63.8</td>
<td>38.8</td>
<td>61.3</td>
<td>60.9</td>
</tr>
</tbody>
</table>

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\(^5\) 2018 Washington State Health Assessment.

\(^6\) Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute School of Medicine and Public Health, County Health Rankings & Roadmaps, [https://www.countyhealthrankings.org/app/](https://www.countyhealthrankings.org/app/)

\(^7\) Ibid

\(^8\) Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Causes of Death 1999-2017 on CDC WONDER Online Database, released December 2018, ICD-10 codes X60-X84 Intentional Self Harm

\(^9\) Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute School of Medicine and Public Health, County Health Rankings & Roadmaps, [https://www.countyhealthrankings.org/app/](https://www.countyhealthrankings.org/app/)

In general, southwest Washington’s behavioral health system capacity is lower than the statewide average, with less overall capacity in rural Klickitat and Skamania counties.\textsuperscript{11} The figure below shows that Clark County has larger numbers of mental health providers and psychiatrists compared to Klickitat and Skamania. The Washington State Directory of Certified Mental Health, Substance Use Disorder, and Problem & Pathological Gambling Services\textsuperscript{12} shows that Clark County has 24 substance use disorder providers, compared to one in Klickitat (Comprehensive Healthcare in Goldendale and White Salmon) and one in Skamania (Skamania County Community Health).

Figure 4. Southwest Washington behavioral health provider overview\textsuperscript{13}

<table>
<thead>
<tr>
<th></th>
<th>Clark County</th>
<th>Klickitat County</th>
<th>Skamania County</th>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health providers (one provider for number of residents)</td>
<td>360</td>
<td>790</td>
<td>820</td>
<td>330</td>
</tr>
<tr>
<td>Psychiatrists (rate per 100,000)</td>
<td>5.4</td>
<td>0</td>
<td>0</td>
<td>10.1</td>
</tr>
</tbody>
</table>

**BEHAVIORAL HEALTH DISPARITIES BY RACE/ETHNICITY**

National data suggests that individuals from racial and ethnic minority groups experience worse behavioral health access, status, and treatment outcomes than their peers from non-minority groups.\textsuperscript{14} The National Institute of Mental Health states that “members of racial and ethnic minority groups in the U.S. are less likely to have access to mental health services, more likely to use inpatient hospitalization and emergency rooms, and more likely to receive lower quality care.”\textsuperscript{15} Nationally, among low-income adults with a mental illness, whites utilize mental health services more than their black or Hispanic peers, cost is the most commonly report barriers to using mental health services, and use of mental health services is relatively low among blacks, Asians, and Hispanics.

The National Alliance on Mental Illness identifies the following barriers that prevent racial and ethnic minorities for accessing and receiving appropriate behavioral health care:\textsuperscript{16}

- Lack of availability
- Logistical barriers related to lack of transportation, child care, or ability to take time off of work
- The belief that mental health treatment is ineffective
- Perceived stigma associated with mental health conditions
- A mental health system aligned disproportionately with non-minority values and norms
- Racism, bias, and discrimination in treatment settings
- Language barriers and insufficient language capacity among providers

\textsuperscript{11} University of Washington Center for Health Workforce Studies, AMA Physician Masterfile, 2016 Analysis
\textsuperscript{12} https://www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf
\textsuperscript{13} University of Washington Center for Health Workforce Studies, AMA Physician Masterfile, 2016 Analysis
\textsuperscript{15} National Institute of Mental Health, “Minority Health and Mental Health Disparities Program” (Bethesda, Md.: NIMH, n.d.).
• Lack of adequate health insurance coverage

Low use of medication and poor doctor-patient communication were also identified as key barriers to equitable access to and treatment of mental illness across racial and ethnic populations.17

Washington state and the Southwest Washington region face similar disparities in mental health for non-white populations. For example, data from the Washington Health Alliance show poorer behavioral health outcomes for Black and Latinx populations compared to other peer racial groups.18 In the Columbia River Gorge region, which includes Skamania County and Klickitat County, mental health diagnosis are more widespread among Non-Hispanic whites, low-income, and Medicaid populations. Furthermore, low-income and Medicaid populations face the greatest access challenges to behavioral health care.19 In Clark County, American Indian and Hispanic youth populations experience increased incidence of poor emotional or mental health. Black, American Indian, and Hispanic youth populations also experience increased rates of substance abuse.20 Moreover, the Clark County 2019 Community Health Needs Assessment identifies discrimination and racism and trauma as the key drivers of health outcomes, including behavioral health, and social factors, including access to health care, community representation, and culturally responsive care.

In 2017, the National Conference of State Legislatures identified several approaches for reducing health disparities that have been adopted in states across the country:21

• Improving awareness about difference in behavioral health status and access to services
• Addressing behavioral health disparities directly and indirectly
• Engaging diverse perspectives and populations
• Promoting cultural and linguistic competence

Additionally, recent review of behavioral health literature suggests increasing cultural and linguistic competence and integrated health care as key strategies to reduce disparities. These themes emerged during stakeholder facilitation regarding the current state of and gaps in behavioral health services in Southwest Washington, as described below. Further development of these issues can support more equitable care all across racial and ethnic groups.

The subsections below summarize current behavioral health services and gaps for Clark, Klickitat, and Skamania counties.

CLARK COUNTY

CURRENT BEHAVIORAL HEALTH SERVICES

Clark County is the largest of the three southwestern Washington counties, and has the most robust behavioral health system. The figures below summarize the county’s adult mental health, children’s mental health, and substance use disorder services and supports. The county has a full continuum of care for adults with behavioral health conditions. Participating stakeholders noted significant focus on implementing recovery programs.

Figure 5. Clark County Current Adult Mental Health System

Figure 6. Clark County Current Children’s Mental Health System
PRIORITIZED NEEDS

Clark County stakeholders prioritized outstanding needs for the county’s behavioral health system, with a focus on meeting needs for specific demographics and cultures as well as general service gaps.

Figure 8. Clark County prioritized behavioral health system needs

<table>
<thead>
<tr>
<th>Housing</th>
<th>• Housing for individuals with high acuity behavioral health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Youth</td>
<td>• Increased hospital diversion</td>
</tr>
</tbody>
</table>
• Increased access to psychiatry services
• Increased access to homebuilders or longer term stabilization
• Increased access to day treatment and intensive outpatient services
• Expanded capacity of child and adolescent treatment at levels 3, 4 and 6
• Expansion of level of child and adolescent treatment care at levels 3, 4 and 6
• Development of psychiatric inpatient services for high acuity/comorbid patients

| Seniors         | • Increased focus on/access for seniors across all behavioral health services
|                | • Development of psychiatric inpatient services for high acuity/comorbid patients
| Adults/General | • Expansion of level of care at levels 3, 4 and 6
|                | • Increased access to psychiatry services
|                | • Development of psychiatric inpatient services for high acuity/comorbid patients

| Diversity/Inclusivity | • Increased provision of culturally relevant services and supports, particularly for Russian, LGBTQ, Latino/a, and African American
| Workforce              | • Increased support for behavioral health workforce including increased professional development and recruitment/capacity

KLICKITAT COUNTY

CURRENT BEHAVIORAL HEALTH SERVICES

Klickitat is a relatively small county and their behavioral health system reflects the rural nature of their county. The two hospitals, Klickitat Valley Health in Goldendale and Skyline Hospital White Salmon, are two points of entry for the mental health and substance use disorder system. Other entry points include Comprehensive Healthcare outpatient and crisis services, as well as law enforcement, self-referrals, schools and primary care, community based social service providers and faith-based networks.

Figure 9. Klickitat County Current Mental Health and Substance Use Disorder System
Stakeholders noted effective collaboration between law enforcement and behavioral health services providers. Law enforcement accompanies providers on home visits and other home-based service/support delivery.

Participants also commented on the strength of the faith-based community in providing recovery services. Referrals to faith-based services are based on client preference with no formal partnerships.

**PRIORITIZED NEEDS**

Klickitat stakeholders discussed numerous behavioral health service gaps to enhance the local continuum of care. Children and youth were identified as an underserved population, with most youth going to neighboring Yakima for support.

**Figure 10. Klickitat County prioritized behavioral health system needs**

<table>
<thead>
<tr>
<th>Children, Youth, and Families</th>
<th>Increased access to specialized services for children and youth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increased access to services and supports for low income families</td>
</tr>
<tr>
<td>Native American</td>
<td>Increased provision of culturally relevant services and supports for Native American residents</td>
</tr>
<tr>
<td>Adult/General Access</td>
<td>Increased responsiveness/timeliness of services (decrease delays/waiting lists)</td>
</tr>
<tr>
<td></td>
<td>Increased responsiveness of after-hours services</td>
</tr>
<tr>
<td>Service Gaps</td>
<td>Increased access to secure hold beds to decrease utilization of emergency room beds</td>
</tr>
<tr>
<td></td>
<td>Increased access to sexual abuse services and supports</td>
</tr>
</tbody>
</table>
SKAMANIA COUNTY

CURRENT BEHAVIORAL HEALTH SERVICES

Skamania County has the smallest population of the three southwestern Washington counties, and is reliant on neighboring Clark County for inpatient behavioral health services and supports. Local resources support the remaining components of a continuum of care for all ages, including short-term crisis response/evaluation, intensive outpatient, outpatient, and recovery support services. The county does not yet provide medication assisted treatment.

Figure 11. Skamania County Current Mental Health and Substance Use Disorder System

PRIORITIZED NEEDS

Skamania stakeholders discussed gaps or prioritized needs primarily focused on housing, recovery services, and transportation. The county has a contract for supported housing and employment, but, according to participants, additional supports were needed. Stakeholders felt it was unlikely the county would ever have a hospital due to its small population, and so felt that they would need to continue to coordinate closely with Clark County to support a full behavioral health continuum of care.

Figure 12. Skamania County prioritized behavioral health system needs

<table>
<thead>
<tr>
<th>Housing</th>
<th>• Increase access to affordable comprehensive supportive housing for people with behavioral health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery</td>
<td>• Further develop recovery services and supports as a county-wide focus</td>
</tr>
<tr>
<td>Transportation</td>
<td>• Increase public transportation options</td>
</tr>
</tbody>
</table>
Across the three-county region, several common behavioral health system needs emerged, including care coordination and integration, housing, behavioral health programming for patients with high acuity needs, and services for children and youth.

**Care coordination and integration.** Stakeholders discussed care coordination challenges, particularly for complex cases. Participants discussed the need for improved:

- Complex care referral
- Care coordination support
- Closed-loop referrals
- Care integration (less disjointed services/transition)

**Housing.** Housing for people with behavioral health conditions, especially high acuity needs, and integrating services with housing was a consistent gap/need across counties.

**Programming for patients with high acuity needs.** Stakeholders discussed lack of sufficient programming or psychiatric inpatient services for patients with complex, high acuity needs.

**Services for children and youth.** All counties felt their service system provided less support for children, youth, and families, particularly high acuity children and youth.

The variation in behavioral health service and support availability necessitates cross-county and broader regional collaboration. Stakeholders discussed universal and distinct regional needs. Meeting participants discussed the importance of acknowledging that responding to a regional need in only one county may not sufficiently address the need across all counties or adequately support the goal of recovery and stability in home and community settings. Responses will need to consider both regional and county specific contexts and considerations.

**SOUTHWEST WASHINGTON BEHAVIORAL HEALTH PRIORITIES AND FUNDING OPPORTUNITIES**

Regional stakeholders prioritized behavioral health system needs for Southwest Washington, and signified whether the needs would require capital resources, policy change, new services, or training. The following figure shows the collective prioritization.

**Figure 13. Southwest Washington behavioral health priorities**
<table>
<thead>
<tr>
<th>Need</th>
<th>Number of priority votes received</th>
<th>Requires capital resources</th>
<th>Requires policy change</th>
<th>Requires new service</th>
<th>Requires training</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health housing with supportive services</td>
<td>8</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Needs for capital will vary by county within the Southwest Washington region and will need to be met on a county-specific basis</td>
</tr>
<tr>
<td>Housing for individuals with high acuity needs</td>
<td>8</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stabilization services for adults/hospital diversion for youth</td>
<td>6</td>
<td>X</td>
<td>X</td>
<td>X*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acuity E&amp;T beds/co-occurring</td>
<td>5</td>
<td>X</td>
<td>X</td>
<td>X*</td>
<td></td>
<td>Policy change is required to make peer supports more systematic and systemic</td>
</tr>
<tr>
<td>Peer supports across the full system</td>
<td>5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Requires capital for more space, policy to track school-based services and develop sustainable infrastructure, and training to integrate into school culture</td>
</tr>
<tr>
<td>MH/SUD professionals in schools</td>
<td>5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Expansion of level of care between levels 3 and 4—more for youth but also adults</td>
<td>4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Complex care referrals (regional system concern): BH/SUD/DD-IDD/Medical/Youth</td>
<td>4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More bilingual culturally relevant services built into top priorities (workforce); general lack of workforce capacity across services and systems</td>
<td>3</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to updated and accurate resources/info</td>
<td>2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation (Skamania)</td>
<td>1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Discussion of the universal need for this that feels bigger than the 1 priority vote it received</td>
</tr>
<tr>
<td>Geriatric/long-term care</td>
<td>1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*Stabilization and high acuity evaluation and treatment services are under active development with Lifeline’s facility.*