A Community Mental Health and Chemical Dependency Assessment
City of Tacoma
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Tacoma-Pierce County Health Department
Office of Assessment, Planning, and Improvement

I. EXECUTIVE SUMMARY

In August of 2012, the City of Tacoma commissioned the Tacoma-Pierce County Health Department to examine the status of the city's behavioral health systems. The Health Department conducted a mental health and chemical dependency (MHCD) assessment and resource inventory. This report outlines the assessment methods and findings.

The assessment request was made as part of the city's planning process in preparation of expected revenue from the City of Tacoma's Ordinance 28057. The ordinance authorized a 0.1% (1/10th of 1%) sales tax to support mental health treatment, chemical dependency treatment, therapeutic court(s), and housing for those receiving treatment services.

The assessment process was developed in collaboration with the City of Tacoma Human Rights and Human Services department. The assessment findings will be used to help identify funding priorities that will obtain the best possible outcomes. The main components of the assessment included collection of existing data, review of relevant literature, and theming of findings.

Methods

A mixed method research methodology (both qualitative and quantitative methods) was used for data collection and analysis. This included a review of existing data sets (quantitative) from community partners, describing the burden of unmet needs in Tacoma. In addition, key-informant interviews (qualitative) were conducted with service providers and community leaders knowledgeable about MHCD issues and needs among Tacoma residents. Extensive literature searches were conducted to examine best practices in MHCD services and programs and to learn from other communities that had previously conducted community behavioral health assessments. Finally, the findings from these multiple sources were themed and summarized to draw out the most important conclusions.

Conclusions

There were a number of reoccurring themes that emerged when analyzing the collected data. These themed issues are not unique to the City of Tacoma. However, the systems and strategies to address them may be. The themes are: a) crime and incarceration among individuals with MHCD needs, b) individuals with co-occurring issues, c) disparities in representation and access to services, d) lack of coordination and integration of services, and e) access to, and availability of, services.

1. The assessment process identified several vulnerable populations who are at higher risk of either having mental health and/or chemical dependency issues or not having access to treatment services. These vulnerable populations were identified as: a) individuals experiencing homelessness, b) active duty military and veterans, c) youth, and d) African Americans.

2. There appeared to be a discrepancy between a perceived lack of availability of MHCD resources versus an actual lack of availability. Service providers reported hearing that certain services were not available in Tacoma, when indeed they were. Services that are difficult to access can also be thought of as unavailable.

3. As is, the MHCD treatment and social service delivery system in the City of Tacoma is fragmented and does not currently provide a comprehensive or continuum of care approach for those residents who are in need of multiple types of services, such as those with co-occurring disorders (both mental health and chemical dependency).

4. Many of the MHCD issues were cross-divisional, in that multiple service sectors are impacted or deal with the same MHCD issues (e.g., homelessness, youth in need of services, lack of collaboration, lack of services, and co-occurring disorders).

Appendix A: Snapshot of Themes

Crime and incarceration among populations with MHCD needs

Local resources	Gaps in resources	Impact/costs	Best practices /approaches	Estimated ROI
• Sober rooms • Prebooking MHCD services • In-custody MHCD (CD is very limited) • Discharge planning • Diversion (adults) • Pretrial diversion (juvenile only) • Drug Court (adult & juvenile) Pierce Co. only • FAST (Family Access to Stabilization and Teaming) • School liaisons (for juveniles) • Multiple treatment modalities	• No Tacoma Drug Courts (only Pierce Co.) • Limited space and long waits for in-pt services • No/limited adolescent in-pt facilities in Tacoma • Limited CD services for those incarcerated • Limited resources for co-occurring • Juveniles in custody receive only crisis MH services • No or limited integrated systems	• Longer stays/ Incarcerations • Delays in court system awaiting MH evals • Pierce Co. estimates a $1.8 million budget overage for staff overtime to supervise mentally ill inmates • Pierce Co. is spending $300,000 on renovations to house mentally ill or suicidal inmates • Mentally ill inmates in for felonies average 158 days in jail at $300 per bed per day, or $47,400 per jail episode	• Multisystemic Therapy (MST) for juvenile offenders • Drug Courts • Family Access to Stabilization and Teaming (FAST); not a best practice • Peer Bridgers (discharge or release peer support) • Offender Re-entry Safety programs • Mental Health Courts	• For MST: every $1 spent there is a $2.51 ROI • For Drug Courts: return was $4.42 for youths and $3.69 for adults per $1 spent For FAST: every $1 spent on out-pt services could have a $4 ROI if it prevents need for in-pt care • Offender Re-entry Safety Program ROI is $2.19 for every $1 spent • MH Courts ROI: $6.96 per $1

For juvenile justice programs: http://www.ojjdp.gov/mpg/search.aspx
For adult offender programs: http://www.crimesolutions.gov/

A large number of adults and juveniles enter the criminal justice system due to mental illness and/or chemical abuse and dependency. Nationally, an estimated 64% of adults in county and city jails suffer from a mental illness, and 53% meet the criteria for substance dependency or abuse; those inmates with both mental health problems and substance dependency or abuse (co-occurring) was 74%.

Data from Pierce County Detentions and Corrections Center (PCDCC) show that 29% of those incarcerated, receiving initial mental health services, have a co-occurring diagnosis. Adults in the mental health system who abused drugs and alcohol were five times as likely to have been incarcerated as those who did not.

Adolescents with substance abuse problems are not adequately served in most existing drug-treatment programs designed for adults. In 2011, 15% of Pierce County youth arrests (ages 10 to 14 years) were for alcohol or drug violations.

The African American population is at particular risk for mental health illness due to an overrepresentation in people who are incarcerated and experiencing homelessness. Most of the Pierce County minorities arrested in 2007 to 2008 were African American.

Homelessness status was reported for 25% of the adults contacted for mental health services provided by PCDCC.

Access to and availability of quality MHCD care & treatment				
Local resources • Satellite MHCD offices • Mobile MHCD providers • Sliding scale or free services (limited) • WA State Medicaid and S-CHIP programs for low income children • School MHCD and homeless services for students (direct & referral) • Flexible operating hours (though still limited) • Helplines (for youth, adults, military & vets) • Crisis services • Methadone clinic • Encampment Project/Housing First approach (Tacoma)	**Gaps in resources** • Limited or no CD professionals within some MH agencies • Transportation • Limited financial treatment assistance for uninsured or insured without adequate coverage • Limited or no specialized services (co-occurring, detox, Infant /toddler) • Limited space and long wait for in-pt beds • No adolescent in-pt facility in Tacoma • Comprehensive family services are lacking • Lack of integrated /coordinated service models • No youth service org. • No homeless youth services/shelters • Lack of self advocacy services • Limited treatment provider training	**Impact/costs** • 784 MH admissions for one Tacoma hospital costs on average $21,000 per admission • Average Medicaid costs for a Tacoma resident for MH treatment are $5,631 • Average Medicaid costs for a Tacoma resident for CD treatment are $2,388 • Nationwide, the economic impact of illicit drug use was est. to be $193 billion in 2007. The majority, $120.3 billion was attributed to lost productivity	**Best practices/ approaches** • Access to Recovery (ATR) • WA Screening, Brief Intervention, Referral and Treatment (WASBIRT) • Strengths-Based Case Management (SBCM) • Frequent User Service Enhancement (FUSE) • Motivational Interviewing • Mapping--Enhanced Counseling • Encampment Elimination Project • Permanent Options for Recovery-Centered Housing (PORCH)	**Estimated ROI** • ATR service clients had lower monthly medical costs ($66) compared to clients not receiving ATR (also showed a decrease in hospital visits, costs and admissions) • FUSE: saved one county in MN an average of $13,000 per year per person housed • Motivational interviewing has a ROI of $44.38 for every $1 spent
MHCD National EBP Registry: http://www.nrepp.samhsa.gov/AdvancedSearch.aspx				

There are certain indicators to consider when looking at barriers to accessing MHCD services and what is available, such as insurance coverage, service usage vs. need and being within a vulnerable population. A high percent (43.4%) of patients admitted to hospitals for substance abuse were more likely to be uninsured. Fewer than 50% of teens who have attempted suicide received mental health services during the year before their attempt.

In looking at vulnerable populations, African Americans make up the highest percent of those below poverty level (30.6%) versus whites (14.1%), and are in frequent need of MHCD DSHS services. The needs of the mentally ill and chemically dependent individuals experiencing homelessness are significant, 27% needed alcohol or drug treatment and 37% were in need of service for mental illness. In Pierce County, 17% of the individuals experiencing homelessness were ages 13 to 18; a 15% increase from 2011 to 2012. Data indicate that 38% of US Army soldiers report psychological symptoms. Among members of the National Guard, the figure rises to 49%.

Co-occurring (mental health and chemical dependency issues)				
Local resources • Satellite MHCD offices • Mobile MHCD providers • Help lines (for youth, adults, military & vets) • Crisis services • Sober rooms (to limit ED/ EMS and law enforcement service use) • Multiple treatment modalities	**Gaps in resources** • No integrated service system • Limited resources for co-occurring • Limited or no CD professionals within some MH agencies • Limited MHCD provider training • Lack of aftercare for MH patients (discharge plan) • Limited financial treatment assistance for uninsured or insured without adequate coverage • Limited space and long wait for in-pt beds • Comprehensive family services are lacking	**Impact/costs** • High-end services use • Hospitalization costs for mental illness exceeded $21,000 per admission (2011) • SFY 2009 highest DSHS cost per co-occurring patient was for ages 14-17 at an average of $22,193 • TFD reported 161 individuals who called 911 three times or more in 2011, had a total of 5,160 calls for MHCD requests • 94% of MHCD patients visiting hosp. ED 21 times or more in a year costs 3.2 million (King Co.)	**Best practices/ approaches** • Integrated Dual Disorder Treatment (IDDT) • Intensive Case Mgmt pilot program for high utilization of crisis services • Modified Therapeutic Community (MTC) for co-occurring disorders • Computer-Assisted System for Patient Assessment and Referral • Frequent User Service Enhancement (FUSE)	**Estimated ROI** • FUSE: saved one county in MN an average of $13,000 per year per person housed
MHCD National EBP Registry: http://www.nrepp.samhsa.gov/AdvancedSearch.aspx				

Persons with co-occurring disorders have higher likelihood of suicide, incarcerations, recidivism, homelessness, HIV infection and high-end services use, and can impact multiple community resources and services. The issue of co-occurring frequently comes up within other themes of this assessment, such as service integration issues, access to treatment services, and crime and incarceration.

According to a 2011 National Comorbidity Survey, more than 40% of persons with addictive disorders also have co-occurring mental disorders. Those individuals tend to have more barriers to accessing and finding available MHCD services. Thirty-seven percent of those organizations surveyed that provide direct services in Tacoma had adult clients that had co-occurring issues, and 15% percent of those organizations had youth clients with co-occurring issues (2012).

In a one year period, 61% of a local hospital's emergency department patients with a mental health diagnosis also had chemical dependency issues. Co-occurring diagnoses were documented for 29% of the individuals incarcerated with the Pierce County Detention and Corrections Center in 2011.

From a Pierce County 2011 Point in Time survey, 132 people (6.4%) reported that they were unsheltered and chronically experiencing homelessness**;** 24% of which had co-occurring issues. High rates of substance use disorders have been discovered among veterans with mental illness; ranging from 21 to 35% (2011).

Lack of coordinated/integrated services among service silos

Local resources	Gaps in resources	Impact/costs of	Best practices/ approaches	Estimated ROI
• City of Tacoma Human Rights and Human Services department • Regional Network (OptumHealth) • Discharge planning • School liaisons (for juveniles) • Community Life Resources	• Lack of Integrated /coordinated service models • Lack of a system-wide continuum of care model • Self-care/self-advocacy resources • Vocational/occupational training for those with MHCD issues	• High-end services use • Hospitalization costs for mental illness exceeded $21,000 per admission (2011) • 94% of MHCD patients visiting hosp. ED 21 times or more in a year costs 3.2 million (King Co)	• Navigator programs (innovative) • Peer Bridgers (discharge or release peer support) • Mental Health Courts • Drug Courts • *OQ-Analyst* is a computer-based feedback and progress tracking system • Brief Strategic Family Therapy	• For Drug Courts: return was $4.42 for youths and $3.69 for adults for each $1 spent (reduced recidivism rate of 13%) • MH Courts ROI: $6.96 per $1 spent

MHCD National EBP Registry: http://www.nrepp.samhsa.gov/AdvancedSearch.aspx

There is no formal continuum of care services system in Tacoma. There are gaps in coordinated efforts among service providers (medical, mental health, chemical dependency, schools, social service, etc.) to ensure efficiency and effectiveness throughout the system. These gaps are even wider for those individuals who are experiencing multiple issues (e.g. co-occurring, detoxing, and homelessness).

Information provided by key stakeholder interviews (2012) revealed that there is lack of a full continuum of high-quality care services that are available locally and that are sufficient to meet the needs of those with multiple issues (e.g. co-occurring, detoxing, and homelessness).

As much as 82% of those agencies that provide services to adults reported that they currently have adult clients with mental health issues (2012 City of Tacoma environmental scan). This same environmental scan found that 44% percent of those agencies that provide services to youth currently reported having youth clients with mental health issues.

Those in treatment or who have recently completed treatment also are in need of the support of a recovery community to sustain recovery.

Disparities in representation of those with MHCD needs and with those who seek/receive services

Local resources	Gaps in resources	Impact/costs of	Best practices/ approaches	Estimated ROI
• Satellite MHCD offices • Mobile MHCD providers • Sliding scale or free services (limited) • WA State Medicaid and S-CHIP programs for low income children • School MHCD and homeless services for students (direct & referral) • Flexible operating hours (though still limited) • Helplines (for youth, adults, military & vets) • Crisis services • Ethnic/minority counseling centers • Encampment Project/Housing First approach	• Limited MHCD professionals trained for cultural differences • Limited financial treatment assistance • Limited or no specialized services (co-occurring, detox, Infant /toddler) • Comprehensive family services are lacking • Lack of Integrated /coordinated service models • No youth service org. • No homeless youth shelter • Lack of self advocacy services • Limited treatment provider training	• 784 MH admissions for one Tacoma hospital costs on average $21,000 per admission • Average Medicaid costs for a Tacoma resident for MH treatment are $5,631 • Average Medicaid costs for a Tacoma resident for CD treatment are $2,388 • Nationwide, the economic impact of illicit drug use was est. to be $193 billion in 2007. The majority, $120.3 billion was attributed to lost productivity	• Strong African American Families-Teen • Racial/ ethnic differences in substance abuse treatment initiation and engagement • Cultural Adaptation of Cognitive Behavioral Therapy (CBT) • Psychiatric Rehabilitation Process Model • Cognitive Assessment and Risk Evaluation • Program for Assertive Community Treatment (PACT) -Clark County	• ROI for drug treatment in the community is $11.05 for every $1 spent • ROI for life skills training is $37.52 for every $1 spent • ROI for Cognitive Behavioral therapy (CBT for adult anxiety) is $52.01 for every $1 spent • ROI for CBT for adult depression is $68.90 for every $1 spent • ROI for CBT for adolescent depression is $7.11 for every $1 spent

MHCD National EBP Registry: http://www.nrepp.samhsa.gov/AdvancedSearch.aspx

African Americans make up 11.2% of Tacoma residents and 31% of all African Americans who live in Tacoma live below poverty. Additionally, the African American unemployment rate of 18.5% is the highest of all races in Tacoma and they are among the highest DSHS users.

Twenty-seven percent of individuals experiencing homelessness were African American. The issue of chronicity of those individuals experiencing homelessness is an important one in the veteran population. Data from HMIS showed that of those 10.4% of survey respondents that were chronically experiencing homelessness, 40% were military veterans.

An additional disparity facing this group may be overrepresentation in those individuals experiencing homelessness, those incarcerated, in child foster care and welfare systems, and as crime victims.