A Community Mental Health and Chemical Dependency Assessment
City of Tacoma
December 2012

Tacoma-Pierce County Health Department,
Office of Assessment, Planning, and Improvement

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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).

II. ASSESSMENT OVERVIEW

Purpose

This assessment report is part of the City of Tacoma's planning process in preparation for expected revenue coming from the state authorized sales and use tax for chemical dependency, mental health treatment services, or therapeutic courts. Because some counties, including Pierce County, have not elected to collect this sales tax, Washington state provided Tacoma officials the authority to enact the tax. In March of 2012, the Tacoma City Council passed Ordinance 28057 which authorized a 0.1% sales tax to support mental health treatment, chemical dependency treatment, therapeutic court(s), and housing for those in treatment services. At that time the Council also requested that staff conduct a community assessment to identify gaps in the current mental health and chemical dependency (MHCD) service delivery system for Tacoma residents. In August of 2012, the City of Tacoma Human Rights and Human Services Department commissioned the Tacoma-Pierce County Health Department's Office of Assessment, Planning, and Improvement to conduct a MHCD assessment.

This report represents the assessment results and will assist the Tacoma Human Rights and Human Services department to better understand: a) gaps in services, b) the impacts/costs of having unmet needs, c) resources that could help fill the gaps in services, and d) possible return on investments by implementing best practices or innovative models. The Human Rights and Human Services department will be sharing this report with the Tacoma City Council as part of their process to identity focus areas for possible funding.

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. One of these data sets came from a survey of MHCD service providers (qualitative and quantitative) conducted by City of Tacoma Human Rights and Human Services department staff in May 2012. The survey identified agencies and programs currently providing services addressing mental health, chemical dependency, housing, and criminal justice.

In addition, seven key-informant interviews (qualitative) were conducted with service providers and community leaders knowledgeable about MHCD issues and needs among Tacoma residents. The City of Tacoma Human Rights and Human Services department staff indentified key stakeholders to be interviewed by Health Department staff. These interviews were conducted in September 2012 and collected information about: a) the agency's role in addressing MHCD, b) client needs and barriers to accessing care, c) service provider workforce issues, d) collaborations between agencies, and e) views about community assets and challenges in addressing MHCD issues.

Finally, literature searches were conducted to examine lessons learned from other communities' previously conducted behavioral health assessments. The review specifically identified common themes from similar assessments, the impacts on the community or costs of

having unmet MHCD needs, best practices and innovative or promising approaches addressing MHCD needs, and the return on investments for implementing specific approaches.

Limitations

There are limitations to this assessment process that should be noted. This assessment and analysis should not be construed as formal research but rather a review of existing data along with original data collection to help explain the MHCD needs and service gaps of Tacoma residents. This assessment does not include an evaluation of the effectiveness of existing services, service provider data on numbers of clients served, and types of services provided. These data were taken at face value and not independently verified.

III. DEMOGRAPHICS

Research shows that understanding a community's demographic makeup is important in gaining a full picture of that community's MHCD service delivery needs. The demographic information provided in this report provides a snapshot of Tacoma's population by race, ethnicity, age, insurance coverage, poverty, unemployment, homelessness, military veterans, active military and youth. This allows one to better understand the need for MHCD services among city residents (where local data was not available, Pierce County or Washington state data was used).

Tacoma is Washington state's third-largest city, with the 2010 U.S. Census reporting 198,397 residents who are grouped into about 79,000 households and 45,000 families. Tacoma is slightly more diverse in its race and ethnicity (see Figure 1 below) than Washington state overall.

- 128,670 (64.9%) White
- 22,210 (11.2%) African American
- 16,274 (8.2%) Asian
- 3,648 (1.8%) American Indian and Alaska Native
- 2,455 (1.2%) Native Hawaiian and Pacific Islander
- 15,976 (8.1%) two or more races
- 9,164 (4.6%) other race

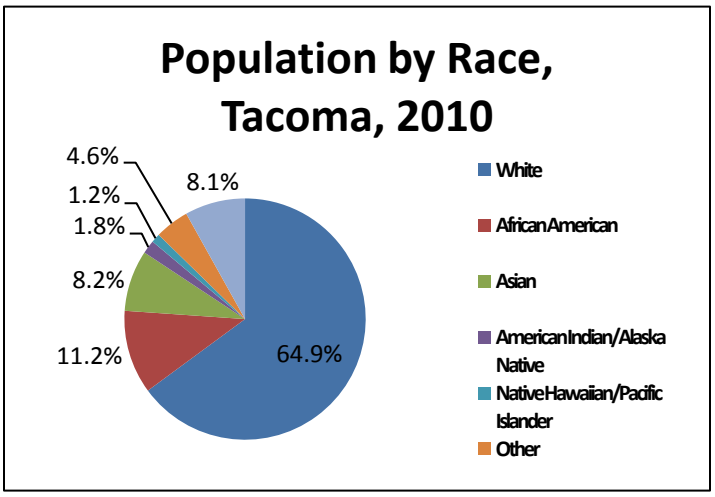


Figure 1

More than 25,000 Tacoma residents were foreign born, which represents 12.7% of the population. Hispanics or Latinos of any race represented 11.3% or 22,390 of Tacoma's resident population. Almost one-third of Tacoma residents were 25 to 44 years of age (29.6%), and another quarter of residents were 45 to 64 years (25.3%). The smallest percentage of Tacoma residents were 14 to 24 years (15.8%) followed by 0 to 13 years (18.0%).[1]

There are several ways to examine the income distribution of a city. The median income for a *household* in the city was $47,862; this is about $10,000 less than the Washington state average of $57,244. The median income for a *family* in Tacoma was $58,870; again about $10,000 less compared to the Washington state average of $69,328. The *per capita* income for the city was $25,377, while Washington state was $29,733.[2] For each picture of income in Tacoma, the average is less for city residents than for the average resident in Washington state.

In Tacoma, 13.5% of all families and 16.1% of individuals were below the poverty line. Those who were 25 to 44 years had the highest poverty rate, followed by 5 to 11 year olds. Almost one fourth (10,706) of Tacoma youth under the age of 18 years reside below the poverty line. Tacoma residents 65 years and older had the lowest rates of poverty at 11.0%. African American residents had the highest poverty rates while White residents had the lowest.[2]

In 2009, 27% of Tacoma residents were Medicaid eligible (Title XIX). The age group least likely to have health insurance was 18 to 24 year olds. Among that age group, American Indian/Alaskan Natives had the highest uninsured rate.[3]

As of August 2012, Tacoma's unemployment rate at 9.1% was slightly higher than the state rate of 8.6%.[4] The 20 to 24 year age group had the highest unemployment rate at 16.4% (excluding 19 years and under who may not be in the labor force).[5]

IV. MENTAL HEALTH/CHEMICAL DEPENDENCY DATA

As part of the assessment, existing data pertaining to MHCD issues are summarized in this section. These data include direct MHCD issues, risk factors for MHCD issues, or results or impacts of MCHD issues (individual and community-based).

A 2010 Risk and Protection Profile (see Table 1) identifies risk factors associated with substance abuse for Tacoma residents compared to Pierce County and Washington state residents.[6] Findings from the data table include the following:

- The risk of alcohol or drug-related deaths in Tacoma was not significantly different than that in Pierce County or Washington state.
- More state-funded alcohol or drug services were used in Tacoma than in Pierce County or Washington state for ages 10 years and older. These services were primarily used by adults (18+ years).
- Alcohol and drug violations represented 6 and 12%, respectively, of total arrests of adolescents (ages 10 to 17).
- Rates of suicide and suicide attempts in adolescents 10 to 17 years did not differ between Tacoma, Pierce County and Washington state.

Table 1 Risk and Protection Profile for Substance Abuse Prevention in Tacoma (2010)

	Tacoma	Pierce County	WA State
Alcohol- or drug-related deaths per 100 deaths	13.13	13.16	12.27
Clients of state-funded alcohol or drug services (age 18+) per 1,000 adults	21.25	11.22	13.43
Clients of state-funded alcohol or drug services (age 10-17) per 1,000 adolescents	12.89	8.51	11.1
Arrests (age 18+), alcohol-related per 1,000 adults	5.73	4.87	9.31
Arrests (age 18+), drug law violation per 1,000 adults	5.3	3.77	4.39
Suicide and suicide attempts (age 10-17) per 100,000 adolescents	43.62	42.75	44.53
Total arrests of adolescents (10-17) per 1,000 adolescents	46.2	31.8	39.35
Arrests (age 10-17), alcohol violation per 1,000 adolescents	2.94	3.13	4.82
Arrests (age 10-17), drug law violation per 1,000 adolescents	5.73	4.02	4.77

Source: DSHS/Research and Data - Analysis Division

Chemical Dependency/Substance Abuse

Adults: The Behavioral Risk Factor Surveillance Survey (BRFSS) of Tacoma adults conducted in 2010 asked about behaviors related to alcohol use.[a] Survey participants reported the following:

- In the last nine years heavy drinking among Tacoma adults remained relatively unchanged. Five percent of Tacoma adults reported heavy drinking in 2010.
- In the last nine years binge drinking among Tacoma adults ranged from 13.1% to 17.1%. The yearly changes were not statistically different from each other.

Youth: According to data on students who were receiving services from the Puget Sound Educational Service District (PSESD) Student Assistance Prevention and Intervention Services for the Tacoma School District[7]:

- Both alcohol and marijuana use in the previous three months had increased from 2010 to 2011 when compared to 2008 to 2009.
- There was a decrease in over-the-counter, prescription and other drug misuse from 2009 to 2010.

[a] The Behavioral Risk Factor Surveillance System is the world's largest, on-going telephone health survey system tracking health conditions and risk behaviors in the United States yearly since 1984.

The table below (Table 2) shows self-reported substance abuse rates among Tacoma School district students who participated in the 2010 Healthy Youth Survey[b]. Of all the estimates listed, only the 8th grade illegal drug use rate was statistically higher than the Washington state average rate.

Table 2 Drug and Alcohol Use Among Tacoma Students (2010)

	6th grade	8th grade	10th grade	12th grade
30-day alcohol use	4.2%	16.2%	29.6%	39.0%
30-day illegal drug use	2.4%	13.0%	24.1%	29.0%

Source: Healthy Youth Survey

The City of Tacoma, Human Rights and Human Services, performed a MHCD environmental scan in May of 2012 (see Appendix F). The survey of 27 direct service agencies found that many agencies that provide multiple types of services had clients with MHCD needs.

- Fifty-nine percent of those agencies that provide direct services to adults reported having clients with MHCD issues.
- Forty-one percent of those agencies that provide direct services to youth reported having clients with MHCD issues.

Mental Health

Adults: The 2010 BRFSS survey of Tacoma residents asked participants to rate their mental health. Survey participants reported the following:

- Eight percent of Tacoma adults reported 15 to 30 mentally unhealthy days in the past 30 days. This compares to 9.7 mentally unhealthy days for Washington state.
- Serious Mental Illness (SMI) computed from scores averaged on six questions on mental illness (2009 to 2010 average) showed a score of 3.3% for Tacoma residents. This compares to 2.9% for Washington state.

Youth: According to data from the PSESD Student Assistance Prevention and Intervention Services for the Tacoma School District[7]:

- Students presenting with mental health needs has decreased by 28.3% from 2008 to 2011.

Table 3 shows responses by Tacoma School District students to questions related to depression and suicide from the 2010 Healthy Youth Survey. None of the estimates listed for Tacoma students were statistically higher than the Washington state average.

[b] The Healthy Youth Survey collects data every two years from students at grades 6, 8, 10 and 12 through a student-completed paper survey.

Table 3 Depression Among Tacoma Students (2010)

	8th grade	10th grade	12th grade
Felt depressed during the past 12 months	29.6%	34.7%	31.5%
Very or somewhat likely to seek help if feeling depressed or suicidal	27.6%	32.4%	38.9%

Source: Healthy Youth Survey

Hospitalization rate data from the Washington State Comprehensive Hospitalization Abstract Reporting System (CHARS) indicate that mental illness was markedly higher (by about 25%) among Tacoma residents as compared to the rest of Pierce County from 2006 to 2011. Excluding Tacoma, hospitalization for Pierce County residents due to mental illness as a portion of all hospitalizations remained relatively stable until 2008. In the next two years there was noticeable growth from 2.9% in 2006 to 3.4% in 2009, and 3.4% in 2010, to 3.6% in 2011[c].

One Tacoma hospital system reported the percentage of emergency department (ED) visits and hospitalizations of patients presenting with severe mental health problems for the period of August 2011 to July 2012:

- Sixteen percent of hospitalized patients were diagnosed with psychosis not otherwise specified.
- Seven percent of ED visits had a diagnosis of schizophrenia.
- Sixty-one percent of patients presenting at the ED with a mental health diagnosis also had chemical dependency issues (co-occurring).

The 2012 City of Tacoma environmental scan of 27 MHCD direct service agencies found the following:

- Eighty-two percent of those agencies that provide services to adults reported that they currently have adult clients with mental health issues.
- Forty-four percent of those agencies that provide services to youth currently had youth clients with mental health issues.
- Thirty percent of those agencies that provide services to infants and toddlers reported currently having infant/toddler clients with mental health issues.

Suicide

Suicide is a serious mental health problem and is most commonly the result of untreated or under-treated mental illness. In Pierce County, suicide is the seventh leading cause of death for all ages and the second leading cause of death for ages 15 to 24 years. Suicide rates during the period from 2006 to 2010 did not differ statistically. In addition, suicide rates did not differ between Tacoma and the rest of Pierce County. The suicide rates for both Tacoma and Pierce County were higher than the Washington state rate. In 2010 the age group 25 to 44 had the highest rate (23.9 per 100,000) in Pierce County.

[c] Washington State Comprehensive Hospital Abstract Reporting System collects coded hospital discharge information. This data set excludes federal facilities.

Youth: Seventeen percent of 6th grade students who participated in the 2010 Tacoma School District Healthy Youth Survey reported that they had seriously thought about killing themselves. This rate was statistically higher than the Washington state rate. The table below shows related responses, which are all consistently (although not necessarily significantly) higher than the Pierce County average rate.

Table 4 Considered Suicide Among Tacoma Students (2010)

	8th grade	10th grade	12th grade
Seriously consider suicide in past 12 months	19.0%	18.9%	17.0%

Source: Healthy Youth Survey

The Healthy Youth Survey 2010 indicates that for the Tacoma School District, on average (grades 8 to 12), 5.7% fewer students actually made a plan to commit suicide, and 9.4% fewer students made a suicide attempt, compared to students who seriously considered suicide.

Data from the Pierce County Child Death Review Case Reporting System show that from 2004 to 2008 (the most recent data reported), 207 Pierce County youth (ages 5 to 17) were hospitalized for suicide attempts. The following is a breakdown of those data:

- Approximately 51 Pierce County youth per year were hospitalized for self-inflicted injuries.
- Among the 207 youth, 191 (92%) had attempted suicide (approximately 48 per year) and 16 (8%) actually committed suicide (approximately 4 per year).
- The most common suicide attempt methods were:
    - Poisoning (includes prescription drug overdose) 165 (86%)
    - Cutting 15 (8%)
    - Other 8 (4%)
    - Firearm 3 (2%)

Research suggests that less than half of teens who attempt suicide received mental health services during the year before the attempt. Between 50 and 75 percent of those who had suicidal ideation had recent contact with a health provider. However, most had three or fewer visits, suggesting that treatment tends to end prematurely. In addition, most teens considering suicide did not receive specialized mental health care. The researchers added that primary care physicians should be screening teenagers for depression and suicidal thoughts.[8]

Additionally, screening of patients leads to more frequent and earlier detection, and improved outcomes compared to patients that had never been screened. Use of validated screening tools and the existence of treatment services and systems for follow-up are key in the effectiveness and improvement of outcomes. An American Academy of Pediatrics (AAP) study found that routine screening in the primary care setting for mental illness was feasible, effective in identifying need, and leads to linkage with services.[9]

Unfortunately, many students don't know where to go for mental health treatment or believe that treatment won't help. Others don't get help because they think symptoms of depressions

are just part of the typical stresses of school or being a teen. Some students worry about what other people will think if they seek mental health care.[10]

Criminal Justice System

Adults: Data from the Pierce County Detention and Corrections Center indicated that there were 2,456 initial contacts for mental health services of incarcerated individuals in 2011.[11] There were 12,870 total contacts for mental health services, including follow-up and collateral contacts. For 42% of the individuals the reason for the initial mental health contact was a danger to self. The age group 18 to 59 years represented 97% of the incarcerated who received an initial contact. Among all individuals, 47% had been charged with a misdemeanor and 53% with a felony. Twenty-five percent of the incarcerated individuals contacted for mental health services reported experiencing homelessness.

The diagnoses at initial contact included non-specified psychosis and bi-polar disorder (19.1%), adjustment disorder (19%), psychoactive substance abuse (17%), alcohol abuse (9%), and depression (9%). Co-occurring (mental health and chemical dependency) diagnoses were documented for 29% of the individuals. Also reported for this population was past inpatient (26%) and outpatient (41%) treatment for their disorder. At the time of release from corrections, 15% were released to treatment.

A national 2006 Department of Justice report shows the following burden of MHCD issues on the criminal justice system[12]:

- More than 64% of jail inmates had a mental health problem.
- Fifty-three percent of local jail inmates had met the criteria for substance dependency or abuse.
- Seventy-four percent of local jail inmates who had mental health problems met the criteria for substance dependency or abuse (co-occurring).
- Nearly a third (32%) of local jail inmates who had a mental health problem were repeat violent offenders as compared to about a quarter (22%) of mentally healthy jail inmates.
- Rule violations and injuries from a fight are more common among inmates who had a mental health problem.
- Mentally ill offenders who commit felonies spend an average of 158 days in jail at costs of $300 per bed per day, or $47,400 per jail episode.
- Additional staff and extra costs for psychiatric services and medications result in a higher daily cost of care for the mentally ill while incarcerated.

Youth: Data about incarcerated youth with MHCD issues reveal that:

- Arrests of Pierce County adolescents (ages 10 to 14), for alcohol or drug violations, made up 15% of the total arrests of adolescents in this age group.[13]
- Total arrests of adolescents (ages 10 to 17), were composed of 6% alcohol violations and 12% drug violations.
- Pierce County juvenile court officials estimate that 20 to 40% of the youth detained need a mental health referral. In 2011 there were 508 mental health referrals of detained youth.

- In comparison, in 2007, 49% of youth admitted to King County secured detention were referred to mental health services.[14]

In combination with crime and incarceration, IDUs make up yet another subpopulation of substance abusers. Research has shown that in US prisons, approximately one-third of prisoners have a history of injection drug use. Approximately 34% of prisoners report injecting cocaine or crack at least weekly for a month at some point in their life and 12% reported use at the time of criminal offense. [15]

Co-occurring Disorders

According to the National 2011 Comorbidity Survey, more than 40% of persons with addictive disorders also have co-occurring mental disorders.[16] Data from the last and often sited 1999 Surgeon General's Report on Mental Health: A Report of the Surgeon General showed[17]:

- Approximately 15% of all adults who have a mental illness also experience a co-occurring substance use disorder at some time.
- Persons with co-occurring disorders reportedly have a higher likelihood of suicide, incarcerations, recidivism, family conflict, and high-end service use.
- Sixty-one percent of patients presenting at a local hospital's ED with a mental health diagnosis also had chemical dependency issues (co-occurring).
- Co-occurring diagnoses were documented for 29% of those individuals who received an initial mental health evaluation with the Pierce County Detention and Corrections Center in 2011.

The 2012 City of Tacoma MHCD environmental scan found that:

- Thirty-seven percent of those organizations that provide direct services had adult clients that had co-occurring issues/diagnoses.
- Fifteen percent of those organizations that provide direct services to youth had current youth clients with co-occurring issues/diagnosis.
- Eleven percent of those organizations that provide direct services to infant and toddlers had current infant/toddler clients with co-occurring issues/diagnosis.

Poverty

Families living in poverty face extraordinary pressures with diminishing community resources and poverty-related difficulties, such as frequent housing moves, unemployment, and lack of insurance and transportation, which may impact the ability to access MHCD services
Almost one of seven low-income adults in Washington state is in need of treatment for a substance use disorder. Projections from the Washington State Needs Assessment Household Survey suggest that in State Fiscal Year (SFY) 2008, 13.5% of adults in households at or below 200% of the Federal Poverty Level had a current need for substance use disorder treatment. In addition to the numbers of individuals needing treatment, those in treatment or who have recently completed treatment, are also in need of community based recovery services which include employment and housing support to sustain recovery.[18]

Table 5 Tacoma Poverty Status by Race, 2010 U.S. Census

	Total	Number below poverty level	Percent below poverty level
Population for whom poverty status is determined	192,307	32,899	17.1%
White	131,379	18,488	14.1%
Black or African American	21,993	6,732	30.6%
American Indian and Alaska Native	3,190	596	18.7%
Asian	14,564	2,128	14.6%
Native Hawaiian and Other Pacific Islander	2,155	401	18.6%
Two or more races	12,723	3,240	25.5%
Hispanic or Latino origin (of any race)	19,540	5,038	25.8%

V. VULNERABLE POPULATIONS

Individuals Experiencing Homelessness

Homelessness is often influenced by problems of mental illness and substance abuse. Nationally, the most common institutional living condition prior to homelessness is medical facilities such as hospitals, psychiatric facilities or substance abuse treatment centers. Almost 8% of individuals who use a homeless shelter arrive directly from one of these three facilities. Approximately 40% of adults experiencing homelessness are estimated to have a disability of some type.[19]

By its very nature, homelessness is impossible to measure with 100% accuracy. There are many limitations and barriers to counting those individuals experiencing homelessness. Many individuals experiencing homelessness have mental illness, chemical dependency, or both. A King County study of prevalence reported that co-occurring disorders in adults who are experiencing homelessness and receiving publicly funded mental health treatment was double that of those who were not homeless.[14]

The Washington State Department of Social and Health Services (DSHS) Research and Analysis Division reported that in 2010, 7.8% of their clients were in need of alcohol or drug treatment and 22.9% had a mental illness. This report also showed that these rates increased significantly for DSHS clients experiencing homelessness, 26.7% of DSHS clients experiencing homelessness were in need of alcohol or other drug treatment, and 37.3% were reported to have a mental illness.[20]

In 2011, the Homeless Management Information System (HMIS) provided a snapshot of those individuals experiencing homelessness in Pierce County.[d] Data from the HMIS showed that 10.4% of survey respondents experiencing homelessness were chronically experiencing homelessness. Of those chronically experiencing homelessness, 40% were military veterans, and 62% were unsheltered. African Americans were disproportionately represented among those experiencing homelessness, as seen in the table below (Table 6).

[d]The HMIS is a U.S. Department of Housing and Urban Development (HUD) product for assisting communities in the collection and reporting of homelessness data for development of local services.

Table 6 2011 Homeless Survey Participants by Race, Pierce County (N=2068)

Race	% of PC survey participants experiencing homelessness	% of total PC populations 2010 Census
White	47.0	77.3
Black/African American	26.6	7.1
Hispanic	9.8	9.4
Native Hawaiian/Pacific Islander	5.9	1.4
American Indian/Alaska Native	5.4	1.6
Other multi-racial	4.6	6.4
Asian	1.3	6.2

Among those surveyed, 6% reported that substance abuse contributed to their homelessness while 3% reported that mental illness contributed to their homelessness. This includes those who are considered transitional, not housed, in emergency shelters, unsheltered and chronically homeless. When looking at the numbers of those who are experiencing chronic homelessness, there is an increase in incidents of mental health and chemical dependency rates which are often contributing factors to homelessness. At the time of the survey in 2011, 132 people (6.4%) reported that they were unsheltered and experienced chronic homelessness**.** Of those 132 people, 52% had mental health issues, 30% had drug and alcohol problems, and 24% had co-occurring (both mental health and chemical dependency) problems**.**

The 2012 Homeless Management Information System (HMIS) survey in Pierce County had limited data available for comparison, noticeably survey participants by race was not currently available. At the time of the survey in 2012, 5.1% reported that they were unsheltered and experiencing chronic homelessness. Most of the individuals experiencing chronic homelessness have more than one disability, such as a combination of mental illness and substance addiction (co-occurring). They also tend to have histories of frequent hospitalizations, incarceration and unemployment.

Table 7 2012 Pierce County Homeless Survey Overview (19)

	Not Housed		Emergency Shelter		Transitional		Total (men, women and children)*
	Count	%	Count	%	Count	%	Count
total persons	192	10.0%	597	30.0%	1208	60.0%	1997

Homelessness (HUD definition) equals not housed plus emergency shelter plus transitional housing. Chronically homeless equals an individual with a disability who has been homeless for more than 1 year or 4 times or more in the past 3 years.

In a Pierce County Point in Time Survey from January 26 to 27, 2012, statistics showed that of 374 families experiencing homelessness, 752 children were included.[21]

- Of the total 752 children, 1.2% were unsheltered, 18.2% were in emergency shelters and 80.6% were in transitional housing.

- A grouping by ages showed that of the total 752 children, 43.0% were from ages 0 to 5, 40% from 6 to 12, and 17.0% from 13 to 18 years old.
- A comparison of 2011 and 2012 indicated that there was a 15% increase in the number of children experiencing homelessness.

Military and Veterans

Pierce County is home to Joint Base Lewis-McChord (JBLM). There is also a Veterans Administration Hospital in the neighboring city of Lakewood. Around JBLM, a major staging base for the wars, neighboring cities and towns are home not only to military families, but to thousands of veterans who have stayed on after their enlistments.

Data indicate that 38% of soldiers report psychological symptoms. Among members of the National Guard, the figure rises to 49%. Further, psychological concerns are significantly higher among those with *repeated deployments*, "a rapidly growing cohort." More than 13% of the Army, which has borne the brunt of the fighting, now meets the criteria for post-traumatic stress disorder.[22]

A 2011 JBLM Community Needs Survey Summary Report showed that 9% of the 2,145 survey respondents representing active duty or their spouses reported living in the City of Tacoma. Tacoma had the second largest group of off-base active duty service members, following Lacey, who participated in the survey. The survey also provided the following data:

- More than three-quarters (77%) of active duty survey respondents had been deployed. Of those who had been deployed, a third had been deployed more than 3 times.
- Almost three-quarters (72%) of active duty members and their families live off-base.
- More than half (59%) of active duty members living off-base are married or have children.

Table 8 City of Tacoma Veteran Population (2010)

	Veterans	Total
18 to 34 years:	1,341	48,654
35 to 54 years:	6,775	53,299
55 to 64 years:	4,540	22,467

Source: American Community Survey.

Approximately, 10.2% of Tacoma adults (18 to 64 years) are military veterans.[2] In a 2011 Pierce County homeless report, an estimated 40% of those Pierce County residents experiencing chronic homelessness were military veterans.[21]

Children and youth in military families tend to have higher rates of mental health problems than those in the general population, and those mental health problems are especially pronounced during a parent's deployment.

- Thirty-two percent of children of military families scored "high risk" for child psychosocial morbidity, 2.5 times the national average.[23]
- There is a higher prevalence of emotional and behavioral difficulties in youth aged 11 to 17 in military families compared to the general population.[24]

- During a parent's deployment, children exhibit behavior changes that include changes in school performance, lashing out in anger, disrespecting authority figures, and symptoms of depression.[25]
- Children age 3 to 5 with a deployed parent exhibit more behavioral symptoms than their peers without a deployed parent.[26]
- The rate of child maltreatment in families of enlisted Army soldiers is 42% higher during combat deployment than during non-deployment.[27]

Table 9 Parent or Guardian Served in the Military Among Tacoma Students (2010)

Grade	6th	8th	10th	12th
% yes	28.7%	32.0%	28.1%	29.7%

Source: Healthy Youth Survey

In Table 9, Tacoma students reported whether their parents had ever been in the military. This includes current active military at the time of the survey and former military personnel (veterans).

A 2011 Yale University School of Medicine study examined rates of substance use disorders among U.S. Veterans who served in Iraq and Afghanistan and who were also diagnosed with PTSD and other psychiatric disorders. The research showed that there were high rates of substance use among veterans with mental illness (range 21 to 35%), with the highest rates of substance abuse occurring among those with bipolar disorder and schizophrenia.[28]

Youth

According to a 2010 report using the National Health and Nutrition Examination Surveys of children ages 8 to 15, approximately one out of eight U.S. children (13.1%) had one of the assessed mental health disorders in the past year.[29] The primary funding source for public mental health and chemical dependency treatment services is Medicaid, and access to services is severely limited for those who are not eligible for Medicaid. Washington state recently increased funding for chemical dependency treatment in order to increase access to treatment, but most of this funding is available only for those who qualify for Medicaid. Often the only services available to those not on Medicaid are the most expensive services: crisis intervention and hospitalization.

An annual average of 3.3 million youths aged 12 to 17 years (13.3%) received services for emotional or behavioral problems in a specialty mental health setting in the past year (average of 2005 and 2006 data). Mental health services for children and youth are provided in community mental health centers, as well as nonspecialty settings such as schools and general medical practice settings. Approximately three million youths (12.0%) received services for emotional or behavioral problems in a school-based setting, and approximately 752,000 (3.0%) received services in a general medical setting. An estimated 2.7% of persons in this age group received inpatient mental health services. The most commonly used inpatient service for emotional or behavioral problems (2.1%) was staying overnight or longer in a hospital.[30]

The data from a 2008 DSHS report breaks down the types of behavioral health needs in Pierce County youth who are receiving DSHS services[31]:

- 81.5% had mental illness
- 18.5% had alcohol/drug problems
- For those youth under 18 with any mental illness (11,488), 26% received mental health Services from RSNs while 21% received mental health medication only.
- For those youth under 18 with any alcohol/drug problem (2,602), 36% received alcohol or drug-specific treatment from DSHS.

A greater proportion of children and youth in the child welfare and juvenile justice systems have mental health problems than children and youth in the general population.[32,33] Half of the children and youth in the child welfare system have mental health problems. More than two-thirds of youth (67% to 70%) in the juvenile justice system have a diagnosable mental health disorder. Without treatment, these children are at increased risk of school failure, contact with the criminal justice system, dependence on social services and suicide.

Also within the youth category are young adults, those who are 18 to 24 years old. They are considered vulnerable youth due to the fact that they may no longer qualify for publicly funded insurance or in some cases, are no longer covered under their parents/caregivers' private insurance. Though having private health insurance doesn't ensure coverage for all aspects of treatment. As noted in the demographic section, those in the 18 to 24 age group in Tacoma are least likely to have health insurance when compared to other age groups, and the 20 to 24 age group has the highest unemployment rate in Tacoma.

When examining youth as a population, there is a sub-category to consider, which is homeless and/ or unaccompanied youth. This report previously highlighted data and MHCD issues around individuals experiencing homelessness as a separate vulnerable population. The term "unaccompanied youth" means that a youth is not in the physical custody of a parent or guardian.[34] This includes young people who have run away from home, been thrown out of their homes, and/or been abandoned by parents or guardians.[35] Unaccompanied youth are at risk for substance abuse and criminal activity and face significant challenges in accessing MHCD services.[36,37] Approximately 3,000 unaccompanied youth and young adults experience or are at significant risk of homelessness in Pierce County each year, with approximately 1,000 being under the age of 18.[19] Data gathered from the Tacoma School District McKinney Vento program[38] reflects a total of 850 students who have been identified as experiencing homelessness since the beginning of the 2012 to 2013 school year. Within that group 68 unaccompanied youth have been identified.

African American

As previously reported, about 27% of the Pierce County individuals experiencing homelessness are African American as compared to the overall City of Tacoma population of 11% African American; 30.6% of which live in poverty.[2] These same individuals are at risk for mental health illness due to an overrepresentation in the homeless population, an increased rate for incarceration, a higher percentage in both foster care and in child welfare systems, and as victims of serious violent crime. Unemployment among African American Tacoma residents is

the highest among all races at 18.5% compared to white residents at 7.7%.[2] Of all minorities, African Americans have the highest rate of use of DSHS services through the Division of Alcohol and Substance Abuse (DASA) and for mental health services.[3]

Other vulnerable groups

There are other vulnerable populations in which there is limited data to help fully determine the magnitude of MHCD issues; further local studies would be helpful. These other vulnerable populations in Tacoma are:

Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ)

One national study found that LGBTQ groups are about two-and one-half times more likely than heterosexual men and women to have had a mental health disorder, such as those related to mood, anxiety, or substance use in the lifetime. The reason for these disparities is most likely related to the societal stigma and resulting prejudice and discrimination that those persons who are LGBTQ face on a regular basis. There also appears to be a lack of mental health professional training that focuses on LGBTQ issues.[39]

People with HIV

A combined 2005 to 2009 National Survey on Drug Use and Health data indicates that an estimated annual average of 420,000 persons aged 12 or older (0.17%) had been told by a doctor or health care professional that they had HIV/AIDS. About one in six individuals with HIV/AIDS had used an illicit drug intravenously in their lifetime (16.6%); nearly two thirds had used an illicit drug but not intravenously (64.4%). Nearly one quarter (23.9%) of persons in the U.S. with HIV/AIDS were in need of treatment for alcohol use or illicit drug use.[40]

Immigrants

The knowledge of racial and ethnic variations in alcohol and substance abuse among U.S. immigrants is limited. A 2011 study on alcohol abuse among U.S. immigrant populations reported the prevalence and correlates of alcohol abuse among U.S. foreign-born versus U.S.-natives by race-ethnicity. The foreign-born population had lower rates of alcohol abuse than the U.S.-born; the U.S.-born showing 6.1% clinical alcohol abuse/dependence and foreign-born showing 4.0%.[41] Although this group had lower rates of reported alcohol abuse, they are still considered vulnerable given that there is limited data about overall MHCD needs, and possible access to service issues due to cultural and language barriers.

VI. THEMES

In addition to the analysis of data presented in sections III through IV, a literature search was conducted to examine lessons learned from other communities that had previously assessed their own community's behavioral health systems and issues. The top recurring MHCD themes were identified from the data analyses, the literature reviews, the MHCD environmental survey and stakeholder interviews conducted with service providers and community leaders knowledgeable about MHCD issues and needs among Tacoma residents.

1. **Crime and incarceration among populations with MHCD needs:** A large number of adults and juveniles enter the criminal justice system due to mental illness and/or

chemical abuse and dependency. The criminalization of mental illness is recognized as a nationwide problem. Nationally, an estimated 64% of adults in county and city jails suffer from a mental illness, and 53% met the criteria for substance dependency or abuse. Seventy-five percent of inmates had both mental health problems and substance dependency or abuse (co-occurring). About 6% of adults in jail have a serious mental illness. The rate of mental health problems varied by the age of inmates with inmates age 24 or younger having the highest rate of mental health problems.[12]

Data from Pierce County Detentions and Corrections Center show that 29% of those incarcerated receiving initial mental health services have a co-occurring diagnosis. An epidemiological study conducted in 1998 by King County Mental Health, Chemical Abuse and Dependency Services Division found that 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 abuse drugs and alcohol. There is a more recent 2006 King County study, but it did not address incarceration rates among those adults within the mental health system.

Adolescents with alcohol and drug problems are not adequately served in most existing drug-treatment programs designed for adults. There is a shortage of treatment options in the correctional system, especially for juveniles. In 2011, Pierce County Detention and Corrections Center data reported 15% of Pierce County adolescent (ages 10 to 14 years) arrests were for alcohol or drug violations.[13]

2. **Co-occurring (populations with both mental health and chemical dependency needs):** Individuals who are in need of chemical dependency treatment in conjunction with their treatment for mental illness face challenges with access to treatment, integration of services, and continuum of care. Close to one third of those receiving mental health services while incarcerated in Pierce County Dentations and Corrections have a co-occurring diagnosis, and just over one third of the recently polled agencies that provide direct services in Tacoma, report having clients with co-occurring issues.

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

3. **Disparities in representation of those with MHCD needs and with those who seek/receive services:** Services may be less available to vulnerable populations, including racial and ethnic minorities, individuals experiencing homelessness, adults and youth living in poverty, and people with co-occurring mental disorders. As part of this MHCD assessment, a number of vulnerable populations were identified. These populations either have a higher number of MHCD incidence rates, MHCD risk factors

or are less likely to access services. The populations identified are a) individuals experiencing homelessness (see theme #5), b) active duty military and veterans, c) African Americans, and d) youth.

More than one fourth of the Pierce County individuals who are experiencing homelessness are African American. Unemployment among African American Tacoma residents is the highest among all races. Of all minorities, they have the highest rate of DSHS services use through the Division of Alcohol and Substance Abuse (DASA) and for mental health services. This population is at particular risk for mental health illness due to an overrepresentation in homelessness incarcerations, children in foster care and child welfare systems, and victims of serious violent crime.[42]

Active duty military, veterans and their families are also identified as a vulnerable population. Although there are multiple military resources for treatment, they have higher rates of MHCD risk factors due to frequent moves away from their support systems, frequent or long deployments, being stationed in combat areas and possible traumatic brain injuries received during combat. A 2009 Military Health Advisory Team study identified barriers for accessing services that included concern about stigma, location of services and lack of command support.[43] Forty percent of the individuals experiencing chronic homelessness in Pierce County are estimated to be military veterans. Children and youth in military families tend to have higher rates of mental health problems than those in the general population, and those mental health problems are especially pronounced during a parent's deployment.[24,26]

Youth, especially youth in poverty, unaccompanied youth, or those who are incarcerated, are considered vulnerable due to limited services targeted toward those age 0 to 17 years. Adding homelessness or parental/caretaker drug use or mental illness increases their risks for MHCD issues. Young adults 18 to 24 years old may age-out of publicly-funded health coverage and be ineligible to receive services. This age group also has the highest unemployment rate in Tacoma.

4. **Lack of coordinated/integrated services among service silos:** For multiple reasons, such as policy, legal, funding and organizational systems, there is a lack of services integration. There is no formal city-wide process of merging separate clinical and social services to meet the individual's substance abuse, mental health, and other needs. Some of the organizations do have an informal system set up that includes client information and record sharing and referrals. Research shows that optimal programs are those that link with other systems of support and intervention to ensure they can produce and sustain their impacts.[44]

   The need for coordination of care in mental health, chemical dependency and homelessness was identified in the recent City of Tacoma MHCD Environmental Scan, based on a survey of agencies that provide services in the City of Tacoma.

During key stakeholder interviews conducted as part of this assessment, many of those interviewed identified several overall issues with coordination and integration of services. They were:

- 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,
- lack of coordinated efforts among service providers (medical, mental health, chemical dependency, schools, social service, etc.) to ensure efficiency and effectiveness throughout the system of service delivery for those with special needs or who are experiencing multiple issues, and
- inadequate discharge plans from treatment services (after care).

5. **Access to quality MHCD care and treatment:** Access to services and treatment means different things to different people; either there is no service at all, limited services, not enough specialized services/providers, long waiting periods, lack of knowledge about available services, or barriers such as location, costs, and insurance coverage issues. There is no one solution that would address all access issues for each person.

   The recent Tacoma MHCD Environmental Scan Report based on a survey of 54 Tacoma organizations highlighted the following access/availability issues:

   - Funding concerns limit access for adults with mental health and/or chemical dependency challenges.
   - Unaccompanied youth, chemically dependent and/or youth who suffer from co-occurring disorders have less access to services than adults or youth in families and those with single disorders.
   - After-hours services, including weekend services, need improvement.
   - Increased need for outreach and engagement with community stakeholders is needed to identify access to resources for non-service providers engaged with MHCD challenges.

   During key stakeholder interviews as part of this assessment, many of those interviewed had identified several overall issues with access to care and availability of service. They were:

   - Clients experienced barriers such as transportation issues, hours of operation of clinics, long waiting periods for in-patient care (especially for those on public assistance), and not having insurance or funds to pay for services.
   - Services were limited or not available at all (in Tacoma or surrounding area), such as residential services for mental health and detox services/centers.

   The key stakeholder interviews revealed an apparent discrepancy between perceived lack of availability of MHCD resources and an actual lack of availability. In some cases, people were unaware that the service was available when it actually was, though perhaps difficult to access.

VII. RESOURCES AND GAPS

Resources:

Based on the identified themes, a resource inventory was conducted by reviewing the MHCD Environmental Survey/Scan Report and conducting a local community scan. This consisted of reviewing the different community resource guides and using on-line resource search tools. This is not an extensive resource analysis but instead, a snapshot of what was found during the resource inventory.

In 2012, the City of Tacoma's Human Rights and Human Services department staff conducted a MHCD environmental survey/scan to determine the types of services in the community that address MHCD issues and the impacts that those clients were having on non-direct service providers. One hundred people were invited to take the survey; 77 people representing 54 agencies responded. Out of the 54 agencies, half provide direct services and the other half do not. Below is a summary of the survey findings, which provide a snapshot of the community's MHCD resources. The complete survey findings are included in Appendix F.

Table 10 Survey of 27 Agencies Providing Direct Mental Health Services within Tacoma*(2012)

Adult MH Services: 20 agencies (74%) provide the following adult MH services (# of agencies):				**Youth MH Services:** 10 agencies (37%) provide the following youth MH services (# of agencies):				**Infant/Toddler MH Services:** 7 agencies (26%) provide infant/ toddler MH services (# of agencies):			
In-pt	Out-pt	Resident	Crisis	In-pt	Out-pt	Resident	Crisis	In-pt	Out-pt	Resident	Crisis
3	18	6	9	3	13	2	8	1	5	1	4

*N=39 people representing 27 agencies

Table 11 Survey of 27 Agencies Providing Direct Chemical Dependency Services within Tacoma*(2012)

Adult CD Services: % of agency providing adult CD services:	**Youth CD Services:** % agencies providing Youth CD services	**Infant/Toddler CD Services:** 1 person/1 agency represented
48% (13 agencies)	11% (3 agencies)	4% (1 agency)

*N=39 people representing 27 agencies

Table 12 Survey of 27 Agencies Providing Housing within Tacoma* (2012)

Housing Provided					
General housing adults	Adults with MHCD needs	General families	Families with MHC needs	General youth	Youth (< 21 yrs) with MHCD needs
52% (14 agencies)	37% (10 agencies)	52% (14 agencies)	30% (8 agencies)	0% (0 agencies)	22% (6 agencies)

*N=39 people representing 27 agencies

Table 13 Agencies and Providers Involved with MHCD Care *This may not be an all inclusive list

Agencies and Providers Involved with MHCD Care in Tacoma or Serving the Tacoma Area*	
Help lines **MHCD Counseling centers** **Youth & Adult Outpatient Contractors** **Native American/Tribal Counseling** **Asian Counseling Center** **Tacoma Rescue Mission** **Hospitals/Medical Clinics** **Mental Health Ombuds of Pierce County** **Regional Network (OptumHealth)** **Religious Centers/Churches** **Tacoma Public Schools** **Youth Suicide Prevention Program** **Private Providers**	**Residential/In-Patient** 3-Adult Facilities 2-Youth Facilities **Government** Pierce County Prevention & Treatment TPCHD Opiate Substitution Treatment Program (Methadone Clinic) **Court/Criminal Justice** Pierce County Juvenile Court/Remann Hall Pierce County Corrections and Drug Court Tacoma Municipal Court

*This may not be an all inclusive list (individual organizations are listed on a resource list in Appendix B).

Gaps:

Gaps that were identified through key-informant/stakeholder interviews and the MHCD Environmental Scan include:

- A comprehensive integrated model
- A master coordinator/case management to provide coordination among services
- Youth MHCD in-patient and residential resources
- A youth center/youth service agency that provides multiple services for youth
- Housing/shelters and MHCD services for youth experiencing homelessness
- Intensive outpatient treatment for adults and youth with co-occurring disorders
- Detox center
- Self-care/self-advocacy resources
- Vocational/occupational training for those with MHCD issues

Further identification of service gaps were completed and reported within the following categories:

Chemical Dependency/Substance Abuse, Mental Health and Co-occurring

Gaps were identified at both the treatment delivery system level and for specific treatment issues. These gaps can impact the whole community and especially vulnerable populations. Organizations that are involved with or impacted by individuals who have mental health and chemical dependency needs are key to further identifying system gaps and solutions to these gaps. Outreach and engagement with community stakeholders is needed to identify access to resources for both MHCD treatment providers and non-service providers engaged with MHCD challenges.

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. One example of a gap in the continuum is the lack of adequate discharge planning (after-care) for individuals who are in in-patient or residential treatment services and for those adults and youth leaving incarceration/detention.

Access and availability issues can be seen as gaps across the MHCD services delivery system. Decreased or lack of funding can limit the availability and quality of services for youth and adults with mental health and/or chemical dependency challenges. Clients experience barriers such as transportation issues, hours of operation of clinics (including weekend service), long waiting periods for in-patient care (especially for those on public assistance), and lack of health insurance or adequate insurance coverage or funds to pay for services. There also is a lack of awareness for some in knowing what resources are available and how to access them.

Some services were limited or not available at all in Tacoma or the surrounding areas, such as in-patient treatment, residential services for mental health, and detox services/centers. There are mental health in-patient services available, although they are very limited for individuals experiencing co-occurring issues or for those youth who are under eighteen years. These individuals often cannot access in-patient services, may have long waits for available beds, or have to leave the area or state to obtain the in-patient care they need. There are limited or no chemical dependency professionals within some mental health service agencies or in some criminal justice agencies. Chemically dependent and/or youth who suffer from co-occurring disorders have less access to services than adults or youth in families with single disorders. There is also a lack of comprehensive family services when one or more family members are in treatment.

Suicide

There are crisis intervention and prevention services for both adults and youth that serve Washington state, Pierce County and Tacoma; these include crisis lines and hospital emergency department services. The organization Youth Suicide Prevention Program provides prevention education and referral to the national suicide hotline, but there is limited coverage within the Pierce County area. There is a current vacancy for a Suicide Prevention Coordinator for the Bethel School district which is the only public school system within Pierce County that has dedicated staff. The Tacoma School District provides suicide prevention education and has resources to address suicidal students. However, these resources may be varied in scope and there can be barriers to accessing these resources, such as stigma and counselor availability.

The military and Joint Base Lewis-McChord have been actively working on increasing mental health resources and suicide prevention efforts, while also trying to decrease the barriers to accessing services for soldiers, veterans and their family members.

Crisis services are available, but there is a gap in the number of those youth and adults who report feelings of suicide and do not access the services.

Criminal Justice System

Once an adult or juvenile has contact with the criminal justice system, they may encounter service gaps throughout the system. On initial arrest or contact there are no mental health or drug courts in the Tacoma Municipal Courts that would connect the offender to services. Once detained or incarcerated, there are no or limited intensive or on-going mental health services available to inmates. This is also true for chemical dependency treatment. Once in the criminal justice system, MHCD assessments are usually only done to advise the court about competency concerns or to provide safety plans/stabilization services. There are limited resources for court ordered evaluations for inmates and the wait list often causes longer incarcerations or psychiatric hospital stays while awaiting the evaluation.

There is a gap for general case management/follow-up for adults and youth transitioning out of incarceration or detention. Case management ensures follow-through and assistance with navigating the treatment service system for those in need of mental health and chemical dependency treatment services.

Military/Veteran

For identification of Military service gaps, a 2009 *Mental Health Advisory Team (MHAT) 6* assessment reported that the behavioral health system in Pierce and Thurston counties is in crisis. Currently, there are not enough providers of services, and existing providers are without the resources to appropriately coordinate services. As a result of the insufficient behavioral health care treatment and prevention system in the region, situations often escalate resulting in domestic violence. In particular, providers report that following the return of many soldiers from abroad, many of whom are suffering from Post Traumatic Stress Disorder (PTSD), domestic violence rates increase. Increases in domestic violence are also the result of the increasing behavioral health needs of military spouses and children.[43]

In August of 2012, there was a Presidential Executive Order directing key federal departments to expand suicide prevention strategies and take steps to meet the current and future demand for mental health and substance abuse treatment services for veterans, service members, and their families. Many of the proposed actions have been started and more are scheduled to begin through 2013.[45]

Youth

As identified in the general community gaps, there is no one agency that acts as an umbrella for youth services. Olympia's Community Youth Services (CYS) was mentioned as a model for such an agency. CYS provides a multitude of services to children, teens and young adults. This umbrella model allows for a more comprehensive and integrated approach to case management.

Specific MHCD services for youth were also identified as gaps, such as residential services for youth in a mental health crisis or with a severe mental health diagnosis. Services for youth with co-occurring issues that provide both mental health and chemical dependency treatment are limited. At the time of the key stakeholder interviews, several agencies mentioned that they are working on increasing their capacity to provide chemical dependency treatment for youth.

Youth who are experiencing homelessness or who are unaccompanied (youth who are not in the physical custody of a parent or guardian) face even more service gaps. There are no youth homeless shelters in Tacoma that could act as a centralized service to identify MHCD needs and provide referrals. The Tacoma School District does work with students who are experiencing homelessness to provide or locate services when available. Youth in the criminal justice system not only face the above mentioned gaps (lack of residential services and specialized treatment) but also face many other barriers to accessing what services are available. Without adequate case management and treatment discharge/release plans if in juvenile detention, research shows that they face increased recidivism and MHCD problems.

Low-income students and at risk populations, such as unaccompanied homeless youth and students of color, account for the majority of high school dropouts.[46] In 2011, Pierce County School Districts have identified approximately 400 unaccompanied youth that are struggling to stay in school in spite of their difficult circumstances, another 100 are estimated to be in school but not yet identified by Pierce County School Districts as homeless, thereby failing to receive special services that are federally mandated to remove barriers to education.[47]
Recently, Pierce County Community Connections (the Human Services Branch of Pierce County Government), the Pierce County Youth Coalition (mainly consisting of service providers and concerned citizens), and the Unaccompanied Youth and Young Adult Steering Committee (mainly consisting of funders, and government representatives) have made progress in developing a continuum of care for youth and young adults experiencing or at risk for homelessness. In May 2012, Pierce County as a community, invested nearly $685,000 in rental assistance and services to assist unaccompanied youth and young adults. This much-needed investment helps, but there is still a huge gap in services for this population.

VIII. IMPACTS AND COSTS

Mental Health and Chemical Dependency
A study commissioned by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington state at $5.21 billion in 2005, a 105% increase over that in 1996. This increase represents $832 for every non-institutionalized resident in the state, an inflation-adjusted per capita increase of 47% over 1996.[48] Substance abuse results in significantly higher state government spending on education, criminal justice, and health. In 2005, 15.4% of Washington state government spending, or $422 for every resident, was related to tobacco, alcohol, or other drug abuse or addiction. Less than $6 of this amount was spent on prevention and treatment.[49]

Findings showed that costs related to mortality, crime and morbidity represent the largest economic costs of drug and alcohol abuse. 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 home, and other professional costs – were almost four times what they were in 1996.[48]

Costs related to alcohol abuse in Washington state in 2005 were approximately 20 times greater than revenues received from state alcohol taxes. Impacts of substance abuse on

Washington state budget: a 2009 study conducted by the National Center on Addiction and Substance Abuse at Columbia University estimated 2005 state government spending related to substance abuse in Washington state at $3.2 billion. Less than 4% of the total was spent on prevention and treatment. Additionally, for every $100 dollars spent by Washington state government on substance abuse and addiction, the average spent on prevention, treatment, and research was $2.81.

Criminal Justice/Court Systems/Law Enforcement

The Criminal Justice Task Force of Pierce County notes that individuals who are both substance abusers and mentally ill, and who are without treatment, are subject to repeated arrests for minor offenses that reflect their desperate need. One area especially associated with mental illness and chemical dependency is homelessness. Pierce County jail booking data indicate that 30% of incarcerated persons with chronic minor offenses experience homelessness.

Once in jail, adults who are mentally ill stay in jail longer than individuals who do not have a mental illness. A study recently conducted by the King County Department of Adult and Juvenile Detention found that the average offender who remains in jail more than 72 hours has an average length of stay of 12 days for misdemeanor offenses and 24 days for felony offenses. If the offender has a mental illness, the average length of stay is 158 days. In addition, the daily cost of care while in jail is much higher for the mentally ill population, due to the additional staff needed to observe and keep safe individuals who are at greater risk for suicide, as well as the extra costs for psychiatric services and medications.

Table 14A Pierce County: City of Tacoma Total Costs of Incarceration

Description	2012 Costs
Daily	$3,759,805
Booking	$902,922
Court Escort	$489,636
Special Identification Process	$31,440
Total (approximate)	$5,093,263

Table 14B Pierce County: City of Tacoma Breakdown Costs of Incarceration

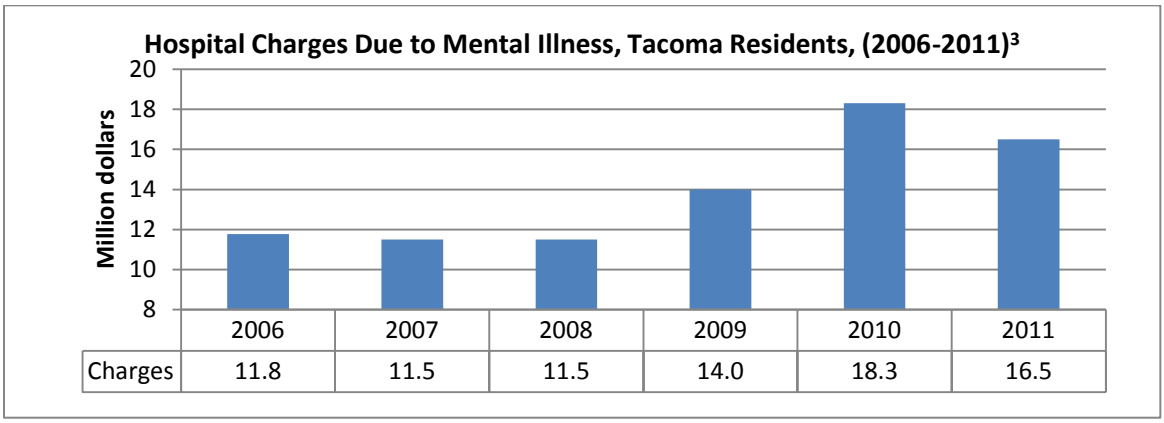
Description	2012 Rate	2013 Costs	2013 Final
Daily	$88	$96	$92
Booking	$216	$289	$225
Court	$84	$99	$90
Special Identification Process	$168	$168	$168
Mental Health Acute	n/a	(Chronic) $170 (Acute) $209	(Daily) $189.50 (Court) $99.50

Healthcare Systems

Hospitals represent a costly treatment setting for individuals who experience mental illness. Hospitalization is often indicated in acute episodes when patients are exhibiting delusional behavior, violent behavior, hallucination, or an indication of potential or actual self harm. Hospital discharge data for patients admitted for mental illness [includes the International

Classification of Diseases, 9th revision (ICD9), codes 290 to 299 mental disorders and 300 to 316 psychoses], indicate that charges due to mental illness remained relatively stable for Tacoma residents from 2006 until 2008 (Figure 2).

In 2009 the charges increased by 22% from $11.5 million to $14 million, and in the next year the charges increased by another 31%. However, in 2011 mental illness charges for Tacoma residents decreased noticeably by 10%. This fluctuation in total charges corresponds with the total admissions for mental illness. In 2010 the total admissions for mental illness was 894; the highest for the period between 2006 and 2011. In 2011 there were 784 admissions for mental illness. If averaged, by the number of admissions, charges for mental illness hospitalizations exceeded $21,000 per admission in 2011.



	2006	2007	2008	2009	2010	2011
Charges	11.8	11.5	11.5	14.0	18.3	16.5

Figure 2

One healthcare system in Tacoma reports that for the period between August 2011 and July 2012, 61.2% of patients admitted for mental illness conditions also had a chemical dependency diagnosis. Alcohol was the leading factor for both mental illness and chemical dependency admissions. Patients admitted for substance abuse were more likely to be uninsured (43.4%) than those with a mental illness diagnosis (18.9%). Medicare was the most common payer for mental illness hospital admissions (34.8%). Medicaid was the most frequent payer for chemical dependency hospitalizations (28.3%). Males were admitted more than females and the average age for both mental illness and chemical dependency patients was in the mid 40's. Public and uncompensated costs for care of those with mental illness and chemical dependency, stress economic resources at both the state and local levels.

Medicaid is also a large payer for mental illness and substance abuse treatment. Cost data for DSHS services to medically eligible Title XIX (Medicaid) Tacoma residents is reported in the table below. The DSHS DASA funds programs and payments for alcohol and substance abuse treatment services, including residential and recovery houses. The highest cost per patient by age group for co-occurring treatment was for 14 to 17 year olds at an average cost of $22,193, for the State Fiscal Year 2009. This compares to an average cost for 45 to 64 year olds of $7,486. For mental health treatment alone, 14 to 17 year olds also had the highest average cost at $21,205. These higher costs may reflect different treatment modalities for youth. Interestingly, this age group had the least expensive treatment costs for substance abuse at $1,484 compared to $2,756 for the age group 45 to 64 years. Preventing hospitalizations for

mental illness or substance abuse through effective treatment programs will yield great savings to the public.

Table 15 Medicaid-Paid Mental Health and Chemical Dependency Treatment

All Ages, Tacoma Residents, SFY 2009 (July 2008 through June 2009)		
Program	**Unduplicated Total**	**Average Cost/Client**
Mental Health	1,638	$5,631
DASA	1,605	$2,388
DASA + Mental Health	200	$8,902

Source: Washington State Department of Social and Health Services, Research and Data Analysis, Client Services Database analytical extract of 5/30/2012.

Individuals with mental illness and chemical dependency are frequent users of expensive hospital emergency department (ED) services. A July 2004 study conducted by the Washington state DSHS found that 94% of clients who visited ED's 21 times or more in King County, in fiscal year 2002, had a diagnosis of either mental illness, chemical dependency or both. The cost for ED services alone for these 125 individuals was more than $3.2 million in FY2002.

Emergency Department visits may indicate cracks or deficiencies in community-based treatment services for the mentally ill or those with substance abuse issues. Data from the same healthcare system above (and for the same time period) shows that there were 1,485 ED visits by Tacoma residents for mental illness and 507 visits for chemical dependency. As reported for Emergency Medical Services, recurrent visits are common among this population. Almost 21% of patients with chemical dependency related visits had a repeat visit within 30 days, while patients with a mental illness condition had a return rate of 18.6%.

Uninsured emergency department care rates for individuals with mental illness are significantly lower (20%) than those with chemical dependency needs (37%). However, Medicaid pay rates for both mental illness (37%) and chemical dependency (35%) varied only slightly. With insurance coverage often tied to employment, for many individuals the mental stress associated with the loss of a job may go untreated until a crisis point brings them to the ED. The most common leading diagnosis for mental illness visits was depression. Alcohol abuse was the most common diagnosis for substance abuse/chemical dependency related ED visits.

Emergency Medical Services

Individuals with chronic mental health and chemical dependency needs also impact the Emergency Medical System (EMS) in Tacoma. The Tacoma Fire Department reports that in 2011 1,161 individuals who called 911 three or more times were responsible for 5,160 calls for either mental health- or substance abuse-related aid requests. Many individuals had multiple calls for aid over the year. For mental health issues alone, 41 individuals had 163 calls for aid and 51 had called 250 times for substance abuse issues. Eventual transport of these individuals to hospital ED's can divert resources away from other medical emergencies in Tacoma.

Business and Commerce

Untreated mental illness or chemical dependency and their related problems have clear and negative impacts on businesses and urban residential living. Insufficient support of those with

mental health illnesses and chemical dependency can result in increased poverty, homelessness, and crime, as well as an increase in public safety and health services costs. While no local data on impact was found, several national studies demonstrate the cost to workplace productivity due to mental illness and substance abuse.

The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism estimate that 10% of the American work force has a chemical dependency problem. A study by the U.S. Chamber of Commerce concluded that workers struggling with chemical dependency issues function at about two-thirds of normal productivity.[50] Nearly 75% of all adult illicit drug users are employed, as are most binge and heavy alcohol users. Studies show that when compared with non-substance abusers, substance-abusing employees are more likely to change jobs frequently, be late to, or absent from work, be less productive, be involved in a workplace accident and/or file a workers' compensation claim.

Nationwide, the economic impact of illicit drug use was estimated to be $193 billion in 2007. The majority, $120.3 billion was attributed to lost productivity. Comparatively, smoking accounts for about $157 billion in health-related costs annually.[51]

The equivalent estimate for mental illness is estimated to be larger still at about $317 billion.[52] When both direct and indirect costs were considered, the most costly health condition among workers was depression.[53] Anxiety was ranked fifth.[54] Workers with depression reported the equivalent of 27 lost work days per year; nine of them because of sick days or other time taken out of work, and another 18 reflecting lost productivity while at work.[54] Providing treatment to those workers impacted by mental illness and chemical dependency will have an economic benefit to employers and communities.

Youth

For the 500 unaccompanied youth that are at risk to drop out or have dropped-out of school in 2011, Pierce County School Districts would lose an estimated $4.8 million a year in revenue with Tacoma, Puyallup, and Clover Park School Districts most affected (Washington State Office of Superintendent of Public Instruction, 2012).[55] Moreover, the dearth of outreach, shelters, services, and housing for unaccompanied youth in Pierce County forces youth to rely on public support systems, including medical and corrections facilities. For example, it costs Washington state $54,000 to maintain one youth in the criminal justice system whereas it will cost the state approximately $6,000 to $10,000 (depending on level of need) to permanently move a young person off the streets.[56]

IX. BEST PRACTICES and EVIDENCE-BASED PRACTICES

A best practice is a method or technique that has consistently shown results superior to those achieved with other means. Results and outcomes from best practices are often used as benchmarks for other similar programs to strive for. The criteria to be considered a *best practice* is that the method must be research-based, standardized, have effective outcomes and able to be replicated.

Evidence-based practices (EBPs) are interventions for which there is scientific evidence consistently showing that they improve client outcomes; in other words, they are those interventions that meet a threshold of evidence for efficacy and effectiveness. In the field of mental health, EBP refers to interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial, and effective for most people diagnosed with mental illness. Critical to EBP implementation is fidelity to all components of the intervention or program.

Included in this review are EPBs, best practices and interventions or programs that have not been extensively researched but have reported promising results. Programs that were solely prevention-based programs were not reviewed. The following were strategies used in the search for EBPs, best practices and innovative or promising interventions or programs that have shown effectiveness in addressing mental health and/or chemical dependency issues:

- A literature review of those studies published within the last two years, using Pubmed,
- Use of websites offering interactive searches for top rated best practices (e.g., SAMHSA, NREPP, SDRG, and CSPV/Blueprints), and
- Review of existing and potential methods and/or programs used locally and regionally by Washington state and Pierce and other counties; and those methods/programs already instituted in Tacoma were reviewed.

Due to the nature and complexity of MHCD issues, a number of the programs and methods may address several of the same themes identified in this assessment.

Key search words and criteria included: age groups (adolescent, young adult and adult), mental health and substance abuse treatment, co-occurring disorders, settings (e.g., outpatient), alcohol, drugs, crime, homelessness, mental health, suicide, treatment/recovery, race and ethnicity, urban location, studies with an experimental design, studies with program replication and comparative effectiveness studies. The results of the search are listed below and in detail in Appendix C:

<u>Criminal Justice</u>

- *Peer Bridger Program; Peer Health CareCoaching*
- *Multisystemic Therapy (MST)* for Juvenile Offenders
- FAST (*Family Access To Stabilization and Teaming*) by Catholic Community Services

<u>Co-occurring</u>

- *Integrated Dual Disorder Treatment (IDDT)* model is an EBP
- *Intensive Case Management (ICM)* pilot program targets individuals with histories of high utilization of crisis services and a chemical dependency diagnosis
- *Modified Therapeutic Community (MTC)* for Persons with co-occurring disorders
- *Computer-Assisted System for Patient Assessment and Referral (CASPAR)*

<u>Disparities</u>

- *Trauma Affect Regulation: Guide for Education and Therapy (TARGET)*
- *Strong African American Families-Teen (SAAF-T)*

- *Racial and 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 (CARE)*
- *Program for Assertive Community Treatment (PACT)* - Clark County
- *OQ-Analyst (OQ-A)* is a computer-based feedback and progress tracking system

Individuals Experiencing Homelessness

- *Encampment Elimination Project (Encampment Project)* in Tacoma
- *Critical Time Intervention (CTI)* is designed to prevent recurrent homelessness
- *Permanent Options for Recovery-Centered Housing (PORCH)* is an EBP

Access

- *WA State Screening, Brief Intervention, Referral and Treatment (WASBIRT)* project
- *Access to Recovery (ATR)* program
- *Brief Strengths-Based Case Management (SBCM)*
- Texas Christian University's *Mapping-Enhanced Counseling*

Re-occurring Themes (Youth, Youth Plus Co-occurring)

- *Multidimensional Family Therapy (MDFT)*

Innovative Programs

King County has created a Crisis Solutions Center (CSC) to provide immediate mental health and drug abuse services to individuals in a crisis situation. The 16 bed facility, opened in August of 2012 is combined with a longer term respite facility (30 day) and a mobile crisis team in a Seattle neighborhood. The goal is to divert those who would otherwise be taken to jail or local hospital emergency departments, both are costly locations that are not intended nor equipped to deal with the chronically mentally ill or those abusing substances. At the CSC they can stay for up to three days to stabilize and be connected with treatment services or admitted for a longer term. Individuals will also be linked to long-term assistance and housing resources. Law enforcement can also refer individuals who have committed minor offenses to the CSC as an alternative to criminal justice system involvement, as long as the individual works toward treatment. The CSC is described as a central strategy in King County's treatment sales tax funded effort to meet the needs of those experiencing untreated mental illness and substance abuse. King County officials project that the public costs from jails and hospital emergency department and in-patient psychiatric care will be reduced as well. A one year delay in the opening of the facility, due to legal disputes over location, was estimated to have cost King County taxpayers a total of $7.2 million in continued use of expensive systems such as jails and hospitals.

Thurston County has established an Offender Re-Entry program which brings together a multidisciplinary team to provide assessment, treatment, and transition services to mentally ill or substance dependent offenders. The team approach provides for collaboration across disciplines and jurisdictional boundaries to address co-occurring needs of offenders. In

conjunction with the team approach, the GAINS Re-Entry Checklist, a best practice tool, is used to facilitate transition planning including health care, housing as well as treatment referral.

Snohomish County has addressed the community issue of the chronically mentally ill and substance dependent with the inclusion of training. Law enforcement officers and treatment professionals have received crisis intervention or de-escalation training. Along with the training, participants also received information on mental illness and community resources.

The mental health and addiction services Navigator program, developed by a community based steering committee, has been successful in increasing access to comprehensive assessments and referral facilitation.[57] Navigator programs have been developed in a variety of clinical and community settings. The Navigator model matches a newly diagnosed individual or family with a trained professional or volunteer who is familiar with a system of care or services. The objective is to eliminate barriers to timely treatment or services. In some programs the Navigators have experienced the same condition or situation as the individual or family being referred. Navigators are usually not care coordinators but can assist with coordination and provide support and encouragement to those working their way through unfamiliar systems. Such a program was implemented in Sooke, B.C., Canada in 2005 after primary care physicians were overwhelmed by patients' mental health needs. Additionally, it was found that often those medical care providers without specialized mental health training were asked to help locate appropriate services.

X. RETURN ON INVESTMENTS (ROI)

The Washington State Institute for Public Policy was directed by the Washington State Legislature to calculate the ROI from EBPs that include mental health and substance abuse. The purpose of the research was to help policy makers identify strategies that produce the best outcomes per dollar of taxpayer spending. A benefit-cost analysis was performed using a three-step approach: 1) assessment of evidence on improvement of outcomes, 2) calculations of costs and benefits to Washington state and ranking of public policy options, and 3) a measurement of the risks by analyzing varying estimates and assumptions.

For example, drug courts use frequent courtroom activity and drug treatment resources in an attempt to modify the criminal behavior of certain drug-involved defendants. The question of: "Do drug courts – when compared with regular criminal courts – reduce recidivism and produce more benefits than costs?" was addressed. Previous drug court evaluations undertaken in the United States revealed that, on average, drug courts have been shown to reduce recidivism rates by 13.3%. An analysis of six adult drug courts in Washington state (1998 and 1999) was performed to test whether Washington's drug courts reduce recidivism rates. Five courts reduced recidivism by 13%, almost identical to the national average. These five adult drug courts (including one in Pierce County) generated $1.74 in benefits for each dollar of costs. A more recent analysis (2012) showed the return for drug courts was $4.42 for youths and $3.69 for adults in 2010 dollars.

The table below (Table 16) shows examples of programs or treatments addressing mental health and substance abuse and their ROI expressed in 2011 dollars:

Table 16

Program	Return on Investment for every dollar spent
Adult Criminal Justice	
Offender Re-entry Community Safety Programs (dangerously mentally ill offenders)	$2.19
Mental Health Courts	$6.96
Drug Treatment in the Community	$11.05
Juvenile Justice	
Multisystem Therapy (MST)	$2.51
Substance Abuse	
Motivational Interviewing/Motivational Enhancement Therapy for Alcohol Abuse	$44.38
Life Skills Training	$37.52
Project Towards No Drug Abuse (TND)	$8.61
Adult Mental Health	
Cognitive Behavioral therapy (CBT for Adult Anxiety)	$52.01
Cognitive Behavioral therapy (CBT for Adult Depression)	$68.90
Children's Mental Health	
Cognitive Behavioral Therapy for Depressed Adolescents	$7.11
Brief Strategic Family Therapy	$6.08

Additionally, a review of the literature found a study of the ROI for the *Frequent User Service Enhancement (FUSE) Program*. In 2007, Hennepin County, Minnesota conducted a study which found that 266 individuals used approximately 70,000 nights of stay in shelters, jails, and detox over five years, costing $4.2 million. As a result, local nonprofit agency, St. Stephen's Human Services, created the Frequent User Service Enhancement program, which has housed 41 of these individuals to date, and saved the county an average of $13,000 per year per person housed. The six participants used $95,000 in services in the year prior to housing. In the year post-housing, they used $16,000 in services, for a savings of $13,000 per person.[58]

FAST (Family Access To Stabilization and Teaming) intervention costs, on average, $4,600 per month for a period of two to three months. Psychiatric hospitalization costs range from $18,400 to $30,000 per month. Because FAST diverts children from out-of-home placement or significantly reduces the time required in group or therapeutic out-of-home care, FAST's assessment is that savings also are realized in Title IV-E dollars (although the precise savings are difficult to document).

Housing First: A Solution to End Chronic Homelessness is an innovative approach to ending chronic homelessness where people are provided rapid access to low-cost apartments, with vital medical, mental health and other support services available on site. It is a more cost-effective method than paying for these same individuals to cycle in and out of the emergency room, the sobering center or jail.

A recent study followed the progress of the Downtown Emergency Services Center (DESC) in Seattle, WA. Seattle has put 280 Housing First units into operation with another 289 expected to be online by 2011. All the residents at the Housing First-styled residents had severe alcohol problems and varying mental health conditions. When taking into account all costs, including housing costs, the participants in the program cost $2,449 less per year per month than those who were in conventional city shelters.[59]

XI. 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.

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 identified are: a) individuals experiencing homelessness, b) active duty military and veterans, c) youth, and d) African Americans.

There appeared to be a discrepancy between perceived lack of availability of MHCD resources versus an actual lack of availability. In some cases, people were unaware the service was available when it actually was, though it might be difficult to access. Outreach and engagement with community stakeholders is needed to identify access to resources for both MHCD treatment providers and non-service providers engaged with MHCD challenges. There is no one solution that would address all access issues for each person.

As is, the MHCD treatment and social service delivery system in the City of Tacoma is fragmented and does not currently provide a holistic or continuum of care approach for those residents who are unable to afford private payment care and who are in need of multiple types of services, such as those with co-occurring disorders (both mental health and chemical dependency). Organizations that are involved with or impacted by individuals who have mental health and chemical dependency needs are key to further identifying system gaps and solutions to these gaps.

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

XII. ACKNOWLEDGEMENTS

We would like to acknowledge individuals from the following agencies for their assistance in providing data and information for this assessment. While not all data and information provided was incorporated into this report, they helped to inform and guide our work.

City of Tacoma Human Rights and Human Services

City of Tacoma Municipal Courts

Comprehensive Life Resources

Department of Social and Health Services, Research and Data Analysis

Franciscan Health Systems

OptumHealth

Pierce County Community Connections

Pierce County Corrections

Pierce County Courts

Puget Sound Educational Services District

Tacoma Fire Department

Tacoma School District

Tacoma-Pierce County Health Department, Treatment Services

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XIV. APPENDICES

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 • City of Tacoma Human Rights and Human Services department • Regional Network (OptumHealth) • Discharge planning • School liaisons (for juveniles) • Community Life Resources	**Gaps in 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	**Impact/costs of** • 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)	**Best practices/ approaches** • 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	**Estimated ROI** • 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.

Appendix B: 2012 MHCD Resource Inventory for Tacoma Residents

This list was compiled to help identify community mental health and chemical dependency resources as part of a community assessment; it is not intended as an endorsement for any agency listed. The resources listed have not been independently verified for current status.

MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT RESOURCES:

Washington Recovery Help Line: 1-866-789-1511
24-hour help for substance abuse, mental health and problem gambling

Washington State 24-Hour Crisis Line for Pierce County: 1-800-576-7764

National Suicide Prevention Lifeline: 1-800-273-8255 TTY Users 1-800-799-4TTY (4889)

Tacoma Rescue Mission for Online Recovery Resources: http://www.rescue-mission.org/

Catholic Community Services (Intensive in-home services for children & their families):
5410 North 44th Street. Tacoma, WA 98407, (253) 759-9544

Comprehensive Mental Health Center
Adults/Older Adults: 514 South 13th Street, Tacoma, WA 98402, (253) 396-5000
Children/Families: 1201 South Proctor, Tacoma, WA 98405, (253) 396-5800

Recovery Innovations Recovery Response Center, Office: (253) 439-5901; Fax: (253) 439-5902

SeaMar Community Health Center - Tacoma
Behavioral Health Center, 1516 S 11th Street, Tacoma, WA 98405, Phone: (253) 396-1634

Mental Health Ombuds of Pierce County assists mental health consumers, families, and recognized advocates with concerns, complaints, or grievances.
6315 South 19th Street, Tacoma, WA 98466
Work Phone: 253-302-5311. Toll Free: 1-800-531-0508, Email: carolyn@TACID.org

OptumHealth-Pierce County RSN: 3315 South 23rd Street Suite 310, Tacoma, WA 98405, Toll Free: 1-866-673-6256

Pierce County Alcohol and Drug Coordinator
Pierce County Community Connections, Chemical Dependency Program
1305 Tacoma Ave Ste 104, Tacoma WA 98402, 253-798-6101 FAX: 253-798-2818, TTY: 253-798-4217

Pierce County Recovery Support Specialist Pierce County Community Connections
1305 Tacoma Avenue S, Ste 104, Tacoma, Washington 98402 (253) 798-4418, FAX: (253) 798-2818

Opiate Substitution Treatment Programs (methadone clinic)
Tacoma-Pierce County Health Department; County Treatment Service
3629 South "D" Street (MS: CHD-049) Tacoma, WA 98418-6813, (253) 798-6576; Fax 798-2972

ALCOHOL/DRUG PROGRAMS (Updated 2/17/2012)

A Avenue of Recovery, 11006 Pacific Ave S Ste. 3 Tacoma WA 98444 (253) 548-0779

A Change Counseling Service, 4002 South M St Ste. C Tacoma WA 98418 (253) 473-1844
ACE Counseling Service, 2302 S Union Ave Ste C29 Tacoma WA 98405 (253) 879-1200
All for You Counseling, 5401 S Puget Sound Ave Tacoma WA 98409 (253) 474-0633
Al'Ta Counseling, 702 Broadway Ste 102 Tacoma WA 98402 (253) 365-2000
Asian Counseling Treatment Service (ACTS), 8739 S Hosmer St Tacoma WA 98444 (253) 302-3826
Building The Bridges Organization, 7209 South Puget Sound Ave Tacoma WA 98409 (253) 314-9242
Casteele, Williams & Assoc., 8833 Pacific Ave Ste. D Tacoma WA 98444 (253) 536-2881 (Bilingual)
Chi You Center, 4301 S Pine St Ste 30-07 Tacoma WA 98409 (253) 306-9265
Community Counseling Institute, Inc., 2502 Tacoma Ave S Tacoma WA 98402 (253) 759-0852
Consejo Counseling, 5915 Orchard St W Unit B Tacoma WA 98466 (253) 383-1528
Griffin and Griffin E.A.P., Inc, 4218 S Steele St Ste. 304 Tacoma WA 98402 (253) 473-7504
In Touch Counseling & Assessment, 1944 Pacific Avenue Ste. 205 Tacoma WA 98402 (253) 473-6299
Lakeside-Milam Recovery Center – Tacoma, 3315 S 23rd St Tacoma WA 98405 (253) 272-2242
Moms and Women's Recovery Center – Parkland, 12108 Pacific Tacoma WA 98447 (253) 798-6655
Moms and Women's Recovery Center – Tacoma, 3408 S Union Tacoma WA 98409 (253) 798-6655
Pierce County Alliance, 510 Tacoma Ave S Tacoma WA 98402 (253) 572-4750
Pioneer Adult Counseling Tacoma, 758 St Helens Ave Tacoma WA 98402 (253) 274-0484
Prosperity Wellness Center, 5001 112th St E Tacoma WA 98446 (253) 531-2103
Puyallup Tribal Treatment, 2209 E 32nd St Bldg 4, Tacoma WA 98404-0188 (253) 593-0247
Sea Mar – Tacoma, 1516 S 11th St Tacoma WA 98405 (253) 396-1634 (Bilingual)
Sea Mar – Tacoma, 1415 Center St Tacoma WA 98409 (253) 627-2250 (Bilingual)
Social Treatment Opportunity Programs, 4301 S Pine Ste. 112 Tacoma WA 98409 (253) 471-0890
Tacoma Detoxification Center, 721 S Fawcett Ave Rm. 100 Tacoma WA 98402 (253) 593-2413
Tacoma /Pierce County Treatment Services - Unit 1 & Unit 2,
3629 South D St MS491 Tacoma WA 98418-6813 (253) 798-6576
The Center – Tacoma, 721 S Fawcett Ave Ste. 203 Tacoma WA 98402 (253) 593-2740
Western Washington Alcohol Inc., 504 S 112th St Tacoma WA 98444 (253) 536-5549

YOUTH OUTPATIENT CONTRACTORS (Revised March 2012)

Community Counseling Institute, Inc 2502 Tacoma Ave, Tacoma, WA 98405, (253) 759-0852
Consejo Counseling & Referral Service 3513 Portland Avenue, Tacoma, WA 98404, (253) 385-1528

Foundation for Multicultural Solutions, Inc 423 Martin Luther King Jr. Way , Tacoma, WA 98405,(253) 572-3214

Pierce County Juvenile Court/Remann Hall 5506 6th Avenue, Tacoma, WA 98406, (253) 798-7900

Puyallup Tribal Treatment Center 2209 East 32nd Street, Tacoma, WA 98404, (253) 593-0291 *Serves Native Americans only*

Puyallup Tribal Treatment Center–Chief Leschi School 5625 – 52nd Street East Puyallup, WA 98371, (253) 445-8000 *Serves Native Americans only*

The Center (Metropolitan Development Council) 721 So Fawcett Avenue #203, Tacoma, WA 98402, (253) 593-2740

MINORITY COMMUNITY MENTAL HEALTH AGENCIES

Asian Counseling Services 301 South Pine Street, Suite 405, Tacoma, WA 98409, (253) 471-0141

Puyallup Tribal Treatment Center–Chief Leschi School 5625 – 52nd Street East Puyallup, WA 98371, (253) 445-8000 *Serves Native Americans only*

Puyallup Tribal Treatment Center 2209 East 32nd Street, Tacoma, WA 98404, (253) 593-0291 *Serves Native Americans only*

Foundation for Multicultural Solutions Inc. (El Camino) 2316 S State St Ste. B Tacoma, WA 98405 (253) 572-3214

Sea Mar – Tacoma 1516 S 11th St Tacoma, WA 98405 (253) 396-1634 (Bilingual)

RESIDENTIAL TREATMENT AGENCIES THAT ACCEPT PUBLICLY FUNDED CHEMICAL DEPENDENCY TREATMENT PATIENTS (Updated December 2009)

Fresh Start (Youth) Perinatal Adolescent Center and Perinatal Treatment Services

Prosperity Counseling & Treatment Services (Adult)
Prosperity Wellness Center (Adult)

SeaMar - Tacoma (Ault and Youth)

HARM REDUCTION

Tacoma Needle Exchange Program Point Defiance AIDS Project Needle Exchange (253) 272-4857

SUPPORT GROUPS

Pierce County Alcoholics Anonymous 3640 South Cedar; Suite "S" Tacoma, WA 98409
24 Hour Telephone Answering (253) 474-8897

MILITARY/VETERAN

JBLM/Fort Lewis Army Substance Program, HQ 1 Corps. Attn. AFZH-PAD (ASAP) (253) 967-6183

Madigan Army Medical Center Substance Abuse Program, Bldg 2008 B 3rd Ave N Tacoma, WA 98431-5000 (253) 967-2202

Military Crisis Line - 1-800-273-TALK (8255)

Military One Source - for help with short-term issues 1-800-342-9647

VA Medical Center/American Lake, Tacoma, WA 98493-5000 (253) 582-8440 ext. 71603

HEALTHCARE SYSTEMS/HOSPITALS

Western State Hospital located in Lakewood, WA

Appendix C: Best Practice Resource List

Criminal Justice System

Peer Bridger Program; Peer Health CareCoaching; New York NYS Association of Psychiatric Rehabilitation Services. This program focuses on collaborations with local community mental health agencies and psychiatric centers and corrections facilities to help ease the transition into community life for individuals being discharged or released from the facilities and offers an array of both intensive individual and group peer support services.
www.nyaprs.org

Multisystemic Therapy (MST) for Juvenile Offenders addresses the multidimensional nature of behavior problems in troubled youth. The primary goals of MST programs are to decrease rates of antisocial behavior and other clinical problems, improve functioning (e.g., family relations, school performance), and to achieve these outcomes at a cost savings by reducing the use of out-of-home placements such as incarceration, residential treatment, and hospitalization.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=254
http://www.mstservices.com/

FAST (Family Access To Stabilization and Teaming) by Catholic Community Services provides intensive support services to families when their children are at risk of being hospitalized due to mental health emergencies or placed in foster care because of a family crisis. This is not a best practice but may be considered an innovative approach.
http://www.nacac.org/adoptalk/innovationspaper.pdf
http://www.ccsww.org/site/PageServer?pagename=families_familypreservation_services

Co-occurring

Integrated Dual Disorder Treatment (IDDT) model is an EBP that promotes positive rehabilitation and recovery outcomes for persons with mental illness and substance use problems. IDDT is a specific set of counseling techniques for persons with mental illness and substance use provided by counselors, clinicians or multidisciplinary teams.
Source: "Bridging the gap in substance abuse treatment: A qualitative study in the dissemination of Evidence Based Practices I Drug and Alcohol Treatment.[60]

Intensive Case Management (ICM) pilot program targeted individuals with histories of a high utilization of crisis services and a chemical dependency diagnosis. The DSHS DASA implemented the program. A preliminary report examined the impact of the ICM pilot program in Thurston and Mason counties, where it is offered as a community-based, stand-alone service. The promising findings showed that participants were linked to needed services and engaged in alcohol or drug treatment. They also show promising declines in Medicaid costs.[61]

Modified Therapeutic Community (MTC) for Persons with Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use disorders and mental disorders. A comprehensive treatment model, MTC adapts the traditional therapeutic community (TC) in response to the psychiatric symptoms, cognitive impairments, and reduced level of functioning of the client with co-occurring disorders. Adaptations to the intervention have been made for a prison population, primarily to incorporate a programmatic emphasis on criminal thinking.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=144

http://www.ndri.org/ctrs/cirp.html

Computer-Assisted System for Patient Assessment and Referral (CASPAR) is a comprehensive assessment and services planning process used by substance abuse clinicians to conduct an initial assessment, generate a treatment plan, and link clients admitted to a substance abuse treatment program to appropriate health and social services available either on site within the program or off site in the community. Includes an electronic resource guide containing information on agencies sorted by agency name, services provided, and 131 keywords.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=160
http://www.tresearch.org

Disparities

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is a communication and decision-making technique designed to support delivery of substance abuse treatment services by improving client and counselor interactions through graphic visualization tools that focus on critical issues and recovery strategies. This technique has been evaluated across diverse outpatient and residential treatment settings, using both individual and group counseling. Its applications address common treatment issues as well as how to facilitate organizational changes within treatment systems. The intervention has been adapted for use with prison populations.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=161
http://www.ibr.tcu.edu

Strong African American Families-Teen (SAAF-T) is a family-centered preventive intervention was shown in one study to deter conduct problems, substance use, substance use problems, and depressive symptoms among rural black adolescents across 22 months.[62]

Racial and ethnic differences in substance abuse treatment initiation and engagement. A study examined variations by race and ethnicity in initiation and engagement, two performance measures of treatment for substance use disorders that focus on the timely receipt of services during the early stage of substance abuse treatment. This study also offers an approach that state agencies may implement for monitoring treatment quality and examining racial and ethnic disparities in substance abuse treatment services.[63]

Cultural Adaptation of Cognitive Behavioral Therapy (CBT) is a short-term intervention for adolescents aged 13 to 17 years who have severe symptoms of depression. The intervention focuses on improving an adolescent's cognitions, behaviors, and relationships, with the goals of shortening the time that the adolescent feels depressed, reducing his or her depressive feelings, increasing the adolescent's sense of control over his or her life, and teaching the adolescent how to prevent the onset of depression. The intervention was adapted from a cognitive behavioral model, considering cultural, developmental, and socioeconomic factors and was tested on Puerto Rican youth.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=219
Addressing silos/collaborations and integrations

Psychiatric Rehabilitation Process Model is a process guiding the interaction between a practitioner and an individual with severe mental illness. Manual driven, the model is a client-centered, strengths-based intervention designed to build clients' positive social relationships, encourage self-determination of goals, connect clients to needed human service supports, and provide direct skills

training to maximize independence. The model, previously called the Choose-Get-Keep Model as well as Choices, can be implemented in a variety of mental health settings (e.g., hospitals, psychosocial rehabilitation centers, clubhouses and drop-in centers, residential programs, vocational programs, intensive day programs) and by practitioners in most mental health disciplines.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=241

Cognitive Assessment and Risk Evaluation (CARE) identifies and assesses adolescents and young adults who are experiencing changes in their thoughts, behaviors or emotions that might be associated with developing serious and/or disabling mental problems. The program reflects not only the extensive educational outreach but also the emphasis on enhancing relationships with community partners.[64]

In Washington state, *Program for Assertive Community Treatment (PACT)* has been evaluated in Clark County. The program provides comprehensive, collaborative, and structured mental health services to clients who are high utilizers of mental health services, from those in their early teens to their elderly years. PACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. PACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, within the comfort of their own home and community.[65]
OQ-Analyst (OQ-A) is a computer-based feedback and progress tracking system designed to help increase psychotherapy treatment effectiveness. By assessing the attainment of expected progress during therapy, the tracking system provides feedback to therapists on whether patients are staying on track toward positive treatment outcomes. In addition, the OQ-A can provide decision support to the therapist to maximize the likelihood of a positive outcome for the client.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=22
http://www.oqmeasures.com

Homeless

Encampment Elimination Project (Encampment Project) in Tacoma coupled the removal of homeless individuals from multiple encampments in the city with the placement of some of these individuals into apartments following the Housing First approach. Housing First centers on providing homeless persons with housing quickly and then providing services as needed. The strength of this program is an immediate and primary focus on helping encampment residents quickly access and sustain permanent housing.

Critical Time Intervention (CTI) is designed to prevent recurrent homelessness and other adverse outcomes among persons with severe mental illness. It aims to enhance continuity of care during the transition from institutional to community living. CTI is intended to be used with individuals leaving institutions such as shelters, hospitals, and jails.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=125
http://www.criticaltime.org

Permanent Options for Recovery-Centered Housing (PORCH) is an evidence-based permanent supportive housing program in Pierce and Chelan/Douglas Counties. The goal is to increase housing stability and encourage independent living among adults with a history of serious mental illness and housing instability or homelessness.[66]

Access

WA State Screening, Brief Intervention, Referral and Treatment (WASBIRT) project (April 12, 2004 through January 31, 2009). Tacoma and Allenmore Hospitals are two of the nine hospitals in WA State that participated in the interventions based on initial screening of primarily emergency department patients for alcohol and drug use and for the level of risk for substance abuse disorders. Patients are then referred for more traditional forms of chemical dependency treatment depending on the severity of the risk. Results showed that those receiving the brief interventions altered their substance use patterns significantly; binge drinking declined, number of days of drinking and other drug use declined, while abstinence from alcohol and other drug use increased.[67]
http://www1.dshs.wa.gov/RDA or http://www1.dshs.was.gov/dasa

Access to Recovery (ATR) program was initiated in 2004 to improve access to substance abuse treatment and recovery services. Pierce County was one of six counties in Washington state that participated. Chemical Dependency treatment clients who received ATR services had lower ($66) average monthly medical costs compare to treatment clients who did not receive ATR services. Other outcomes that showed a decrease include hospital emergency department per member per costs, admission to the hospital during the follow-up year and hospital inpatient costs per member per month.[68]

Brief Strengths-Based Case Management (SBCM) for substance abuse is a one-on-one social service intervention for adults with substance use disorders that is designed to reduce the barriers and time to treatment entry and improve overall client functioning. The case manager strives to develop a strong working alliance with the client, which is considered central to the process of linking with, and using, substance abuse treatment services effectively. The case manager also works to resolve any client-identified barriers to treatment, such as lack of transportation, child care, and social support.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=58

Texas Christian University's *Mapping-Enhanced Counseling* is the cognitive centerpiece for an adaptive approach to addiction treatment that incorporates client assessments of needs and progress with the planning and delivery of interventions targeted to client readiness, engagement, and life-skills building stages of recovery. It is a communication and decision-making technique designed to support delivery of treatment services by improving client and counselor interactions through graphic visualization tools that focus on critical issues and recovery strategies.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=161
http://www.ibr.tcu.edu

Re-occurring Themes (Youth, Youth Plus Co-occurring)
Multidimensional Family Therapy (MDFT) is a comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=16
http://www.med.miami.edu/ctrada

Appendix D: Program and Service Examples in Other WA Counties

Examples of programs or services implemented in selected counties with the 1/10th 0.1% sales tax

County	Programs/Services
Clallam County	• New family treatment court • Psychiatrist availability in person or via telephone • Intensive outpatient treatment for people with co-occurring disorders • Adult jail treatment services • Juvenile detention case manager • New family treatment court
Clark County	• Expanded inpatient treatment for meth addicts • Operating costs for new Evaluation and Treatment Facility for involuntarily committed individuals • Expansion of outpatient co-occurring disorder treatment • Expansion of capacity at detoxification facility • New family dependency and juvenile recovery courts, with treatment resources dedicated to courts • Expansion of existing felony drug court, substance abuse court and mental health court, with treatment resources dedicated to courts • Expansion of in-jail mental health services and mental health and chemical dependency services for those leaving jail
San Juan County	• Mental health and substance abuse services for school-age children who have family members with mental illness or substance abuse problems • Therapeutic family court
Snohomish County	• Crisis Intervention Training • Crisis Triage for adults and youth • Intervention specialists • Family, Adult and Juvenile drug treatment courts • Mental health at juvenile detention • Expanded Detox • Youth center and respite beds • Transportation assistance • Rental vouchers for permanent supportive housing
Spokane County	• Mental health court (pays for prosecutor, public defender, clerks) • Jail and juvenile detention nurse and therapist, and case manager for youth on probation who have no services • Outpatient mental health treatment services, including school-based services

	• Expanded residential facilities • Expanded capacity at the detox facility • Implementation of assertive community treatment program for adults who are homeless and have co-occurring mental health and substance abuse disorders
Thurston County	• Jail mental health services • Mental health court • Drug court • Family dependency court • Crisis intervention training for law enforcement • Multi-systemic therapy

Appendix E: Key Stakeholder Interview Questionnaires

COT MHCD Interview Script for Criminal Justice Agencies

Name of interviewee:_____ Agency: _____ Interview Date: _____

Introduction: Thank you for agreeing to speak with me, and for your participation in this assessment. As previously mentioned, the Tacoma-Pierce County Health Department has been asked by the City of Tacoma to examine the status of the city's behavioral health systems. The Health Department is conducting a mental health and chemical dependency needs assessment and resource inventory. Your feedback and the assessment findings will be put into a report that will be shared with community stakeholders.

I anticipate the interview will last about 30-45 minutes, and appreciate any information you can provide. It is helpful for accuracy to record your responses, so I will be taking notes and want to know if it is okay to tape record this interview. The recording will be deleted once I transcribe your answers.

Questions:

These first set of questions are about your agency.

1. Could you tell me more about your agencies role in addressing mental health and chemical dependency issues?
   - Any MHCD services?
   - Coordinated care?
   - Integrated systems?
   - Ideally, what should integration look like, what would you envision?

2. How are those with mental health and chemical dependency needs impacting the City of Tacoma's criminal justice system?

3. What kind of challenges does your agency have in either providing or finding mental health and chemical dependency services?
   - What about for specialized services?

4. Which best practices or innovative models are being used within your network?

My next set of questions are about the needs of the community.

5. Who do you think are the most underserved populations when it comes to needing mental health and chemical dependency services? (Follow-up: Why do you think that is?)

6. For those in need of services, what do you think the barriers are for accessing services?

7. What do you think the barriers are for your contractors in providing services?

My last set of questions are about the community efforts, specifically in the City of Tacoma

11. Are you on any community collaboratives, committees or boards? If so, which ones?

12. Which other organizations that address mental health and chemical dependency do you collaborate with, what does the collaboration entail?
    - Data sharing agreements?

13. What do you think the City of Tacoma's strengths are in addressing mental health and chemical dependency issues?

14. What do you think the City of Tacoma's challenges or system gaps are in addressing mental health and chemical dependency issues?
    - What role would you or your agency play in addressing these gaps

15. Is there anything that you would like to add about mental health and chemical dependency needs or issues for the City of Tacoma?

COT MHCD Interview Script for Agencies That Provide or Coordinate Direct Services

Name of interviewee:_____ Agency: _____ Interview Date: _____

Introduction: Thank you for agreeing to speak with me, and for your participation in this assessment. As previously mentioned, the Tacoma-Pierce County Health Department has been asked by the City of Tacoma to examine the status of the city's behavioral health systems. The Health Department is conducting a mental health and chemical dependency needs assessment and resource inventory. Your feedback and the assessment findings will be put into a report that will be shared with community stakeholders.

I anticipate the interview will last about 30-45 minutes, and appreciate any information you can provide. It is helpful for accuracy to record your responses, so I will be taking notes and want to know if it is okay to tape record this interview. The recording will be deleted once I transcribe your answers.

Questions:

These first set of questions are about your agency or your contractors/providers

1. Could you tell me more about your agency's Role in the City of Tacoma's mental health and substance abuse services system?
    - Specialized services?
    - Client coordination?
    - Integrated systems?
    - Ideally, what should integration look like, what would you envision?

2. Could I get a list of your providers within the City of Tacoma?

3. What kind of challenges do you have with finding providers or contractors to provide services?
    - What about for specialized services?

- What about for new programs?
- Any current capacity issues?

4. Do you provide professional training for your providers/contractors? If so, what type?
    - Any training requirements?

5. Do you have any certification requirements for providers/contractors? If so, what are they?

6. Which best practices or innovative models are being used within your network?

My next set of questions are about the needs of the community and clients.

7. Who do you think are the most underserved populations when it comes to needing mental health and chemical dependency services? (Follow-up: Why do you think that is?)

8. How does your agency monitor or analyze mental health and chemical dependency needs and trends of the community?
    - What unmet needs or tends have you noticed in Tacoma?

9. For those in need of services, what do you think the barriers are for accessing services?

10. What do you think the barriers are for your providers/contractors in providing services?

My last set of questions are about the community efforts, specifically in the City of Tacoma

11. Are you on any community collaboratives, committees or boards? If so, which ones?
    As part of your collaborations, do you have data sharing agreements?

16. Which other organizations (outside of your contractors) that address mental health and chemical dependency do you collaborate with, what does the collaboration entail?

17. What do you think the City of Tacoma's strengths are in addressing mental health and chemical dependency issues?

18. What do you think the City of Tacoma's challenges or system gaps are in addressing mental health and chemical dependency issues?
    - What role would you or your agency play in addressing these gaps

19. Is there anything that you would like to add about mental health and chemical dependency needs or issues for the City of Tacoma?

Appendix F: Environmental Scan

MENTAL HEALTH, CHEMICAL DEPENDENCY/HOUSING ENVIRONMENTAL SCAN – SUMMARY REPORT – JULY 2012

The City of Tacoma, Human Rights and Human Services, performed an environmental scan in May of 2012 with results compiled through July. Identified as a key element of Phase I of the Mental Health and Chemical Dependency (MHCD) Funding Program Implementation Plan (hereinafter, the "plan"), the scan provided data identifying agencies and programs currently engaged in providing services throughout Tacoma addressing mental health, chemical dependency, housing, and criminal justice services for the MHCD population. The results of the scan are being used to assist the City in identifying current community strengths as well as clarify areas where gaps may be identified in current service provision.

The survey tool was divided into two categories: direct (survey A) and non-direct (survey B) service providers[1]. In total there were over 100 surveys distributed with 78 completed. Along with a demographic analysis, questions allowed for subjective responses. The subjective responses are helping to drive directives for Phase II of the Plan; the gaps analysis but are not reflected in this report.

Survey A Responses

Identification of services provided by type and age category:			
	Adult	Youth (K-20)	Infants and Toddlers
Mental Health Services	27	13	7
Numbers Served 2011	9212	3117	342
Co-Occurring Disorders	1422	252	22
MH Residential Services	273	1	
Inpatient MH Services	375	23	
Crisis Services	9130	337	35
Criminal Justice Diversion Services	8	3	0
Pre-booking	620	20	
Pre-trial		5	
In custody	1056	44	
Discharge planning	895	5	
Chemical Dependency Services	19	5	1
Numbers Served 2011	5189	735	99
	Adult	Family	Youth (K-20)

[1] Direct service providers were identified as housing or behavioral health care providers serving individuals or families impacted by one or more of the following challenges; mental health, chemical dependency, homelessness. Non-direct providers were organizations or businesses impacted by encounters with individuals who have chemical dependency or mental health issues.

Survey B Responses

Responses identified percentage of clients encountered with unmet needs.			
Area of Need Identified	Mental Health	Chemical Dependency	Homelessness
Percentage of unmet needs	82	77	91

Respondents were asked to rate their perceptions of availability of services within the Tacoma city limit relative to mental health, chemical dependency and homelessness services. Respondents were offered the option to select "did not know". Considering responses from all who had knowledge, the results are as follows:

3 – Services are available on demand
2 – Services are available but difficult to access
1 – Services are not available

Responses to perception of availability of services						
	Mental Health		Chemical Dependency		Homelessness	
	Adult	Youth	Adult	Youth	Adult	Youth
Overall scaled rating	2	2.1	2.1	2.0	2.1	2.1

The Environmental scan responses represent a single step of multiple steps planned to assist the City in developing effective and efficient services to benefit Tacoma citizens. Studies clearly identify that Tacoma has a robust and diverse social service delivery system. While too early to draw conclusions, early analysis of objective and subjective responses, when added to input from the MHCD Citizen Advisory Group, provided the following insights into potential gaps in service delivery:

- Funding concerns limit access to adults with mental health and/or chemical dependency challenges
- Unaccompanied youth, chemically dependent and/or who suffer from co-occurring disorders have less access to services than adults or youth in families and those with single disorders
- Intensive outpatient treatment for adults/ youth with co-occurring disorders need improvement
- Specialized co-occurring disorder treatment requires further study
- Coordination of care in mental health, chemical dependency and homelessness can be improved
- After hour services, including weekend services, need improvement
- Increased need for outreach and engagement with community stakeholders to identify access to resources for non-service providers engaged with individuals with mental health and/or chemical dependency challenges; access is difficult for non-service providers
- Representation and associated costs in the correction system are disproportionate for adult and juveniles with mental health challenges

These areas will continue to be explored and refined in the next phase where a formal gaps analysis will be conducted in partnership with the Tacoma Pierce County Health Department (planned to be completed in October, 2012).