

***MENTAL HEALTH SYSTEM OVERVIEW  
SUPPORTIVE HOUSING INSTITUTE  
MARCH 2009***

The Mental Health Division (MHD) operates with many partners, including the 13 designated Regional Support Networks (RSN) and their network of over 150 subcontracted community-based mental health providers. The MHD operates an integrated public mental health system for persons experiencing mental illness who are enrolled in Medicaid, for those who are low income and meet the statutory need definitions, and for those in psychiatric crisis.

**MISSION**

The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community by administering a public mental health system that promotes recovery and resiliency as well as personal and public safety.

**VISION**

MHD is committed to creating a seamless system of care that is timely, effective and efficient, that treats each person holistically and embraces each person's ability to recover and gain the skills, insight and personal and interpersonal reserves needed to be resilient as circumstances and symptoms change. The hope is that people living with a mental illness will live, work, learn, and participate fully in their communities and without fear of discrimination.

**GUIDING PRINCIPLES/CORE VALUES**

The guiding principals and core values of MHD include:

- Promote the understanding that mental health is essential to overall health for all Washington residents.
- Encourage consumers, their families, and advocates to drive their own mental health care and to be involved in their own individual recovery and resiliency process supported by the mental health system.
- Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
- Establish early mental health screening, assessment, and referral to services as common practice.

**FUNDING:**

<b>MENTAL HEALTH SYSTEM FUNDING</b>	<b>FY 2007</b>
<b><u>Community Mental Health System</u></b>	
Title XIX/Medicaid - Federal	<b>\$177 million</b>
State Match	<b>\$162 million</b>
State-Only	<b>\$141 million</b>
Federal Block Grant	<b>\$8.4 million</b>
Local (does not include .1% county option)	<b>\$6 million</b>
<b>Total Community</b>	<b>\$494.4 million</b>
<b>State Hospital System</b>	<b>\$246 million – primarily State</b>

- ✓ Medicaid funding (and required State Match) is allocated to RSNs based on a formula that includes the number of disabled and non-disabled adults and children eligible for Medicaid in the region.
- ✓ State-Only funding is allocated to RSNs based on the region's proportion of total population – except when funding is directed for a specific purpose, for example PACT – among the main uses of State-Only funding is operating the crisis and involuntary treatment systems.
- ✓ Federal Block Grant
  - 5% is reserved for administrative costs/ salaries at MHD (grant limit)
  - Of the *remaining* 95%:
    - 80% goes to RSN's through a historical distribution formula (per WAC)
    - 20% stays at MHD for Division Initiatives (e.g.: Conferences such as Co-Occurring or the Behavioral Healthcare Conference, trainings for RSNs, tribal supports, research)

**OVERVIEW OF PEOPLE SERVED**

Mental health consumers include Medicaid eligible persons, publicly funded persons not eligible for Medicaid, and all citizens of the state (for crisis, ITA and disaster response services). Tribal mental health consumers receiving tribal services or care in tribal clinics are not reflected in MHD service data unless they are contracted by an RSN. The percentage of tribal consumers who receive both tribal and RSN services is presently unknown.

Following is an overview of statistics related to individuals served in the public mental health system in fiscal year **2008**:

- 118,074 people, approximately 92,000 of whom were covered by Medicaid, utilized mental health services in community outpatient settings
- 8,129 people received services in community hospitals
- 2,281 people received inpatient services in state hospitals
- Medicaid eligible people received about 88 percent of service hours delivered
- Some non-Medicaid consumers receive outpatient services (these tend to be minimal hours as would be consistent with a mental health evaluation.
- Many mental health consumers tend to be customers of other human service programs

Indicator	2006	%	2007	%	2008	%
Total served Community Outpatient	120,941	N/A	119,208	N/A	118,074	N/A
Adult Living Independently	54,010	63.8%	54,139	64.1%	52,992	62.9%
Adult w) Episode of Homelessness	6,751	8%	6,831	8.1%	6,744	8.0%
Child Living in Own Home	28,100	77.3%	26,667	76.9%	25,881	76.5%
Child w) Episode of Homelessness	520	1.4%	473	1.4%	498	1.5%
Child in Foster Care	3,501	9.6%	3,360	9.7%	3,139	9.3%
Child Living in Other Residence	2,447	6.7%	2,541	7.3%	1,906	5.6%

### **REGIONAL SUPPORT NETWORKS AND COMMUNITY OUTPATIENT SERVICES**

In 1989, the Washington State Legislature enacted the Mental Health Reform Act, which consolidated responsibility and accountability for individuals' community mental health treatment and care through Regional Support Networks (RSNs)<sup>1</sup>, also known as Pre-paid Inpatient Health Plans (PIHPs). This consolidation included crisis response and management of the involuntary treatment program. Beginning in October 1993 through 1996, MHD implemented capitated managed care for community outpatient mental health services through a federal Medicaid waiver, creating prepaid health plans operated by the RSNs. In 1996, the waiver was amended to include community inpatient psychiatric care. By 1999, all RSNs were responsible for full risk management of inpatient community mental health care.

Under the Federal managed care 1915 (b) Medicaid waiver, RSNs enter into full risk PIHP contracts with the state to provide community inpatient and outpatient services to Medicaid eligible children and adults. As prepaid inpatient health plans, the RSN/PIHPs provide community mental health services described in the State Plan to consumers who meet the Access to Care standards for authorization into public outpatient mental health services. The Access to Care Standards were developed as a response to a condition of the 1915 (b) Medicaid waiver renewal which required the state to "develop and implement a standard set of criteria, and a standard set of methods of implementation, to be used statewide in all RSNs/PIHPs for screening, assessment and authorization of services. Criteria and methods for implementation must assure that all Medicaid eligible individuals in need of mental health services have access to needed services. Treatment activities must be designed to support consumer goals as documented in the consumer's individual recovery plan. Services provided through the Medicaid waiver include:

- Individual counseling and psychotherapy services

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<sup>1</sup> In Pierce County, DSHS has assumed the duties of the former Pierce County Regional Support Network which terminated their contract in January of 2008. Services in Pierce County will be delivered through fee for service contracts between the state and local mental health providers through June 2009. OptumHealth through a competitive process was awarded the contract to manage mental health services for Pierce County beginning July 2009. This includes both the responsibilities for the state funded mental health services and to function as the at risk PIHP.

- Medication management
- Crisis and stabilization services
- High Intensity Treatment teams, and evaluation and treatment centers (E&Ts)
- Peer Support services
- Respite care for caregivers, clubhouses, and supported employment as funding allows
- Day treatment (day support) for individuals needing an intensive rehabilitative program

The State Legislature has provided additional state funding designed to address the gaps in services created by restrictions in the Medicaid program. Key non-Medicaid services include:

- Crisis and limited outpatient services for primarily low income individuals who are not eligible for Medicaid
- Room and board for mental health consumers in licensed residential treatment programs
- Program of Assertive Community Treatment (PACT) teams implemented in nine counties
- Services to individuals in and transitioning from jails implemented statewide
- Community integration assistance program services for individuals with mental illness identified as high risk who are transitioning to the community from state prisons
- Innovative service grants for clubhouse and other consumer directed services
- Select evidence based practice pilot programs for children

RSNs are also required to promote access to safe and affordable housing and provision of services to individuals who are homeless and the active search of comprehensive resources to meet the housing needs of consumers. RSN community support services emphasize supporting consumers in their own homes and RSNs provide and/or coordinate with rehabilitation and employment services to support consumers seeking employment.

RSNs must ensure that eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights. If supervised residential services are needed they are provided only in licensed facilities that may include an adult family home, boarding home facility or an adult residential rehabilitation center facility.

King County, for example describes its residential services as follows:

“KCMHP contracts for specialized housing services known as Residential Services. These residential environments are licensed boarding homes and residential treatment facilities. They are available for adults who are not yet ready to live on their own and need daily supervision. The facilities are staffed 24-hours-a-day seven days a week and provide room and board, housing stabilization services, and medication monitoring. Residential facilities are licensed by either the Department of Social and Health Services (DSHS) or the Department of Health (DOH).

KCMHP offers two levels of residential care:

Supervised Living (SL): This transitional level of care is for people with mental illness who are not yet able to live on their own in the community. Individuals receive room and board, residential stabilization services and daily support services. Individuals have the opportunity to join in-house and agency organized community activities.

On-site staff assist residents with housing issues. Residents also have an outpatient mental health case manager that provides mental health treatment in the community.

Long Term Rehabilitation (LTR): This transitional level of care is more intensive than Supervised Living. Additional services provided at Long Term Rehabilitation facilities include: on-site psychiatric evaluation, medication management and case management for both housing and mental health needs.”

## **INVOLUNTARY TREATMENT AND INPATIENT SERVICES**

RSNs administer the involuntary treatment act and the crisis response system for all people in their service area regardless of income or citizen status. In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour per day crisis line and in-person evaluations to the people of the community presenting mental health crises. Crises are to be resolved in the least restrictive manner and should include family members and significant others as appropriate to the situation and at the request of the consumer.

Involuntary treatment act services are available in all of the communities of the state 24-hours per day. These services include in-person evaluation of the need for involuntary psychiatric hospitalization. This evaluation is used to determine if a person meets any of the following criteria as the result of a mental disorder ; is gravely disabled (as defined in 71.05 RCW) or a likelihood of serious harm (to self, others, or to property). In order to be hospitalized involuntarily, the person must meet the evaluation criteria and have refused or failed to voluntarily accept evaluation and treatment to address the presenting symptoms.

For children and youth acute inpatient services are provided either in community psychiatric hospitals or in special units set aside for children and youths. Children’s Long-Term Inpatient facilities, CLIP, provide inpatient care for those children and youth who need extended inpatient services. The CLIP facilities include the Child Study Treatment Center which is a 47 bed state run facility on the grounds of Western State Hospital. MHD also holds contracts for the operation of three CLIP programs. These facilities provide capacity for an additional 44 children statewide. Standing agreements between CLIP and the RSN detail the responsibility for the resource management of these 91 beds.

Adult acute services begin in community psychiatric hospitals or in freestanding evaluation and treatment centers (E&Ts.) Freestanding E&Ts are stand alone psychiatric treatment facilities certified to provide short term involuntary treatment services. For individuals requiring longer periods of treatment than community hospitals and E&Ts are able to provide, long term treatment services are provided by the two adult psychiatric hospitals operated by the state. Eastern and Western State Hospitals provide care for approximately 1200 individuals each day. Approximately 70% of individuals at the state hospitals are under civil commitment orders. The remaining 30% are receiving court ordered forensic services. These include:

- Evaluation of individuals for competency to stand trial
- Treatment to restore competency for those deemed not competent to stand trial
- Ongoing treatment for individuals judged not guilty by reason of insanity

## **CHALLENGES AND OPPORTUNITIES**

Since 2004 significant research, legislation, policy interpretation and funding patterns have dramatically impacted the public mental health system in Washington State and to which much of the Mental Health's Division's strategic plan responds and upon which it is built.

- ✓ In 2006, the WA State Legislature began providing \$10.3 million annually for the statewide implementation of 10 Program of Assertive Community Treatment (PACT) teams, part of the comprehensive package to transform the delivery of Washington State's public mental health services. Besides improved outcomes for the most difficult-to-serve clients, the PACT teams are expected to result in eventual reductions in overall State Hospital utilization. Between Sept 2008 through Oct 2009, 4 State Hospital wards (3 Western State and 1 Eastern State) are expected to close due to PACT success.
- ✓ In July 2007, the Legislature provided funding for RSNs to develop community alternatives for many of the individuals living in the PALS program at WSH. The Legislature directed MHD to begin charging RSNs for the cost of any individuals remaining in PALS. RSNs have utilized the funding to develop a variety of innovative community alternatives and the average daily census at the PALS program has dropped from 110 beds to 39 beds.
- ✓ In 2006 SHB 1088 the Children's Mental Health Act was passed and will shape the Division's activities relating to children's mental health program and planning over the next several years. By 2012, the Department is required to substantially improve the delivery of children's mental health services.
- ✓ Over the last several years the Washington State Legislature has provided state funding to lessen the impact of federal actions as well as enhancing funding for additional services and increases specifically for mental health line staff wages/ cost of living. Additional people will be income eligible to receive Medicaid mental health services in 2009 because of Legislative action in 2008 (SSB 6583) to increase the income eligibility ceiling for Categorically Needy to 85% of the federal poverty level.
- ✓ Between 2005 and 2009 \$27.5 million was provided for community hospital in-patient rates for psychiatric services to reverse the trend of community hospitals eliminating psychiatric beds due to inadequate reimbursement rates.
- ✓ In 2008 SHB 2654 directed the Division to submit a report to the Legislature by January 2009 that lays out strategies for the development and funding of consumer and family-run services, including possible changes to the state plan and federal waiver.
- ✓ The 1999 Washington State Legislature passed SSB 5011/RCW 71.24.470 to improve the process of identifying and providing additional mental health treatment for mentally ill offenders who are being released from the Department of Corrections (DOC) and who pose a threat to public safety. The program is called the Dangerous Mentally Ill Offenders Program (DMIO)/ Community Integration Assistance Program (CIAP). Through interagency collaboration, the legislation intends to promote a safe transition to the community by having state funds support intensive mental health treatment with intensive case management, chemical dependency treatment and

other services. Since April 2000 there have been more than 500 individuals designated as Dangerous Mentally Ill Offenders. As of 2008 only 8 of 39 counties in the State were served by CIAP/DMIO contractors. Limited funding may require reduced service and potentially effect community safety in the future. The Washington State Institute for Public Policy, February 2008 Update found that the DMIO Program reduced overall felony recidivism rates by 37% and generated \$1.24 for every dollar spent.

- ✓ The dissolution of the Pierce County RSN on January 1, 2008 has led to the creation of a fee-for-service (FFS) system in that County. In order to provide the Department with greater ability to select qualified RSN management, SSB 6404 in 2008 establishes a process to replace a managing entity that voluntarily no longer continues as the RSN operator and allows for additional entities to serve as an RSN.
- ✓ The 2008 Legislature provided funding for a comprehensive plan for reducing the Spokane RSN use of Eastern State Hospital (Spokane Acute Care Diversions). The Legislature also provided funding for increasing non-Medicaid services to other RSNs.