Washington State Institute for Public Policy

110 Fifth Avenue Southeast, Suite 214 • PO Box 40999 • Olympia, WA 98504-0999 • (360) 586-2677 • www.wsipp.wa.gov

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WASHINGTON'S PUBLIC MENTAL HEALTH SYSTEM: REGIONAL NEEDS AND APPROACHES

Background

Public mental health providers in Washington State offer crisis services, outpatient care, and inpatient treatment to eligible individuals. In Fiscal Year 2007, over $400 million was spent on the state's public community mental health system. In addition, the state operates two psychiatric hospitals for adults and one for children. State hospital operations and other functions brought the annual total (FY 2007) for all public mental health services to $675 million.

The federal Center for Medicaid and Medicare Services (CMS) plays a large role in mental health funding and eligibility guidelines within the state. Medicaid dollars account for $300 million of the overall mental health budget. Medicaid funding includes both state and federal dollars.

In Washington, community mental health services are overseen by regional networks. The 1989 Washington State Legislature passed the Mental Health Reform Act (SSB 5400) which established 14 Regional Support Networks (RSNs). Since 1993, the state has contracted directly with the RSNs using a "capitated" financing system that allocates Medicaid funds based on a fixed amount per month for the care of each eligible person.

RSN administrators contract directly with service providers to meet the mental health needs in their catchment areas. While provider oversight and payment responsibilities rest with the RSNs, the state determines funding allocations across the regions. Legislation adopted in 2005 required a competitive bidding process to provide public mental health services for the state. Following this process, RSNs were consolidated from 14 to 13 regions.

Summary

In 2001, the Washington State Legislature directed the Washington State Institute for Public Policy (Institute) to conduct a study of the long-term outcomes of public mental health consumers. Last year, over 120,000 adults were served through Washington's public mental health outpatient programs, inpatient treatment, and state hospitals.

In Washington, community mental health services are overseen by 13 Regional Support Networks (RSNs) under contract with the state Division of Mental Health. This report describes the circumstances and approaches in Washington's 13 regional mental health networks. Among the variations discussed:

- Across all regions, the rate of adults who received non-Medicaid (state only) mental health services in 2007 ranged between 5 and 28 adults per thousand.
- A significant percentage of adults received services on a regular basis over four years (2004–07). Among the RSNs, the percentage of regular consumers ranged between 7 and 36 percent.
- A small percentage of adults accounted for half of all service hours reported in 2007. At the RSN level, between 3 and 12 percent of consumers accounted for half of all service hours.
- The focus on outpatient and crisis services and expenditures differed by region.
- The availability and type of inpatient beds also varied significantly across RSNs.

This report examines these regional variations and discusses the implications for future outcomes research.

Exhibit 1
Regional Support Networks

In the last eight years, Washington's public mental health system has undergone a number of significant changes related to funding allocations, service priorities, and eligibility guidelines. Some of these changes were in response to a 2000 performance audit by the Joint Legislative Audit and Review Committee (JLARC).[1] The JLARC report recommended:

1) Enhanced coordination between the Mental Health Division (MHD) of the Department of Social and Health Services (DSHS) and related state agencies
2) Improved data collection on client and system outcomes
3) Better consistency in reporting fiscal, client, and service data from providers and RSNs

The report noted that a lack of consistency in data reporting made comparisons of the *efficiency* of services difficult. Furthermore, a lack of statewide outcome data at the time made it impossible to determine the *effectiveness* of each region in achieving desired outcomes. Following the release of this audit, the 2001 Washington State Legislature passed ESSB 5583, which directed the Washington State Institute for Public Policy (Institute) to "conduct a longitudinal study of long-term client outcomes to assess any changes in client status at two, five, and ten years. The measures tracked shall include client change as a result of services, employment and/or education, housing stability, criminal justice involvement, and level of services needed."

In recent years, data collection efforts have become more comprehensive and financial reporting has grown more uniform across the Regional Support Networks. A comparison of differences and similarities among the RSNs can help illustrate why certain outcomes may be achieved in some areas and not others.

[1] R. Perry, L. Brubaker, V. Whitener. (2000). *Mental Health System Performance Audit*. Olympia: Joint Legislative Audit and Review Committee, Document No. 00-8.

This paper focuses on regional variations and addresses questions related to the following:

- Client Population
  - What is the prevalence of serious mental illness in each region?
  - How many Medicaid-eligible individuals live in each area? How many of these persons are served by the mental health system?
- Utilization
  - Are there different patterns of service utilization (i.e. continuous or regular use) in certain regions?
  - Do consumer characteristics (diagnoses, functioning) vary across regions?
- Services
  - What is the mix of service delivery in each RSN?
  - How do expenditures and costs for services vary across Regional Support Networks?
- Program Initiatives
  - To what extent have evidence-based practices (EBPs) been implemented among various providers in each region?
  - What other local or regional initiatives are taking place in the public mental health system?

The purpose of this paper is to examine regional variations and lay the groundwork for future analyses of long-term outcomes among adult consumers of mental health services.

Prevalence of Serious Mental Illness in Washington

History

In 1994, DSHS completed a federally funded survey that focused on the mental and physical health status of Washington State adults—the Washington State Needs Assessment Household Survey (WANAHS). The sections in WANAHS related to mental health provided the basis for the first estimates on the prevalence of mental illness among Washington residents. In 1998, Dr. Charles Holzer (University of Texas) released the Prevalence Estimates of Mental Illness and Need for Services (PEMINS) study, in conjunction with DSHS. The study found the rate of serious mental illness in Washington was 3.9 percent among adults and 6.3 percent for adults in households below 200 percent of the federal poverty level.[2] While this survey had an excellent response rate and good coverage of frequently underrepresented subpopulations, WANAHS did not cover homeless, group quarters, or institutionalized populations.

The 2001 Washington State Legislature sought to address potential shortcomings of the 1998 PEMINS study and requested "a study of the prevalence of mental illness among the state's regional support networks" (ESSB 6153). This study[3] was completed in 2003 and revised previous estimates by:

1) Basing estimates on underlying demographics from the 2000 U.S. Census
2) Conducting smaller studies to obtain estimates for certain target groups (homeless, jails and prisons, community residential, state hospitals)
3) Including estimates of children with serious emotional disorders (SED)

The PEMINS update, based on 2000 census data, found a 4.3 percent prevalence of serious mental illness (SMI) among adults. In households with incomes below 200 percent of the federal poverty level, the rate was 8.5 percent (Exhibit 2).

A legislative review of this 2003 study found that "by including estimates for groups either excluded or underrepresented in the original PEMINS study, the new study adds substantially to the estimated prevalence of serious mental illness within the state."[4] Exhibit 3 provides regional detail on the most recent estimates of adult serious mental illness in Washington.[5]

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[2] <http://www1.dshs.wa.gov/pdf/ms/rda/research/3/26.pdf>

[3] <http://www.dshs.wa.gov/pdf/EA/GovRel/Leg1203/Preval1203.pdf>

[4] R. Krell. (2004). DSHS Mental Illness Prevalence Study: Follow-up to JLARC's 2000 Mental Health System Performance Audit. Olympia: Joint Legislative Audit and Review Committee, Document No. 04-1, p. 4.

[5] The 2003 PEMINS estimates differ from the federal definition of SMI (http://tie.samhsa.gov/TAPS/tap22/APPE.htm). Caution should be exercised when comparing estimates from different data sources.

Regional Prevalence Estimates

Estimating the prevalence of mental illness represents the first step in establishing a need for services. Exhibit 2 displays the statewide prevalence of mental illness among adults. The regional distribution of these estimates is presented in Exhibit 3, along with the overall adult population. In 2003, of the 4.4 million adults who lived in Washington, 31 percent were from King County. Of the estimated 189,070 adults with serious mental illness in Washington, 60,630 (32 percent) resided in King County. Across each RSN, the total share of adult serious mental illness corresponds closely to the share of the overall adult population.

Exhibit 3 also shows the prevalence of mental illness among low-income adults (below 200 percent of the federal poverty level). In the next section, we discuss Medicaid services and coverage for low-income public mental health consumers in Washington State.

Exhibit 2
Prevalence of Serious Mental Illness
Among Washington State Adults, 1998–2000

	All Adults			Under 200% FPL		
	Cases	Population	Percentage	Cases	Population	Percentage
1998 PEMINS	157,070	4,051,183	3.88%	60,332	955,647	6.31%
2003 PEMINS	189,070*	4,380,278	4.33%	84,833*	992,884	8.54%

*Includes estimates for community residential, jails and prisons, homeless, and state hospitals (excludes children).

Exhibit 3
RSN Share of Serious Mental Illness Prevalence (Adults) in Washington State
2003 PEMINS Estimates

Regional Support Network	Adult Population (Share)	Adult SMI Estimate (Share)	Adults Under 200% FPL SMI Estimate (Share)
Chelan/Douglas	70,981 (2%)	2,978 (2%)	1,710 (2%)
Clark	246,253 (6%)	10,519 (6%)	4,435 (5%)
Grays Harbor	49,943 (1%)	2,178 (1%)	1,178 (1%)
Greater Columbia	427,105 (10%)	17,376 (9%)	9,658 (11%)
King	1,346,388 (31%)	60,630 (32%)	22,988 (27%)
North Central	140,333 (3%)	5,961 (3%)	3,602 (4%)
North Sound	707,046 (16%)	28,805 (15%)	11,638 (14%)
Peninsula	241,075 (6%)	9,875 (5%)	4,500 (5%)
Pierce	510,251 (12%)	22,790 (12%)	10,584 (12%)
Southwest	68,043 (2%)	2,948 (2%)	1,468 (2%)
Spokane	310,439 (7%)	14,724 (8%)	7,887 (9%)
Thurston/Mason	192,614 (4%)	7,963 (4%)	3,554 (4%)
Timberlands	69,807 (2%)	2,816 (1%)	1,489 (2%)
State Total	**4,380,278 (100%)**	**189,070 (100%)**	**84,833 (100%)**

Source: Washington State Department of Social and Health Services. (2003). The Prevalence of Serious Mental Illness in Washington State <http://www1.dshs.wa.gov/pdf/hrsa/mh/2003Prevalence.pdf>

Note: The PEMINS studies utilized an indirect estimation method that applied a model to RSN and state totals separately. This resulted in small differences between the statewide totals and the sum of RSN estimates.

Medicaid Funding for Mental Health Services

As noted previously, Medicaid dollars represent a significant portion of the state's public mental health system funding. In 2007, Washington's annual Medicaid budget totaled about $3.7 billion—nearly 8 percent of these Medicaid dollars were spent on mental health services. To qualify for most of these mental health services, adults must first meet eligibility guidelines. While Medicaid covers all children in families with incomes up to 200 percent of the federal poverty level (FPL), not all adults who are poor qualify for Medicaid. In addition to having a low income, qualifying for Medicaid requires meeting other categorical tests, such as age, permanent disability, pregnancy, or receipt of public assistance (cash benefits).[6]

Washington's Medicaid Mental Health State Plan

In 1993, Washington State received an ongoing Medicaid "Section 1915(b)" waiver to implement a managed care delivery system for mental health services. Under this waiver, each Regional Support Network administered a Prepaid Health Plan (PHP) and received a fixed amount of revenue for each Medicaid-eligible consumer. To control costs, each plan limited the number of approved providers and developed other cost-saving measures. Prior to 2004, any savings from these capitated payments could be used to fund additional mental health services for other state residents (non-Medicaid individuals). State-only (general fund) dollars are also used to fund non-Medicaid services, but before new rules were implemented in 2004, the state increasingly utilized these Medicaid "savings" to pay for public mental health services. An analysis of services and expenditures between 1999 and 2004 found that "non-Medicaid service hours *increased* 9.5 percent...while non-Medicaid funding decreased 19 percent."[7]

Changes in Medicaid funding rules occurred with the implementation of the federal Balanced Budget Act (BBA) during 2004. These changes included:

1) Development of payment rates based on actuarial projections
2) Decreases in future rates as a result of reported cost savings
3) Enhanced federal oversight based on an External Quality Review (EQR) process
4) Narrowed definition of service modalities that could be funded with Medicaid dollars and included in the calculation of capitation rates
5) A mandate that the state have uniform "Access to Care Standards" for Medicaid enrollees needing public mental health services (both functional impairment criteria and approved diagnoses)

In addition to transforming priorities and procedures within the state's mental health system, the changes meant a reduction of about $40 million per year in funding for non-Medicaid clients and services. As a result, many RSNs reduced or eliminated services to non-Medicaid clients. The 2005 Washington State Legislature restructured mental health funding in an attempt to restore funds to previous levels. In an effort to achieve equity among RSNs and continuity with prior funding levels, several different "backfill" strategies were employed. As a result of shifts in payment methodologies and new eligibility standards, the past few years have been a period of uncertainty and adjustment for RSN staff.[8] The following sections explore how RSNs have responded with service delivery, spending priorities, and treatment initiatives.

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[6] <http://fortress.wa.gov/dshs/maa/News/Fact/FS008009 WashingtonMedicaidfacts.pdf>; <https://fortress.wa.gov/dshs/maa/News/Fact/FS007002WashingtonMedicaidataglance.pdf>

[7] D. Jarvis & B. Mauer. (2005). *An Analysis of Washington State Public Mental Health Funding – Pre and Post Implementation of the Balanced Budget Act of 1997*. Seattle: MCPP Healthcare Consulting, Inc., (p. 6). <http://www.mcpphealthcare.com/products_tools/2005_MHD_Funding_Analysis.pdf>

[8] Other changes are occurring at the regional level, as well. In 2007, Pierce County Human Services notified the Washington State Mental Health Division that the county would no longer manage the Regional Support Network for Pierce County. The Pierce County RSN is currently administered by MHD under fee-for-service contracts with providers. In 2009, the Division will contract with a public or private organization that has entered a successful bid to manage mental health programs in Pierce County.

Access to Public Mental Health Care (Medicaid and Non-Medicaid Rates)

Given the transformation in Medicaid rules and guidelines, has access to mental health services been affected? The state Mental Health Division measures the "reach" of services using a "penetration rate." The penetration rate gives an indication of how many Medicaid-eligible individuals may require mental health services. Exhibit 4 shows the total number of adult Medicaid-eligible adults receiving outpatient mental health services as a percentage of all adult Medicaid clients between 2005 and 2007.

As Exhibit 4 indicates, 14 percent of the 453,000 adults eligible for Medicaid in 2007 received outpatient mental health services at some point during the year. The outpatient Medicaid penetration rate in King, Peninsula, Southwest, and Timberlands RSNs remained higher than the state average between 2005 and 2007.

It is important to note that RSNs operate with a mix of federal (Medicaid), state, local, and block grant funds. Medicaid guidelines are clear about the services and eligibility for these funds. However, RSN administrators can set different policies to expand Medicaid services and provide treatment to non-Medicaid consumers.

Exhibit 4
Community Outpatient Penetration Rates (Medicaid Population by RSN)
Adults (2005–07)

	2005		2006		2007	
Regional Support Network	**Medicaid Clients**	**Served**	**Medicaid Clients**	**Served**	**Medicaid Clients**	**Served**
Chelan/Douglas	8,313	984 (12%)	8,251	873 (11%)	8,006	914 (11%)
Clark	27,910	3,610 (13%)	27,800	3,656 (13%)	27,067	3,403 (13%)
Grays Harbor	8,296	1,153 (14%)	8,287	1,231 (15%)	7,889	1,123 (14%)
Greater Columbia	59,729	7,916 (13%)	60,538	7,659 (13%)	59,813	7,343 (12%)
King	108,526	19,562 (18%)	107,705	19,486 (18%)	103,558	19,268 (19%)
North Central	24,518	2,249 (9%)	29,770	2,488 (8%)	23,177	2,239 (10%)
North Sound	66,987	8,250 (12%)	65,908	7,428 (11%)	63,935	7,300 (11%)
Peninsula	23,388	4,183 (18%)	23,173	4,191 (18%)	22,596	4,101 (18%)
Pierce	57,505	6,306 (11%)	57,430	6,536 (11%)	55,509	6,075 (11%)
Southwest	10,592	1,911 (18%)	10,565	1,897 (18%)	10,006	1,967 (20%)
Spokane	42,632	5,167 (12%)	42,692	4,707 (11%)	41,368	4,767 (12%)
Thurston/Mason	20,698	2,702 (13%)	20,642	2,638 (13%)	19,829	2,890 (15%)
Timberlands	10,703	1,567 (15%)	10,647	1,585 (15%)	10,049	1,700 (17%)
State Total	**458,607**	**64,223 (14%)**	**456,827**	**63,003 (14%)**	**453,263**	**61,919 (14%)**

Source: WA Mental Health Performance Indicator System, generated on: September 17, 2008. <http://mhd-pi.com>, secure website

Exhibit 5

Community Outpatient Penetration Rate (Non-Medicaid Population by RSN), Adults (2005–07)

	2005		2006		2007	
Regional Support Network	**Adult Population**	**Served (Rate per 1,000)**	**Adult Population**	**Served (Rate per 1,000)**	**Adult Population**	**Served (Rate per 1,000)**
Chelan/Douglas	73,642	458 (6.2)	75,121	575 (7.7)	76,518	487 (6.4)
Clark	279,252	1,452 (5.2)	288,453	1,643 (5.7)	297,276	1,631 (5.5)
Grays Harbor	51,441	456 (8.9)	51,997	453 (8.7)	52,404	567 (10.8)
Greater Columbia	454,333	4,794 (10.6)	462,920	4,594 (9.9)	470,666	4,311 (9.2)
King	1,391,025	7,280 (5.2)	1,413,956	7,708 (5.5)	1,435,831	7,591 (5.3)
North Central	144,643	1,213 (8.4)	147,222	1,513 (10.3)	150,130	1,544 (10.3)
North Sound	761,134	4,185 (5.5)	779,527	3,332 (4.3)	797,164	3,862 (4.8)
Peninsula	248,583	2,391 (9.6)	252,528	2,832 (11.2)	254,869	2,772 (10.9)
Pierce	549,359	4,597 (8.4)	563,323	4,986 (8.9)	576,827	4,889 (8.5)
Southwest	69,626	1,186 (17.0)	70,432	1,338 (19.0)	71,312	1,980 (27.8)
Spokane	320,689	1,729 (5.4)	326,785	1,757 (5.4)	332,786	2,141 (6.4)
Thurston/Mason	206,007	1,396 (6.8)	212,540	1,425 (6.7)	219,225	1,848 (8.4)
Timberlands	71,391	825 (11.6)	72,639	907 (12.5)	73,835	1,011 (13.7)
State Total	**4,621,126**	**31,440 (6.8)**	**4,717,443**	**32,441 (6.9)**	**4,808,844**	**34,061 (7.1)**

Source: WA Mental Health Performance Indicator System, generated on: September 17, 2008. <http://mhd-pi.com>, secure website

Exhibit 5 provides the penetration rate for outpatient services for all non-Medicaid adults between 2005 and 2007. In this case, the penetration rate is listed as the number of adults receiving outpatient services per 1,000 adults in the general population.[9]

In 2007, 7.1 out of every 1,000 adults in Washington received state-funded community outpatient mental health services. Interestingly, three of the RSNs with high Medicaid penetration rates (Peninsula, Southwest, and Timberlands), also had higher than normal coverage for non-Medicaid adults.

As noted earlier (page 5), the allocation formulas for state funds have fluctuated over the previous five years. An RSN's ability to fund non-Medicaid outpatient services will depend heavily on this funding distribution. RSNs must also balance other costs (such as involuntary treatment admissions and crisis services) when making decisions about providing outpatient care.

The penetration rate represents only one measurement of service adequacy. The service needs in any given area may be impacted by:

- Likelihood that consumers will receive services on a continual or regular basis
- Diagnostic profile of consumers in each region
- Geographical differences in per-capita income and benefit eligibility

In addition, the ability of the public mental health system to respond to estimated need across the RSNs may be affected by:

- Budget allocations and funding/service priorities
- The number of qualified providers and licensed facilities in each region
- Overall program efficiencies or treatment strategies

The remaining sections discuss the various ways to measure service patterns and utilization in Washington's public mental health system.

[9] A related measure could include low-income adults. According to the 2006 State Population Survey <http://wa-state-ofm.us/SPSOnline>, there were 1,114,433 adults under 200 percent of the federal poverty level who did not list Medicaid as their primary insurance coverage.

Service Utilization Patterns in Washington's Mental Health System—Outpatient Care

In May 2008, the Institute released a report in this series that examined service utilization patterns among public mental health consumers.[10] Following a statewide cohort of adults who received public mental health services in January 2004, we found that at the end of four years:

- 9 percent received services continually (every month)
- 18 percent regularly utilized mental health services (every quarter)
- 10 percent had intermittent use of mental health services (breaks longer than three months)
- 64 percent were classified as "leaving" clients who received services and did not return

For the approximately 39,000 adults receiving mental health services in January 2004, 27 percent went on to become regular consumers (monthly or quarterly service) over the next four years. Exhibit 6 highlights how the proportion of regular consumers varied by region. King County had the highest rate of regular utilization, with 36 percent of the initial cohort remaining as monthly or quarterly consumers over four years.

Regional Support Networks with primarily rural populations also had the lowest rate of adults receiving services on a regular basis. In four of the RSNs, the rate of regular utilization (over four years) was under 20 percent.

Exhibit 6
Adults Receiving Public Mental Health Services in January 2004, Percentage With Regular Utilization Over Four Years

Regional Support Network	January 2004 Adult Consumers	Regular Utilization Over Four Years (Monthly or Quarterly)
Chelan/Douglas	700	12%
Clark	1,816	25%
Grays Harbor	560	21%
Greater Columbia	5,087	16%
King	12,608	36%
North Central	1,177	7%
North Sound	4,493	22%
Peninsula	2,224	31%
Pierce	3,997	26%
Southwest	1,305	21%
Spokane	2,578	31%
Thurston/Mason	1,431	25%
Timberland	1,019	17%
State Total	**39,048**	**27%**

Several factors are associated with regular or ongoing use of public mental health services over the course of four years. These factors include:

- Individuals with a primary ***diagnosis of schizophrenia or bi-polar*** were more likely to receive ongoing services (compared to those diagnosed with depression or anxiety).
- Consumers with a ***low functioning score***[11] had a higher likelihood of continued service use.
- ***Prior service history*** was also related to future utilization. Consumers who received services on an ongoing basis during the last 24 months were two to three times more likely to become regular utilizers of mental health services over future years.

[10] M. Burley. (2008). *Who Stays and Who Leaves? A Profile of Adult Public Mental Health Consumers*. Olympia: Washington State Institute for Public Policy, Document No. 08-05-3401.

[11] General Assessment of Functioning (GAF) scores between 1 and 50 indicate low functioning.

Regional Consumer Characteristics—Diagnosis and Functioning

We may expect different utilization patterns in those RSNs with a greater percentage of "high-needs" consumers. Exhibit 7 breaks out the regional profile of the January 2004 study cohort by primary diagnosis and functioning level. This table demonstrates that the primarily urban RSNs (Clark, King, North Sound, Pierce, Spokane, and Thurston/Mason) have a higher rate of clients with Schizophrenia/Bi-Polar diagnoses. In addition, among clients who had Global Assessment of Functioning scores, King, North Sound, and Pierce RSNs had the highest proportion of adult clients with serious functioning impairments (score of 50 or below).

Exhibit 7
Diagnosis and Functioning of Adults Receiving Public Mental Health Services in 2004
Regional Characteristics

Regional Support Network	January 2004 Adult Consumers	Schizophrenia/ Bi-Polar Diagnosis	Adult Consumers With Global Assessment of Functioning Scores	Serious Functioning Impairment (GAF 50 or less)
Chelan/Douglas	700	235 (34%)	528	354 (67%)
Clark	1,816	866 (48%)	1,413	791 (56%)
Grays Harbor	560	241 (43%)	390	265 (68%)
Greater Columbia	5,087	1,754 (34%)	4,820	2,169 (45%)
King	12,608	5,878 (47%)	11,282	10,041 (89%)
North Central	1,177	340 (29%)	973	545 (56%)
North Sound	4,493	2,088 (47%)	3,316	2,852 (86%)
Peninsula	2,224	1,025 (46%)	1,874	937 (50%)
Pierce	3,997	2,190 (55%)	3,319	2,755 (83%)
Southwest	1,305	435 (33%)	1,018	458 (45%)
Spokane	2,578	1,607 (62%)	2,326	1,419 (61%)
Thurston/Mason	1,431	711 (50%)	1,328	1,049 (79%)
Timberland	1,019	298 (29%)	758	364 (48%)
State Total	**39,048**	**17,696 (45%)**	**33,374**	**24,029 (72%)**

Frequency of Service Utilization by Region

Exhibits 6 and 7 describe adult mental health consumers who received services on an ongoing basis between 2004 and 2007. The length and consistency of service represents only one of many ways to measure utilization.

Frequency of utilization is another important metric for understanding service patterns. During 2007, 83,487 adults received over 1.4 million hours of public outpatient mental health services in Washington State. Statewide, half of all service hours recorded were provided to about 5,500 adults (Exhibit 8). In other words, *6 to 7 percent of all clients used half of all outpatient service hours in 2007*. At the RSN level, between 3 and 12 percent of all adult clients accounted for half of the outpatient service hours.

Clearly, the bulk of outpatient service hours are focused on a small percentage of the total outpatient population. Regional demographics, provider reimbursement structures, and service priorities can all play a role in how mental health services are delivered within a region. Eligibility for services and client retention can also impact service dynamics.

In looking at usage patterns, we are not attempting to make an assessment about the *adequacy* of services provided. As noted in previous reports, it may be appropriate and necessary for certain consumers to receive ongoing or frequent treatment. By looking at usage in this manner, however, we can focus future analyses on subgroups of clients. Future reports, for example, will determine how often frequent utilizers of mental health services use other services, such as emergency rooms.

Exhibit 8

Frequent Utilizers of Outpatient Public Mental Health Services (2007)

Regional Support Network	Total Outpatient Service Hours	Total Adults Served	Number of Adults Who Accounted for Half (50%) of All Service Hours	Percentage of Adults Who Accounted for Half (50%) of All Service Hours
Chelan/Douglas	14,653	1,268	146	11.5%
Clark	91,804	4,471	463	10.6%
Grays Harbor	17,600	1,514	133	8.8%
Greater Columbia	107,927	10,605	785	7.4%
King	552,942	22,674	1,194	5.3%
North Central	36,535	2,549	221	8.7%
North Sound	116,304	9,931	1,080	10.9%
Peninsula	131,167	6,094	190	3.1%
Pierce	113,000	9,853	798	8.1%
Southwest	32,674	3,503	411	11.7%
Spokane	99,184	6,244	662	10.4%
Thurston/Mason	60,762	4,319	248	5.7%
Timberland	38,368	2,369	169	7.1%
State Total	**1,412,921**	**83,487**	**5,495**	**6.6%**

Note: Outpatient hours *do not* include services billed on a per-diem (daily) basis.

Distribution of Service Hours by Region

Exhibit 9 displays the distribution of service hours for adults receiving outpatient services in 2007. As noted earlier, in 2004, changes to Medicaid guidelines restricted the service modalities that could be provided to public mental health clients with federal dollars. To receive Medicaid-funded services, clients must meet eligibility criteria and be engaged in one of the Medicaid "state plan" services. Statewide, nearly 90 percent of all hours were recorded as approved Medicaid ongoing outpatient services.[12] King County RSN had the highest percentage of hours (93 percent) spent on outpatient treatment under the Medicaid state plan services.

Intake and crisis services are still provided to all individuals regardless of eligibility. Intake and crisis services accounted for 9 percent of recorded hours.[13] Intake hours accounted for a greater percentage of activity in Chelan-Douglas, Grays Harbor, Greater Columbia, and Southwest RSNs. This could be explained by a number of factors, including a lower outpatient retention rate or fewer clients eligible for services. Greater Columbia (Yakima), Pierce, and Spokane offer crisis stabilization centers where individuals at risk of hospitalization may receive short-term crisis services and treatment.[14] In these RSNs, crisis services represent 8 to 14 percent of all service hours.

Exhibit 9
Distribution of Outpatient Service Hours (2007)

Regional Support Network	Total Outpatient Service Hours	Total Hours for Ongoing Services (Medicaid Approved)	Total Hours for Crisis Services	Total Hours for Intake
Chelan-Douglas	14,884	11,968 (82%)	1,254 (9%)	1,420 (10%)
Clark	91,951	81,544 (89%)	4,947 (5%)	4,448 (5%)
Grays Harbor	17,797	15,001 (85%)	1,120 (6%)	1,472 (8%)
Greater Columbia	108,207	86,521 (80%)	8,838 (8%)	8,290 (8%)
King	553,311	516,219 (93%)	6,407 (1%)	17,341 (3%)
North Central	36,766	32,993 (90%)	1,940 (5%)	1,265 (3%)
North Sound	116,378	95,978 (83%)	1,769 (2%)	7,334 (6%)
Peninsula	131,553	119,223 (91%)	7,777 (6%)	3,552 (3%)
Pierce	103,142	92,562 (82%)	15,511 (14%)	4,267 (4%)
Southwest	32,684	26,264 (80%)	2,035 (6%)	3,211 (10%)
Spokane	90,585	84,023 (85%)	9,308 (9%)	5,408 (5%)
Thurston-Mason	64,567	53,141 (87%)	3,604 (6%)	3,154 (5%)
Timberland	38,736	35,010 (91%)	1,569 (4%)	1,782 (5%)
State Total	**1,400,562**	**1,250,445 (89%)**	**66,080 (5%)**	**62,944 (4%)**

[12] These services include Brief Intervention Treatment, Clubhouse, Day Support, Family Treatment, Group Treatment Services, High Intensity Treatment, Individual Treatment Services, Medication Management/Monitoring, Peer Support, Psychological Assessment, Rehabilitation Case Management, Respite Care Services, Special Population Evaluation, Stabilization Services, Supported Employment, Therapeutic Psychoeducation. For modality definitions, see: <http://www1.dshs.wa.gov/pdf/hrsa/mh/medicaid_state_plan_ modalities_&_b3_service_ modalities.pdf>

[13] Other services, including Community Transition, Engagement and Outreach, Interpreter Services, Transportation, Supported Housing, Hearing for Involuntary Treatment, Involuntary Treatment Investigation, and Co-occurring Treatment constitute 3 percent of all service hours statewide but are not displayed.

[14] Individuals can remain in a crisis center for a period up to 24 hours (12 hours in Yakima). Since these services cannot be differentiated from other crisis services using administrative data, crisis hours were truncated at 4 hours for comparison purposes.

Washington's Mental Health Expenditures

Exhibit 11 displays state expenditures for Fiscal Year 2007 in each Washington State Regional Support Network. During this year, RSNs spent $405 million on outpatient services, residential and inpatient treatment, and other programs (e.g., crisis services and involuntary treatment). Approximately half of all expenditures involved crisis intervention or Medicaid-approved (state plan) services. These outpatient state plan service modalities are described on the previous page.

Direct RSN administrative costs accounted for 4 percent of all expenditures in 2007, while service support costs added another 13 percent. RSNs in primarily rural areas tended to have higher than average administrative and direct service support costs as a percentage of all expenditures. (Category definitions are presented in Exhibit 10.)

Inpatient treatment (community hospital, evaluation and treatment facilities, and residential) makes up nearly a quarter of all expenditures. The next section describes capacity and service issues in the state's inpatient treatment system.

Exhibit 10
Expenditure Category Detail

Administrative
- RSN Administrative
- Other Administrative Costs

Direct Service Support
- Crisis Telephone (Dedicated Hotline)
- Information Services
- Interpreter Services
- Ombudsman
- Public Education
- Transportation
- Utilization Management and Quality Assurance
- Other Direct Service Support Costs

Crisis
- Crisis Service

Outpatient—Medicaid Approved
- State Plan Outpatient Treatment
- State Plan Waiver Services ("B3 Waivers")

Other Direct Service
- Crisis Integrated System Pilot Project
- Dangerous Mentally Ill Offender Project
- Expanding Community Services Project
- Federal Block Grant
- Jail Services
- Liquidated Damages
- Medicaid Personal Care
- Partners in Action for Teens Health
- Program for Active Community Treatment (PACT)

Involuntary Treatment—Commitment & Judicial
- ITA Judicial
- ITA Commitment Services

E&T (Freestanding and IMD)
- E&T (Freestanding Evaluation and Treatment)
- E&T (Institution for Mental Disease—IMD)

Inpatient
- Inpatient Treatment
- Hospital (Provided by MHD)
- Hospital Reimbursement (Western and Eastern State Hospitals)
- Inpatient (18 Month Adjustment)
- Inpatient (Month of Payment)
- CLIP (Children's Long Term In-Patient)

Residential
- Mental Health Residential Treatment
- Other Direct Service Costs (Residential)

Exhibit 11

Fiscal Year 2007 Mental Health Expenditures by RSN

Regional Support Network	Administrative	Direct Service Support	Crisis	Outpatient—Medicaid Approved	Other Direct Service	Involuntary Treatment (Commitment & Judicial)	E&T (Freestanding and IMD)	Inpatient	Residential	Total
Chelan/ Douglas	$408,739 (8%)	$1,276,700 (24%)	$338,590 (6%)	$2,904,997 (54%)	$76,306 (1%)	$95,105 (2%)	$0 (0%)	$147,158 (3%)	$130,406 (2%)	$5,378,003
Clark	$1,559,035 (7%)	$2,659,676 (11%)	$2,364,232 (10%)	$11,343,623 (48%)	$941,426 (4%)	$21,400 (0%)	$1,744,674 (7%)	$1,404,448 (6%)	$1,383,031 (6%)	$23,421,546
Grays Harbor	$258,586 (4%)	$691,971 (11%)	$656,583 (11%)	$3,192,485 (53%)	$100,827 (2%)	$107,477 (2%)	$312,063 (5%)	$614,877 (10%)	$98,304 (2%)	$6,033,172
Greater Columbia	$1,413,550 (3%)	$4,565,635 (10%)	$3,393,330 (7%)	$26,979,552 (58%)	$2,105,167 (5%)	$595,794 (1%)	$0 (0%)	$3,717,664 (8%)	$3,729,847 (8%)	$46,500,539
King	$2,534,201 (2%)	$13,442,697 (12%)	$6,408,802 (6%)	$49,389,795 (45%)	$5,593,025 (5%)	$2,808,414 (3%)	$7,966,245 (7%)	$14,961,096 (14%)	$6,997,604 (6%)	$110,101,879
North Central	$329,746 (2%)	$4,944,222 (27%)	$1,818,007 (10%)	$9,774,625 (54%)	$195,274 (1%)	$127,292 (1%)	$0 (0%)	$634,211 (3%)	$383,998 (2%)	$18,207,373
North Sound	$2,007,378 (4%)	$10,296,827 (19%)	$4,668,051 (9%)	$17,517,795 (33%)	$4,255,677 (8%)	$1,537,582 (3%)	$4,436,896 (8%)	$6,376,690 (12%)	$2,235,819 (4%)	$53,332,713
Peninsula	$581,834 (3%)	$2,796,007 (12%)	$2,054,003 (9%)	$11,003,353 (49%)	$498,271 (2%)	$197,642 (1%)	$3,800,770 (17%)	$187,031 (1%)	$1,260,454 (6%)	$22,379,364
Pierce	$2,902,043 (6%)	$5,862,678 (12%)	$4,653,304 (10%)	$17,668,291 (37%)	$2,376,832 (5%)	$2,092,855 (4%)	$5,568,760 (12%)	$1,350,731 (3%)	$5,308,293 (11%)	$47,783,788
Southwest	$93,050 (1%)	$617,742 (8%)	$497,824 (6%)	$5,081,247 (66%)	$363,742 (5%)	$45,220 (1%)	$0 (0%)	$458,759 (6%)	$522,927 (7%)	$7,680,509
Spokane	$3,131,595 (9%)	$1,671,431 (5%)	$3,838,016 (11%)	$18,499,991 (51%)	$851,391 (2%)	$457,803 (1%)	$0 (0%)	$2,931,397 (8%)	$5,038,024 (14%)	$36,419,649
Thurston/ Mason	$333,829 (2%)	$1,559,183 (8%)	$2,982,287 (15%)	$7,725,167 (38%)	$1,196,606 (6%)	$516,189 (3%)	$3,108,265 (15%)	$2,583,631 (13%)	$172,462 (1%)	$20,177,619
Timberlands	$314,932 (4%)	$1,076,033 (14%)	$1,299,516 (17%)	$4,179,039 (54%)	$214,734 (3%)	$30,587 (0%)	$0 (0%)	$621,555 (8%)	$0 (0%)	$7,736,396
State Total	**$15,868,516 (4%)**	**$51,460,802 (13%)**	**$34,972,544 (9%)**	**$185,259,959 (46%)**	**$18,769,278 (5%)**	**$8,633,360 (2%)**	**$26,937,673 (7%)**	**$35,989,247 (9%)**	**$27,261,170 (7%)**	**$405,152,550**

Note: Local expenditures not included.

Source: Regional Support Networks Revenue and Expenditure Reports (FY2007).

RSN Use of Inpatient Treatment and State Hospitals

In Washington State, 24 community hospitals provide inpatient mental health services. Of these hospitals, 13 are certified to accept individuals detained under Washington's Involuntary Treatment Act. Typically, a Community Designated Mental Health Professional (CDMHP) conducts an evaluation in an emergency room, clinic, jail, or other setting to determine if the individual presents a significant danger to him/herself or others and should be involuntarily admitted to a community hospital or freestanding evaluation and treatment (E&T) facility.[15] An involuntary treatment admission can last up to 17 days in an inpatient hospital setting.[16]

Exhibit 12 shows available inpatient beds for psychiatric admissions in each RSN. In 2008, 57 percent of the 647 available inpatient beds were certified to accept involuntary admissions. RSNs also oversee freestanding evaluation and treatment facilities that include 182 beds and accept involuntary detentions.

Unfortunately, detailed data on involuntary treatment admissions in community hospitals are not verifiable at the regional level.[17] The availability and utilization of inpatient psychiatric beds, however, represents an area of concern for policy makers, administrators, and community professionals.[18] Future research in this series will consider inpatient admissions and involuntary treatment in more detail.

Exhibit 12
Inpatient Mental Health Beds in Community Hospitals and Evaluation and Treatment Facilities (2008)

Regional Support Network	Inpatient Psychiatric Beds (Voluntary Admissions Only)	Inpatient Psychiatric Beds (Certified for Involuntary Admissions)	Freestanding Evaluation and Treatment Facility Beds
Chelan/Douglas	0	0	0
Clark	16	0	12
Grays Harbor	0	0	0
Greater Columbia	0	48	0
King	214	168	69
North Central	0	0	0
North Sound	0	61	31
Peninsula	12	0	25
Pierce	16	0	30
Southwest	0	22	0
Spokane	0	72	0
Thurston/Mason	18	0	15
Timberlands	0	0	0
State Total	**276**	**371**	**182**

Source: Washington State Hospital Association and reported figures from Regional Support Networks.

[15] There are seven freestanding evaluation and treatment facilities throughout Western Washington (Navos–formerly Highline West Seattle E&T Center, Pierce County E&T, Hotel Hope, Kitsap E&T Center, Thurston/Mason Evaluation and Treatment Facility, Snohomish County E&T, and Skagit County E&T).

[16] RCW 71.05

[17] For more information, see TriWest Group. (2007). *Statewide Transformation Initiative Involuntary Treatment Act (ITA) Review*. Seattle: Author. P. 14. <http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_ita_final_report_2008_01_17_final.pdf>

[18] C. Smith. (2008, Oct. 9). Task force recommends changes to state's involuntary commitment laws system is faulted in Capitol Hill killing. *The Seattle Post-Intelligencer,* p. B1.

State Hospitals

The state of Washington owns and operates two long-term psychiatric hospitals for adults with acute and chronic mental illness.

Eastern State Hospital (ESH), located in Medical Lake, Washington, serves clients from four RSNs. ESH has a capacity of 319 patients and maintains an annual budget of $57 million (FY 2007).

Western State Hospital (WSH) in Lakewood, Washington, was founded in 1871 and is the largest state-run psychiatric hospital in the western United States. WSH receives clients from nine RSNs and can serve approximately 1,000 patients. The hospital has an annual budget of $155 million (FY 2007).

The state Mental Health Division assumes budgetary responsibility for these two psychiatric hospitals. Legislation in 2006[19] required the RSNs to agree on an allotment of state hospital beds for each RSN. If an RSN exceeds this bed allocation, they must pay the costs of admitting additional patients to the state hospital.[20]

In 2007, the number of beds allocated for use by RSNs was 222 per day at Eastern State Hospital and 777 per day at Western State Hospital.[21] Exhibit 13 displays the RSN allocation for beds at the state hospitals. At Western State Hospital, King, North Sound, and Pierce RSNs maintain three-quarters (77 percent) of the overall bed allocation. Spokane RSN has nearly one-half of the beds at Eastern State Hospital allocated. Exhibit 13 also displays the average daily census for each RSN.

Exhibit 13
State Hospital Bed Allocation and Average Daily Census (Non-Forensic Adults 2007)

Regional Support Network	2007 RSN Allocation	Average Daily Census
Chelan/Douglas	13	9
Greater Columbia	76	59
North Central	32	26
Spokane	101	102
Eastern State Hospital	**222**	**189**
Clark	46	34
Grays Harbor	10	5
King	287	245
North Sound	145	117
Peninsula	44	28
Pierce	173	141
Southwest	16	10
Thurston/Mason	42	35
Timberland	14	10
Western State Hospital	**777**	**617**

Note: Monthly bed allotment as of July 1, 2007.

Overall, Western and Eastern State Hospitals served 2,055 adults in 2007 (Exhibit 14). During this year, there were 1,533 admissions at these two hospitals. King, North Sound, and Pierce RSNs have the greatest share of responsibility for patients in the state hospitals.

[19] 2SSB 6793, Section 107, Chapter 333, Laws of 2006.
[20] The rate of payment for reimbursement for Eastern State Hospital is $550 per day. The rate of payment for reimbursement for Western State hospital is $452 per day. This reimbursement is distributed to the state and among RSNs that do not exceed allocated state hospital bed days.
[21] Non-forensic allocation

Exhibit 14
State Hospital Admissions and Adults Served (2007)

Regional Support Network	Number of Admissions (2007)	Adults Served
Chelan/Douglas	34	32
Greater Columbia	184	208
North Central	119	119
Spokane	345	370
Eastern State Hospital	**682**	**727**
Clark	36	69
Grays Harbor	11	17
King	293	503
North Sound	172	239
Peninsula	55	79
Pierce	216	313
Southwest	8	22
Thurston/Mason	42	75
Timberland	18	26
Western State Hospital	**851**	**1,332**
State Total	**1,533**	**2,055**

Statewide and Regional Initiatives in Public Mental Health

Program of Assertive Community Treatment

The Washington State Legislature approved targets (proposed by the Division of Mental Health) to reduce the utilization of state hospital beds by the end of 2009. One of the strategies for reducing reliance on state hospital beds and promoting community-based alternatives includes a program of intense services for individuals with severe symptoms and impairments.

The Program of Assertive Community Treatment (PACT) was developed nearly 30 years ago, and has been implemented across the United States and several other countries.[22] In 2006, MHD made a commitment to start this program in Washington State.[23] According to the adopted program standards, PACT is a "person-centered recovery oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefitted from traditional outpatient programs."[24]

PACT is a program based on teams of qualified professionals working together to provide ongoing treatment and support in a community setting.[25] Services are available around the clock and are designed with a low staff to client ratio. Admission to PACT is targeted to individuals who have:

- A severe and persistent mental illness
- Difficulty maintaining employment and housing or meeting other daily living needs
- A high use of inpatient services, emergency room admissions, or criminal justice involvement

A PACT team includes a psychiatrist, registered nurse, peer specialist, mental health professional, chemical dependency and vocational specialist, program assistant, and team leader. By October 2007, ten PACT teams had been hired, trained, and assigned to work with high-needs consumers in Washington. The following regions are currently being served:

Full Teams
- ✓ Greater Columbia
- ✓ King (2 teams)
- ✓ North Sound
- ✓ Pierce
- ✓ Spokane

Partial Teams
- ✓ Chelan
- ✓ Clark
- ✓ Peninsula
- ✓ Thurston

In state fiscal years 2008–09, $16.9 million per year was allocated for ongoing operations of the new PACT teams. The implementation of PACT teams is expected to result in an average daily reduction of 120 to 160 state hospital beds by 2009.

[22] See <http://www.actassociation.org/> for more information.
[23] <http://www1.dshs.wa.gov/mentalhealth/sti_taskforce.shtml>
[24] <http://www1.dshs.wa.gov/mentalhealth/sti_pact.shtml>
[25] <http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=50248>

Evidence-Based Practices

Several initiatives within Washington's public mental health system have encouraged and promoted the usage of "evidence-based practices" (EBPs). Previous laws passed by the Washington State Legislature have defined an EBP as a "program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population."[26]

In 2007, the Washington Institute for Mental Health Research and Training–West created an inventory of mental health evidence-based practices from research sources. Using this inventory, a survey was developed and administered to identify mental health EBP utilization in Washington State's social and health service system.[27]

Among mental health providers surveyed (n=96, 62 percent), the most common evidence-based practices reported included:

- Cognitive Behavioral Therapy (CBT)
- Medication Management
- Motivational Interviewing
- Dialectical Behavioral Therapy (DBT)

Unfortunately, data reported by mental health providers to the state do not permit a close examination of these evidence-based approaches. In addition, the reported fidelity, or close adherence, to program practices for these EBPs varies considerably among mental health providers. In the 2007 survey, 43 percent of the agencies stated that they assessed or monitored program fidelity for the EBPs offered.[28] The report did not include the extent to which program fidelity was assessed by external reviewers.

In a 2007 review of Washington State's mental health benefits and services, the TriWest Group recommended that the Mental Health Division prioritize the following evidence-based practices for statewide implementation with adult populations:[29]

1) *Collaborative Care*—for populations (usually older adults) more effectively served in a primary care setting[30]
2) *Integrated Dual Disorder Treatment*—providing treatment in one setting for people who have co-occurring disorders: mental illness and a substance abuse addiction[31]
3) *Peer Support*—services provided through a non-licensed but certified individual who advocates, supports, and assists mental health clients[32]

These recommended services, and most of the other evidence-based practices identified in the 2007 studies cited here, are not recorded in a consistent and uniform manner across the RSNs. Statewide efforts to introduce and support specific evidence-based treatment programs should be accompanied by data protocols that allow the tracking and comparison of outcomes for participants.

Regional differences, such as those outlined in this paper, may also provide conditions and settings where certain evidence-based practices can show the greatest promise.

[26] E2SSB 5763, Chapter 504, Laws of 2005

[27] <http://www.mhtransformation.wa.gov/pdf/mhtg/EBPs_in_WA_with_Appendices.pdf>

[28] Since there was no independent review of the extent and quality of EBP implementation, this estimate should be viewed with caution.

[29] The selection criteria included a unit cost calculation and the "documented potential to reduce inappropriate use of restrictive services, promote cross-system integration, support culturally relevant and competent care, and facilitate recovery." See TriWest Group. (2007). *Statewide Transformation Initiative Mental Health Benefit Package Design*. Seattle: Author. <http://www1.dshs.wa.gov/pdf/hrsa/mh/sti_benefit_design_final_2008_01_23_execsummaryfinal.pdf>

[30] <http://impact-uw.org/>

[31] <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

[32] <http://www.azdhs.gov/bhs/tr_resources/psp_training.htm>

Conclusion

In the last five years, services and eligibility for the state's mental health system have changed considerably. While funding levels and access guidelines are set at the federal and state levels, programs and treatment approaches are overseen by 13 Regional Support Networks and delivered by contracted local providers. All available evidence indicates that the prevalence of mental illness does not differ dramatically across these regions. Consumer profiles and service patterns, however, vary considerably.

The larger, more urban RSNs tend to have a higher percentage of clients who receive ongoing or regular care, and have a greater emphasis on outpatient treatment. Several regions operate crisis stabilization (triage) centers that work with law enforcement and emergency rooms to respond to emergency mental health situations. The mix of services and approaches will be important to consider as outcomes are examined and assessed.

As the state's mental health system begins to implement new treatment strategies and expand outcome tracking, regional needs, differences, and priorities should be considered carefully. Future reports in this series will look at outcomes in the context of local variations to help determine which areas and approaches are achieving the results that can serve as models for other regions.

For further information, contact Mason Burley at
(360) 528-1645 or mason@wsipp.wa.gov

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