Whatcom County Behavioral Health Facility Planning Report:

Envisioning a new Substance Use Disorder Continuum of Care

(June 1, 2016)

PUBLIC HEALTH
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Executive Summary

This report was created for the purpose of informing the North Sound Behavioral Health Organization (BHO) of the existing and future behavioral health service needs in Whatcom County. The particular focus of this report is on treatment facilities. In June of 2018, in-patient and residential Substance Use Disorder (SUD) treatment beds currently located in Sedro Woolley will need to be relocated throughout the region. The facility's lease will terminate at that time. Whatcom County has engaged in an assessment process to determine local needs for these services, in conjunction with regional planning with our four county partners (Island, San Juan, Snohomish and Skagit) and the North Sound BHO.

Recent needs assessments and stakeholder meeting recommendations are a component of the report. The report facilitates a further understanding of the current needs in both substance use disorder treatment and mental health treatment services comprising the behavioral health continuum of care in the county. Many of the needs assessments and stakeholder conclusions resulted in similar findings.

A summary of the findings includes gaps in the county's triage facility capacity and the level of service in both the detox unit and the mental health crisis stabilization unit. Additional findings include the need for local substance use disorder residential treatment facilities and an expansion of medication assisted treatment with physicians willing to prescribe. Finally, identified needs for ongoing recovery support services in the community are outlined including, but not limited to the following,

- recovery house treatment,
- outpatient program capacity,
- staff monitored housing for residents in recovery, and
- an increased quantity of well-trained behavioral health professionals.

More specifically, recommendations of the Crisis Triage center include two 16-bed units joined in one building off a common foyer and intake space, but separately licensed to effectively establish a ***Recovery Stabilization Facility***. One unit should be certified as a voluntary ***Crisis Triage Program*** to receive persons in mental health crisis and another should be an ***Addiction Stabilization Center*** that is licensed for acute substance use withdrawal. This Center will also serve as a site to initiate medication assisted treatment, and ensure linkages to community providers for ongoing services. The addition of a potential nearby residential treatment program and the development of a ***Recovery House*** level of care, affirm the possibility of a ***Recovery Campus*** with patient care ranging from medically monitored detox through outpatient care and into full long term recovery.

We look forward to working with our regional partners to build a comprehensive system of treatment and recovery support services.

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1. Introduction

Over the last 10 years, many national policies and statewide changes have impacted the behavioral health treatment service system. Among those most prominent are, the implementation of the Affordable Care Act (ACA), the rising tide of opiate addiction, and the emphasis on reducing incarceration for people challenged with behavioral health issues. These three factors indicate the need to expand and enhance the behavioral health treatment delivery system in the North Sound region and in Whatcom County, especially the substance use disorder continuum of care. The standard "alcohol-based" treatment system is inadequate for dealing with complicated populations who may have any combination of the following conditions:

- serious mental illness,
- opioid addiction,
- complicated physical health issues, or
- criminogenic and antisocial attitudes and behaviors.

Washington State has approached the initial challenge of the ACA by developing nine (9) Behavioral Health Organizations (BHOs) representing nine (9) regions across the state. In addition to administering publicly funded mental health services, the BHOs began administering state and federal funds for all substance use disorder (SUD) services as of April 1, 2016. Prior to that date outpatient SUD services were administered by a statewide County system while inpatient SUD services were administered directly by the state. Public mental health services were previously administered by clusters of counties comprising Regional Support Networks (RSNs). Transitioning RSNs to BHOs was considered an intermediary step. By 2020 the state expects behavioral health services to be fully integrated with physical healthcare.

As our first steps, Whatcom County in partnership with North Sound Behavioral Health Organization (North Sound BHO) is committed to developing critical components of our SUD treatment continuum which do not currently exist or are under-represented in the community or the region. North Sound BHO's goals are to work toward replacement of the Pioneer Center North beds (144 beds) by 2018, and ultimately to understand the SUD residential needs and acute stabilization needs of Whatcom County citizens.

This report is focused on adding or enhancing withdrawal management services, residential treatment services, and ongoing care for people after discharge from detox or treatment services. Our overarching goal is to maximize the number of adults with SUDs who enter into long term recovery. The report will:

- outline and summarize recent Whatcom County needs assessments and stakeholder recommendations,
- synthesize and summarize the recommendations of our needs assessment activities,
- discuss the prevalence of SUDs in Whatcom County,
- apply utilization data for SUD withdrawal management services (detox), residential services, and outpatient treatment to determine capacity needs,
- make recommendations for recovery supports necessary to ensure success for Whatcom County's addicted citizens, in particular those which could be funded by local dollars, and
- provide a description of the future Whatcom County SUD system and a flow chart based on the evidence presented.

The increased complexity of our citizens needing SUD treatment requires a multipronged approach of integrated behavioral health and primary health care through the course of a person's recovery. In addition, expanded resources for ongoing aftercare (post-treatment) are an essential component of an effective and robust SUD service system. These approaches and the community recommendations are detailed in our community needs assessments.

2. Whatcom County Needs Assessments and Community Stakeholder Feedback

The following are short descriptions of needs assessments completed by the County or one of its community partners and recommendations from stakeholder meetings conducted, in the last two to three years. The key findings are summarized below.

1. *The Whatcom County Health Department (WCHD)* held a one day "Community Forum on Addiction" in 2014, after hearing major concerns within the community over the lack of SUD services. Attended by over 90 people from various disciplines, the forum included law enforcement, criminal justice, human services, medical, school, and other professionals. (November, 2014)
2. A partnership between PeaceHealth, WCHD, the Chuckanut Foundation, and the Whatcom Community Foundation addressed initial concerns stemming from the Community Forum on Addiction. Their combined efforts resulted in the Whatcom County *Community Health Assessment* (CHA) and *Community Health Improvement Plan* (CHIP). Both the CHA and CHIP identified significant concerns regarding behavioral health service gaps and made recommendations about enhancements for SUD care (Whatcom County Community Health Assessment and the Community Health Improvement Plan, 2012 – 2016).
3. The *Incarceration Prevention and Reduction Task Force* (IPRTF) was formed in 2015 by the Whatcom County Council to:
    - alleviate problems with overcrowding in the Whatcom County jail,
    - develop the triage facility, and to
    - develop more effective behavioral health treatment in the community as an alternative to jail.

    This Task Force includes over 30 members from every sector of criminal justice (CJ), law enforcement and provider communities, as well as members who have been personally impacted by the criminal justice system. The Task Force has three (3) ad-hoc committees: Triage, Behavioral Health Alternatives to Jail, and Justice Alternatives to Jail. Recently, the Task Force produced a "Phase One Report" with recommendations regarding behavioral health services and Whatcom County triage facility. (February 2016, Phase 1 Report, "Phase 2 Report" due November, 2016.)
4. The *Behavioral Health Advisory Board (BHAB*) is comprised of advocates of mental health, substance use disorders, and professionals with knowledge of behavioral health issues. BHAB provides advice on general policy issues and service priorities. This board meets to offer input on a bi-monthly basis.
5. The *Behavioral Health Revenue Advisory Committee (BHRAC)* has a similar arrangement as the BHAB, but guides budget and service priorities for the local 1/10th of 1% sales tax funding. This board meets and makes recommendations on a quarterly basis.

    The *Whatcom County Substance Abuse Program* developed a "Substance Use Disorder Needs Assessment Plan". The plan was submitted to the state for the two year period of 2014-2016 and clearly identifies the need for residential services in the county. The plan included a survey of gaps and community needs. This plan focused on the lack of a SUD workforce and the inadequate compensation provided by the state for SUD outpatient services. (Final Report, 2014.)
6. *Whatcom Alliance for Health Advancement (WAHA)* completed a Needs Assessment in 2016 which focused on the entire Prevention, Intervention, Treatment and Aftercare (PITA) continuum. The PITA continuum was created and promoted several years ago by Institute of Medicine (IOM) as the model for SUD continuum of care. (Substance Abuse Treatment Project, Phase I Report, December 2015)

7. The Local *Crisis Oversight Committee* is a group of community stakeholders and treatment service providers who meet regularly to identify and address crisis service system issues, gaps and needs. The focus of this committee is on behavioral health services, housing, homelessness, and SUD treatment.
8. The local *Homeless Coalition* is a group of housing and community service partners, as well as homeless advocates who meet on a regular basis. This group regularly provides feedback regarding gaps in the SUD service system where the gaps pertain to homelessness.
9. Employees and Board Members of the *Chuckanut Health Foundation,* which invests resources to advance community health, engaged the County in assessing the need for small or short term SUD related projects for potential funding. (Final report has been finalized, but not yet distributed.)

The combined challenges and recommendations of the needs assessments conducted to date reflect directly on the issue of residential services and are summarized below.

3. Recommendations from Needs Assessments and Community Stakeholder Input

Each community meeting or needs assessment report describes similar gaps and needs in the Whatcom County SUD service, particularly in regard to residential services and recovery supports for publicly funded clients with complex needs. The specific needs and gaps identified are summarized as follows:

1. We need a comprehensive, robust, and effective SUD system of care which is oriented towards principles of long term recovery.
2. We need to develop effective options to divert people with SUD from hospitals and the local justice system.
3. There is a lack of effective residential treatment service options in the community, especially services for complicated populations such as people with co-occurring disorders, people with intractable and challenging addictions (opiates), and people with criminogenic and antisocial thinking and attitudes.
4. There is a lack of services and programs to assist people who are waiting for treatment admission, including interim housing for those waiting to enter residential treatment.
5. There are inadequate outpatient treatment options to transition people with SUD upon discharge from residential services or as a primary intervention in lieu of a higher level of care.
6. There is a lack of recovery housing, and stable supported housing. People who cannot function independently risk losing their housing if there is no stable support and daily structure. This lack of housing includes “Clean and Sober Housing” which many think should be regulated. There is inadequate housing available for people who are not ready to commit to SUD treatment or who need non-traditional approaches to SUD treatment services.
7. The eight (8) detox beds at the triage facility are not sufficient for the community need.
8. There is a lack of mental health crisis stabilization beds in Whatcom County.
9. The SUD workforce capacity in the county is inadequate and professionals lack the training necessary for the complexity of the population.
10. There is insufficient medication assisted treatment (MAT) options. There is inadequate supply of prescribers and little case management support to ensure coordinated care. There is no centralized infrastructure for MAT treatment. Physicians have little incentive to become certified as buprenorphine providers and those who are certified are reluctant to engage this population without more training.

While needs assessments provide the qualitative information to inform our decisions, the qualitative processes used in the assessment of SUD needs are supported by prevalence data and data on utilization of existing services. We begin our analysis by reviewing the data as to how widespread SUD is within our community; including the extent of the incidence of SUD is within the local jail.

4. DATA

Data regarding the prevalence of SUD as well as the utilization of services offers a small glimpse into the need for SUD treatment in Whatcom County. There are several state published reports from DSHS, and SUD service utilization is recorded by the Treatment and Report Generating Tool (TARGET) and System for Communicating Outcomes, Performance, and Evaluation (SCOPE).

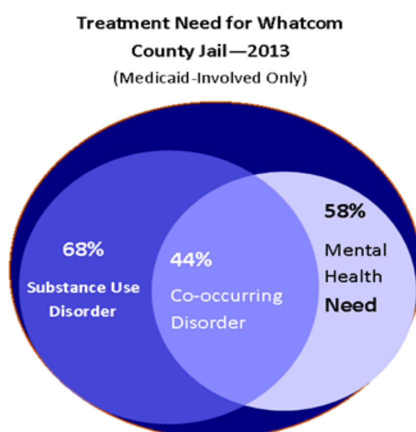
A. Prevalence of SUD in Whatcom County

Two recent reports from Washington State Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) estimate the prevalence of SUD in the community at large and in the jail population for Whatcom County.

In the first DSHS report, Whatcom County ranks as the second highest county in the state for estimated need of SUD treatment. This data is based on estimates for people at or below 200% of the federal poverty level (DSHS, May 2015). Estimates of the occurrence of SUD for the general adult Whatcom County population are 14.3% which is higher than the state average at 12.4% (DSHS, May 2015). For the youth population, the estimate of need is 7.7% which is higher than the statewide estimate of 6.9% (DSHS, May 2015). Historically, Whatcom County providers have provided adequate youth treatment sufficient to meet the demand for services.

In 2014, the United States Census Bureau estimated the County population to be 208,531 people. If we apply the 14.3% figure from the DSHS report above means that nearly 30,000 Whatcom County residents on Medicaid may have had a need for SUD treatment. If 1628 people were actually served in the treatment system, a significant gap remains between those who needed treatment and those who were actually served. (SCOPE, 2014)

In the second report, DSHS provides convincing evidence of the prevalence of SUD in our jail. This report compared Medicaid recipients with SUD related jail bookings and determined the level of SUD, mental health (MH) and co-occurring disorders (COD) in jail inmates who received previous Medicaid services over the last 5 years in 2013 (DSHS, January 2016). See the figures below for the results. (1A)



A recent report from RDA indicates the incidence of SUD in the Whatcom County Jail Medicaid population for 2013 was 68%. The percentage of inmates with co-occurring SUD and mental health disorders is 44%. Since the data was constructed around those inmates who had any DSHS Medicaid service in the last 5 years (86% of inmates), the actual incidence of SUD and COD is likely to be higher. (821 people have SUD; of those, 521 people have COD, 290 have SUD only, and 170 have MH only.)

Prevalence data for the general population along with the jail inmate data and opioid use disorder admissions clearly support the need for a robust SUD treatment delivery system. Past indicators suggest that Whatcom County had both a high need for adult treatment services in all levels of care and a low treatment penetration rate.

B. Utilization of SUD Treatment (2015)

It's unknown exactly how many people would attend SUD treatment voluntarily, but with approximately 1906 SUD treatment admissions in Whatcom County in 2015, and a total of 1715 served, we are barely scratching the surface of the estimated SUD need for any type of service. When compared with the number of people who might be in need of and eligible for services, the need for SUD treatment far exceeds the capacity. Other issues impacting our capacity relate to the growing opioid use disorder (OUD) problem, the loss of SUD providers in the community, and the ACA expansion of Medicaid.

Whatcom County is ranked second highest in the state for opioid treatment admissions according to a recent report by the Alcohol and Drug Institute at the University of Washington (ADAI, April 2015). The ADAI also reports that Whatcom County ranked third highest in the state for crime lab cases involving opioids (ADAI, April 2015). The report confirms a growing opioid addiction problem which has yet to be adequately addressed.

Lastly, the wait time for admission to treatment at the largest outpatient provider in the county is currently four weeks. The wait time for admission at the only remaining outpatient provider is a minimum of 2 weeks. Treatment admission wait times have been consistently lengthy, especially since losing two of the four treatment agencies over the last five years. As a result of the implementation of the ACA and other variables, the need and demand for SUD treatment is high and capacity has diminished. The need for services and the demand for additional capacity are most obvious in our detoxification program.

5. WHATCOM COUNTY PROGRAM NEEDS

The County uses the Institute of Medicine's (IOM) Prevention, Intervention, Treatment, and Aftercare (PITA) model when assessing needs and when designing services. Most of the issues identified which are directly related to residential services for adults fall into the Intervention, Treatment, or Aftercare categories of PITA. Mental health stabilization and withdrawal stabilization services fit into intervention, while residential and outpatient services are clearly part of the treatment category. Programs supported by our local dollars are often overarching throughout the continuum of care (i.e. care coordination and housing) or they fit near the topic of aftercare in this document. Since our mental health stabilization program (triage) is embedded with our detoxification program, and both serve people with co-occurring disorders, we're including a discussion of triage as well.

A. Crisis Triage Program (CTP)

The Whatcom County Crisis Triage Program has a capacity of 5 beds designed to provide stabilization for people with acute psychiatric symptoms. The mental health triage program is located at the same facility as the Whatcom County detox program. These five (5) beds, which are increasingly well utilized, prevent psychiatric hospitalization and ensure smooth transitions for people exiting psychiatric hospitalization. WAHA conducted a one month survey which revealed that First Responder staff could have brought 59 people to the triage facility if there had been beds available (WAHA IPRTF Phase One Report, March 2016). Based on this information, increased capacity of 11.5 beds is easily justified for 5 day stays and community stakeholders estimate the need for additional beds is even higher. Many community professionals and First Responders appear reluctant to refer clients to the CTP having had several clients denied access due to a lack of bed space in the past.

Our local IPR Task Force recently made recommendations to County elected officials to increase the beds for both triage and detox. The final recommendations included two 16 bed units constructed on the current site. These recommendations were approved by the County Council on February 23, 2016. We also conducted a one month survey of people requesting detox services who were denied admission due to a lack of bed space. The history and data trends for detoxification and the results of the survey are discussed below.

B. Detoxification/Withdrawal Stabilization (Level 3.7-D):

History and Trends:

Whatcom Community Detox (WCD) is a sub-acute (social) detox model, as opposed to an acute or medical model. Detoxification and crisis services are considered "Intervention" services on the PITA continuum. Medical staffing is limited in the sub-acute model and Whatcom County detox data trends reflect the fact that we have incurred both a loss of beds and a simultaneous increased demand for services. Our detoxification program dropped from ten beds in 2003 to eight beds in 2005. Fewer people have been admitted to detox in recent years as staff have made strides to ensure that people were clinically stabilized prior to discharge. As a result, more bed days were utilized for existing patients, which made fewer beds available for new admissions. In addition, special medication assisted withdrawal protocols for opiate addiction, requiring extended stays for monitoring placed a premium on detox beds. In 2009, we introduced tapering for opioid use disorders (OUDs.) At that time, tapering was an inexpensive and appropriate response to a burgeoning opiate crisis.

WCD admissions have decreased since 2003 and decreased again in 2011 as shown by the graphs below (Figure 2A). The initial decrease in admissions and number of people served was directly related to the loss of beds (Figure 2B). The decrease in admissions in 2011 was due to increased lengths of stay after the introduction of the opiate tapering program.

Figure 2A

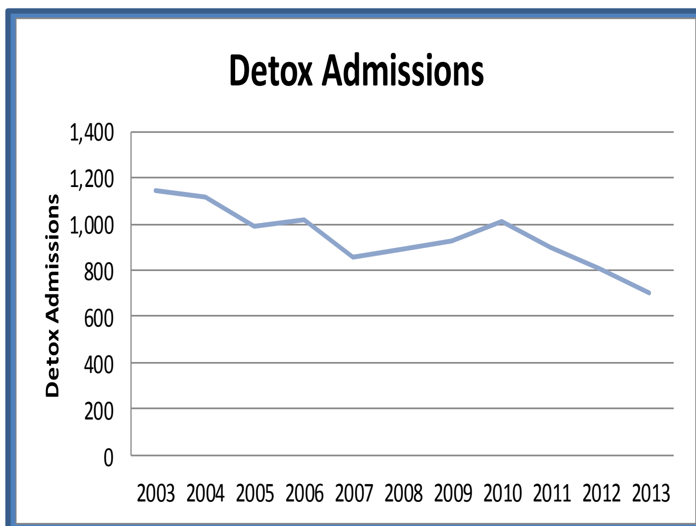
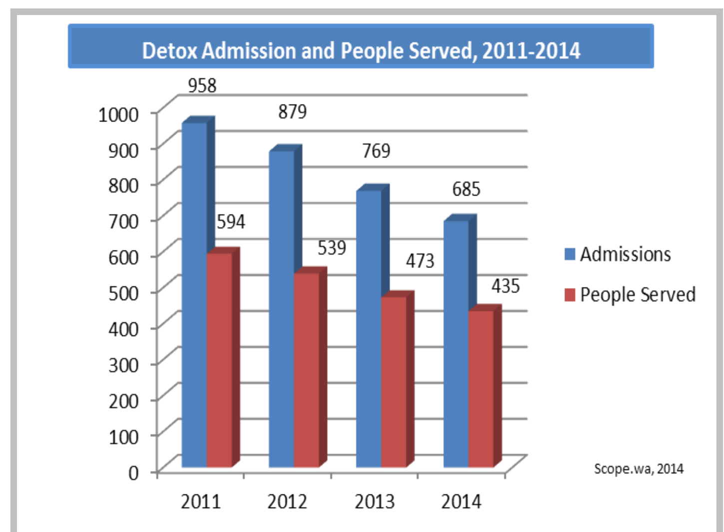


Figure 2B



In addition, clients admitted to detox often have a higher level of symptom acuity and co-occurring disorders than in previous years. Thus, medication assistance for withdrawal is a more frequent response made by our subacute detoxification and local hospital staff. Frequently, clients are transferred from one facility to the other in order to ensure appropriate medication administration. As soon as the medications are administered, and the client is stabilized, he/she is transferred to our subacute detox for further monitoring. Two years ago, PeaceHealth determined that the hospital could no longer provide medications to people discharging from the hospital's Emergency Department. This policy change resulted in the need for detox to dispatch a staff person to a pharmacy to secure

medication for clients entering detox from the Emergency Department. This "para-acute" detoxification system has evolved over time to meet the demand of uninsured people with severe alcohol withdrawal and a more complex drug addicted clientele.

Survey of Callers Requesting Detox Beds:

Over the last few years, the incidence of callers requesting detoxification services increased, indicating a greater demand than ever for detoxification services. We conducted a one month survey of calls related to detox admission denials to provide missing data regarding the need for additional beds and services.

In the month of March 2016, the Health Department verified a total of 120 calls from 86 people who called to attempt a detox admission but who were refused due to lack of beds. Out of those 86 people, 45 needed withdrawal services for either drugs or alcohol and drugs, while 41 people needed withdrawal from alcohol only. The distinction is important since the length of stay for Medicaid rules is 3 days for alcohol withdrawal and 5 days for drug withdrawal. Although detox stays are sometimes extended for clinical reasons, there is no way of determining which callers would have needed an extended stay once admitted. The same issue applies to detox as to MHT that, over time, people discontinue inquiries about bed space due to the consistent difficulty in obtaining an admission. Nevertheless, the number of people denied services due to a lack of beds was 86 as shown in the table below.

March Detox Data, 2016

Denials for No Bed	People	Males	Homelessness	Drug or both Alcohol and Drug	Alcohol
120	86	65	46	45	41

An additional 348 bed days is presumed to be needed to enhance our existing detox program. Self-referrals made up 65% of all referrals while 12% were referrals from the Emergency Department of PeaceHealth. The rest of the referrals were from family, friends, Bellingham Police Department, and other clinical programs.

We calculated the total bed days needed to ensure ample detox services for Whatcom County's future growth up to 2020. An estimate of 8% increase in population was used along with the figure of 85% full capacity for utilization. The 85% capacity figure is a standard used by the North Sound for residential facilities throughout the nation. See the table below.

Additional Beds Needed for Withdrawal Management

(Based on 2020 Population Growth)

	Bed days	Average Daily Census	85% Occupancy	Additional Beds Needed
Scope Admissions	314	10.1		
Denials	348	11.2		
2020 Population Growth at 8%	53			
Total	715	23.5	20	15

In order to effectively manage the current and projected needs for Whatcom County and the North Sound region, the detox facility will require additional beds. We need flexible space so that beds or chairs can be used depending on the withdrawal needs of the individual or on the person's decision to move forward in their recovery.

Future Considerations:

The primary goal of the facility is to ensure stabilization for people in behavioral health crisis. The secondary goal is to provide immediate services to people who are brought to the facility by first responders.

In support of these goals, it will be necessary to “re-tool” the model for our behavioral health services to include:

- the development of acute care services for withdrawal management,
- facilitation of quick turnaround drop offs for first responders,
- providing sobering chairs/beds, and
- possible expansion of space to conduct Substance Abuse Protective Custody (SAPC) services at the facility.

Our new design includes a Recovery Stabilization Facility (RSF) which will allow Whatcom County to ensure more effective services for our residents experiencing behavioral health crisis. Crisis Triage Program will gain more space and will incorporate the recovery model. This redesign will ultimately support the development of a Recovery Campus in Whatcom County. (Vandersloot, 2016)

Embedded in the Recovery Stabilization Facility (RSF), detoxification will become the Acute Stabilization Center (ASC). The primary goal of the ASC is to provide the first step in recovery to people with serious substance addictions. The new model will recognize both the local opioid epidemic and the seriousness of alcohol withdrawal (AW). While opioid withdrawal (OW) is rarely fatal, alcohol withdrawal (AW) can result in seizures and delirium tremens leading to unconsciousness and death for people. Treatment for withdrawal of this severity can only be conducted safely with medication. Treating both AW and OW with medication can lead to better outcomes.

The arrival of an epidemic of (OUDs) to our community and the young age of onset are alarming new trends. Given the high rate of drop out from detox due to the pain and discomfort of withdrawal, we must consider recent advances in medications as part of our withdrawal management protocol. These medications aim to reduce withdrawal discomfort and promote completion of the withdrawal protocol, thereby decreasing recidivism. Only in stabilizing the clientele physically can success be achieved in assisting them with the first step in their recovery. The increased availability of acute services will also increase first responder “drop-offs”. People who are dropped off at the facility will come with two levels of need; those who need sobering services and those who are ready to make a commitment to recovery.

Although the model we propose is recovery oriented, the facility should have one or two chairs for people who are unable to commit to or who refuse additional services. The chairs can be utilized for overflow and for people who are sobering up, but who do not wish to engage further in recovery services. Sobering chairs will assure facility capacity for intoxicated people transported by first responders regardless of the person’s commitment to long term recovery. Additional chairs should be considered for the CTP program as well.

Whatcom County ASC will initiate recovery for people who are in need of ongoing medication assisted treatment (MAT). MAT services will then be continued at an inpatient or outpatient setting or through a physician’s office, depending on client need. Whatcom County has been working with various clinics, medical partners, and providers to initiate supports to the MAT infrastructure and MAT prescribers in particular.

The prospect of continuing to provide withdrawal stabilization in the same facility as mental health (MH) stabilization is important. Mental Health issues are underrepresented in the SUD treatment system data and are often incorrectly diagnosed. The SUD professionals are not qualified to assess or treat mental health, and often fail to identify the presence of mental health issues when faced with continuous SUD relapse. The likelihood that mental health issues pose significant barriers to successful recovery is quite high.[3,9]

The new ASC should encompass space to conduct Substance Abuse Protective Custody (SAPC) 8-hour holds under RCW 70.96A.120, for people who are intoxicated and a danger to themselves or others. Whatcom County is the only county which utilizes the law for this service and the services have been in place for over 20 years. Currently the hospital provides space for Whatcom Community Detox to conduct holds in the Emergency Department.

The current facility was designed with two rooms to be used for Substance Abuse Protective Custody. These rooms were converted to office space after the Washington State Department of Health determined that there were no medical services on site. The law allows the designation of a chemical dependency specialist to conduct SAPC holds, in lieu of a peace officer. SAPC holds are a primary gateway to a secure detoxification facility for people with chronic SUD. (North Sound's future plans include the development of a secure detoxification facility). Sobering chairs should be considered for SAPC holds at the newly designed Addiction Stabilization Center.

Conclusion and Recommendations:

In conclusion, Whatcom County's primary goal of ensuring the first step toward recovery for people in behavioral health crisis, lends itself to renaming the facility as a "Recovery Stabilization Facility". The *Recovery Stabilization Facility* will be a key component of our *Recovery Campus*.

We should ensure sufficient capacity for both the CTP and the *Acute Stabilization Center* (ASC) within that facility. The County Executive and the County Council remain committed to ensuring a robust behavioral health crisis service system. Whatcom County has earmarked funding and is dedicated to siting a new facility for our behavioral health crisis services. We are committed to seeking additional capital funding from the state legislature and plan to remodel the current facility to include more beds and program space.

Specific recommendations include adding 11 beds to the CTP upon expansion of the facility, to a total of 16 beds. We will add an additional 13 beds plus two sobering chairs/beds to the ASC. The recommendation from the IPRTF was for an additional eight beds in the ASC. Those recommendations were made prior to the survey about the number of callers who were requesting services. The County should have further discussions with community stakeholders about whether the addition of five beds (over the eight already recommended by the IRPTF) or additional programming space would provide the maximal benefit to people entering recovery from the ASC.

We will redefine the services as medical services and establish new protocols for treating and stabilizing people in withdrawal to ensure seamless care for Whatcom County residents. First responders will be able to transport people in behavioral health crisis. The facility design will support a rapid turnaround for 10-minute drop offs. This change will maximize efficiency of First Responder personnel. The Whatcom County Recovery Stabilization Facility should be the first step to a person's ongoing recovery. It should provide services necessary to assist the individual with the next step of their recovery. Recovery is self-defined and has many pathways, but often a person leaving the ASC will be most appropriate for residential treatment. Residential treatment needs as described by our community partners and as confirmed by the data are described below.

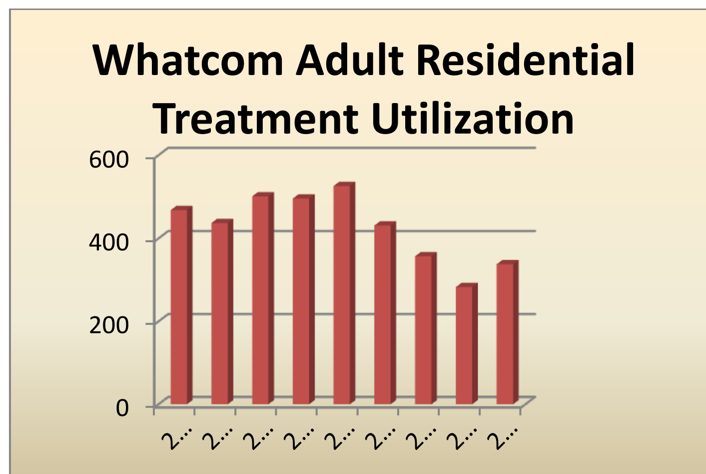
C. Residential Treatment (ASAM 3.7):

Although many people enter residential treatment without withdrawal services, residential services are often the next step in the PITA continuum for people suffering from SUDs. Approximately one third of all Whatcom County admissions to SUD treatment were for residential services over the last three years. The lack of local residential treatment programming has been repeatedly identified as a deficit by various community planning activities. We are limited to utilization data for identifying the extent of our residential need. We collected reports from SCOPE which included all residential services used by public funded county residents attending treatment at any facility in Washington State

(inpatient, recovery house, long term residential.) The SCOPE reports included admissions and the level of mental health need as indicated by client self-report.

The data shows 366 admissions with a total of 328 adults served over the last year. Although utilization of residential services by Whatcom County residents has fluctuated, since 2011 our utilization has decreased as shown by the chart below. This trend is likely related to ongoing reductions in funds for state sponsored SUD treatment, as well as the closure of several residential programs. Over the years, agencies have closed their doors due to reimbursement rates which were too low to cover the cost of operations.

Low rates of reimbursement were cited as a major reason for the two outpatient closures as well from 2012 to 2014. The combined result is that there are fewer Chemical Dependency Professionals (CDPs) completing assessments and facilitating placement to residential treatment. In 2015, Whatcom Community Detox began assessing people and assisting them with admissions, most of which were to residential treatment. Hence, there is a decline in residential admissions from 2011 to 2014 and a renewed increase in admissions by 2015 as shown in the chart below.



This data includes the two Whatcom County tribes (Lummi and Nooksack). The results indicate that 60% of the clients were male while 40% were female. The following table illustrates the projected 2020 residential bed demand using an estimated 8% population growth by the year 2020. This data is based on current utilization only.

Whatcom County Projected Residential Needs to 2020

	Intensive Inpatient	Long Term Care (LTC)	Recovery Home
Number of People Served	260	101	5
Avg Length of Stay	22 Days	42 Days*	N/A
Expected Length of Stay	Up to 30 days	Up to 60 days	Up to 180 days
Total bed days Needed	7800	6060	N/A
At 8% Population Growth	8424	6545	N/A
Total Projected Bed Need	281 beds	109 beds	N/A
Number of Beds Filled at 80% Occupancy	224 must be consistently filled	87 beds must be consistently filled	N/A

* Based on PCN data

Co-occurrence of SUD and MH in Residential:

It proved to be difficult to determine the statistical need for co-occurring disorder (COD) services amongst those who received residential services with the available data. One report indicated that between 50% and 60% of clients admitted to residential services stated that they had a self-described moderate, considerable, or extreme problem in need of psychiatric care. In other data, clients indicated that they had, within 30 days prior to admission to SUD residential treatment, experienced 15 or more poor mental health (MH) days.

This data was compared to outpatient treatment admissions for consistency. Approximately 50% of clients reported a score of three or above for externalizing or internalizing mental health symptoms (SCOPE, 2016). This data is a little higher than national estimates that 35-43% of adults, depending on age, who have an SUD also have a mental health disorder. (SAMHSA, 2014) Other research, however, estimates the prevalence of MH in people with SUD as between 25% and 50% (Stirling, S., et. al., 2011). The higher number is assumed here because it's consistent with self-reports by clients and anecdotal reports relayed by agencies.

In addition, recent research indicates that females in SUD treatment who have certain comorbid Major Depressive Disorder (MDD) are more than twice as likely to have *drug use disorder*, than those females without an MDD. Both genders with certain MH/SUD combinations were more likely to have abused *prescription drugs* (Lian Yu Chen, et. al, 2013). Research also indicates that MH issues are associated with a lack of improvement in SUD symptoms (Stirling, S., et.al. 2011). These findings reaffirm our understanding of the high comorbidity with drug use and suggest that MH issues are a frequent cause of relapse.

Based on this information, SUD facilities should have both MH and MAT enhanced capability in the provision of SUD services. Such services should engender curricula which educates people about their behavioral health relapse risks and assists with the creation of robust recovery plans. The data for Whatcom County residents in SUD residential treatment with high and low MH issues for last year is provided below.

Whatcom Projected Residential Demand by High and Low MH Need			
	Intensive Inpatient (Based on 30 days)	**Long Term Residential (Based on 60 Days)**	**Total Beds Needed by MH Severity**
Unknown, none or slight MH Admissions	97	73	
Mod- Extreme MH Admissions	163	33	
Total Admissions	**260**	**106**	
Low MH Bed Days	2910	4380	
High MH Bed Days	4890	1980	
Total Bed Days	**7800**	**6380**	
Low MH Bed Days + 8% pop. growth	3143	4730.4	
High MH Bed Days + 8% pop. growth	5281	2138.4	
Total Bed Days + pop Growth	**8424**	**6868.4**	
Total Low MH Admissions	105	74	**14.9 Beds**
Total High MH Bed Days	176	35 - 40	**17.6 Beds**
Projected Total Admissions	**281**	**109**	**390 Admissions**
Total Beds Needed by SUD level of Care	**23.4**	**9.1**	**33 Beds**

The data above appears to support one intensive inpatient facility in Whatcom County with a capacity of 33 beds encompassing both levels of SUD (including inpatient and long term residential) and all severities of MH. Alternatively,

the data supports a smaller 25 bed facility for people with high severity MH and a 15 bed facility treating people with low MH severity. This data is based only on the last year of utilization. Over 15 years ago, PeaceHealth had 18 beds for inpatient treatment. Those beds were part of the statewide residential system but were heavily utilized by Whatcom County residents.

Additional qualitative information indicates that our utilization of residential treatment could be higher if the capacity existed, especially if a percentage of beds are accessed by people who covered under health plans. Tribal members and other stakeholders expressed opinions that Whatcom County residents are more likely to engage in SUD inpatient services when those services are available locally. We believe that our community could support another intensive inpatient unit with 20 to 30 beds for people with none or very mild mental health disorders.

Lastly, 70% of Whatcom County residents who were admitted to residential treatment in 2015 successfully completed their treatment. Treatment retention rates for Whatcom County residents could be boosted by having residential treatment available in our community.

The odds of getting a clean start on recovery are high while in a residential treatment program. Subsequent to completion of a residential treatment program the next step, whether it's admission to an outpatient program or into a support network which embodies a clean and sober lifestyle, is essential. Most people will need additional professional services. Subsets of people with SUDs will need outpatient treatment, Recovery House, or a combination of these two services after inpatient treatment. One subset of people will begin and end their entire treatment episode in outpatient treatment.

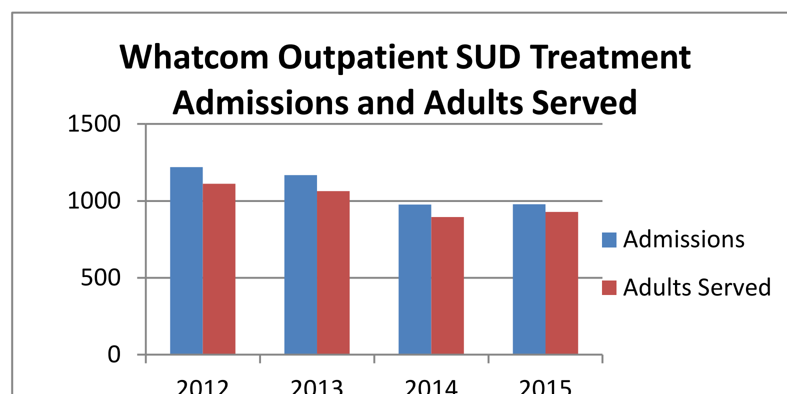
D. Outpatient Treatment (ASAM 2.3 and 2.1)

Although the purpose of this report is to review and discuss the data and community feedback pertaining to the withdrawal management and residential needs of our residents struggling with addiction, it is prudent to discuss the obvious gaps in our outpatient treatment capacity. Outpatient treatment and recovery supports are critical services for a successful continuum of care.

Whatcom County lost two outpatient treatment providers over the last five years. This loss left us with a total of two providers. Both agencies were integral to the SUD treatment infrastructure of our community and the impact to the community has been significant. This factor along with a low number of qualified workforce personnel relegated us to a low volume of assessments, therefore fewer admissions to all phases of treatment (outpatient and residential).

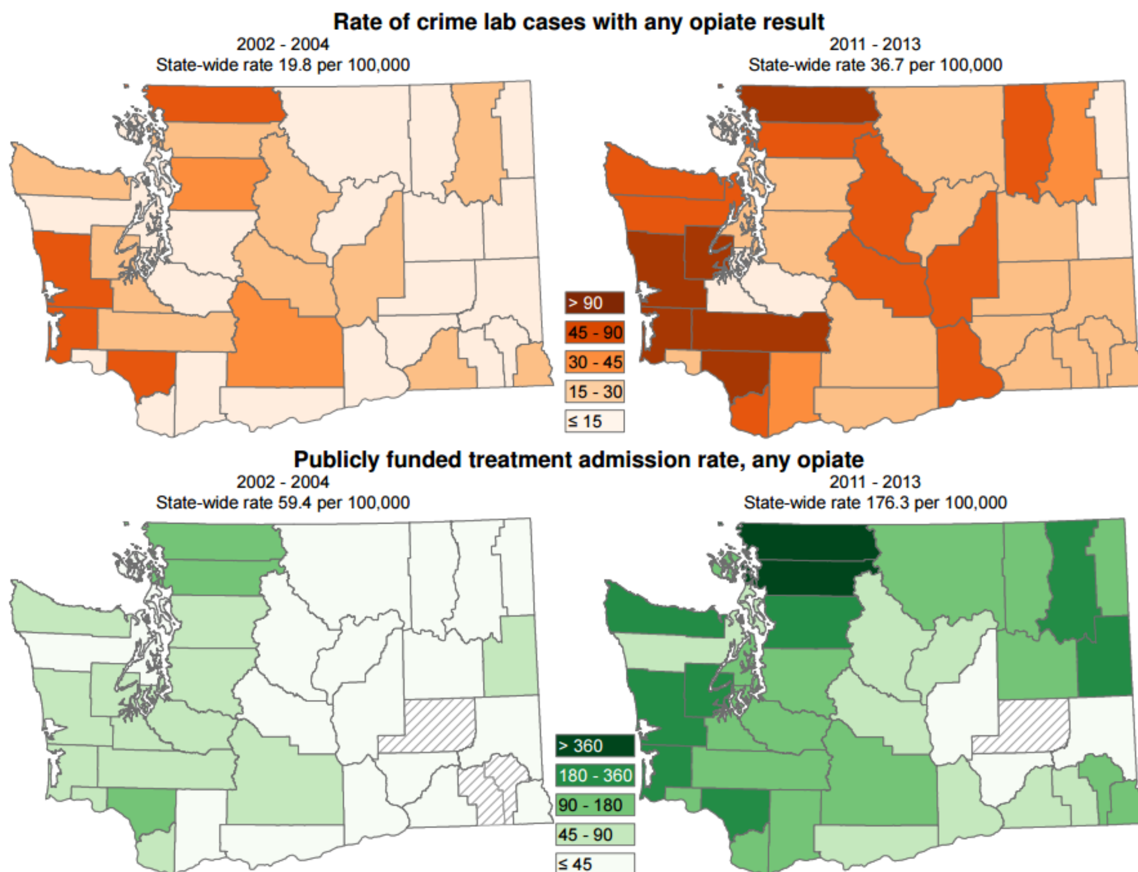
In 2015, despite admissions of over 900 people to SUD outpatient treatment, 297 people waited 15 days or more to be admitted to treatment(Figure 3A where is it?). A subset of 132 of those people waited for over 30 days to be admitted to outpatient treatment. Waitlists of this magnitude provide neither effective primary treatment nor a smooth transition from residential care. We strive to ensure an effective continuum of care and lower recidivism rates.

Figure 3A



Based on the 40-50% estimates and the research from above for people, we concluded that nearly 450 people who attended outpatient treatment needed mental health services in order to be successful in their recovery, particularly where relapse is concerned. Expanded and enhanced outpatient services are essential to the health of our community, especially that which can contribute additional co-occurring disorder (COD) and medication assisted treatment (MAT) capacity.

There are few reliable indicators to determine MAT treatment need except for opiate treatment admissions. These admissions have increased dramatically over the last several years (ADAI). Over the two year period, 2011-2013, Whatcom County ranked second in the state for opiate use disorder treatment admissions and third in the state for crime lab cases involving any opiate. These factors and other trends underscore a high need for increased MAT services in Whatcom County.



The addition of one or two outpatient SUD treatment agencies, depending on the agency and workforce availability, would allow more and quicker access to treatment, and help drive the quality of treatment to higher standards. One or two additional facilities would allow us to assess and admit close to 75 additional people per week to treatment. North Sound BHO has plans to solicit providers for a MAT pilot program later this year. North Sound also intends to acquire treatment capacity for people with co-occurring disorders once the state has developed the regulations concerning integrated services.

Our efforts at providing treatment are likely to be unsuccessful unless we commit to on-going, post-treatment supports which are consistent with healthcare reform policies. Those policies focus on long term recovery rather than acute care. Focusing on long term care entails ensuring regular on-going service, particularly for complex Medicaid populations, over the course of a five year period. Rather than providing acute short term (21 or 28 day care) and a return to the

community with a “sink-or-swim” skill set, we can provide Recovery Care Coordination and housing options to ensure ongoing engagement with clients as well as to ensure stability for people’s basic needs. Our outcomes from these efforts should result in less recidivism.

E. Recovery Supports to Enhance the SUD System of Care

The final component in the PITA SUD Continuum of Care is aftercare or ongoing recovery support. North Sound’s goal is to prevent readmission to treatment and while our proposed model and program support that goal, the final cornerstone to our model is the recovery support system.

The rate of remission from lifetime SUDs is between 40% and 60%. Research indicates that the rate of remission for adults who receive treatment is between 40% and 80%.[8] Whatcom County will need to establish both critical overarching and “chronic care” services such as Recovery House and Recovery Care Coordination (RCC), MAT supports, and training. It is vital that we provide a well-qualified workforce with updated knowledge and readiness to assume a role in the upcoming integrated future of primary care/behavioral health care.

Local funding can be used as available to fill the gaps where state and federal funds cannot ensure linkages or recovery supports. Examples of those services are detailed in the *Transitioning Behavioral Health Services into the Community: Strengths, Needs, Community Recommendations and Models for Consideration* by Deena Vandersloot M.Ed.as indicated

- “Consider adding a case management/recovery coaching component to the program that will serve to initially engage clients, remain in contact with them during residential treatment, and work with them in the continuing care phase of the treatment continuum to enhance linkage with recovery supports.
- Build strong collaborations with the recovery community and design “reach-in” services to enhance linkage with mutual support groups.
- Build in a phase of treatment that is focused on linking patients with recovery support services (housing, employment, peer support, transportation).”

Based on these recommendations and input from our community partners, Whatcom County may fund aspects of the services indicated below to enhance on-going recovery maintenance. Whatcom County struggles with multiple gaps in aftercare and the early recovery phases of our services. Our residents with severe alcohol withdrawal or serious drug addiction, much of which is complicated by co-occurring disorders, are frequently homeless. We need to examine ways to transition people who make a commitment to recovery, and those who do not, to safe and stable housing. Housing is essential for stabilizing people with SUDs.

Data from 2012 demonstrated that 48% of people leaving state funded inpatient treatment were homeless at the time of their discharge. Consistent with those statistics, Whatcom County’s Point in Time (PIT) survey revealed that 21% of the 553 respondents reported they were homeless as a result of their alcohol/drug use. The Whatcom Community Detox survey revealed that 53% of the participants indicated they were currently homeless. The lack of housing looms as a primary obstacle to residents continuing to move toward a successful recovery lifestyle. Specific attention should be focused on chronically homeless people in need of recovery services and people with co-occurring disorders. The County will partner with the North Sound BHO to provide services which ensure low rates of recidivism. The proposed services include:

1) **Recovery House** (ASAM Level 3.1 - 60 or more days)
   Whatcom County needs a facility which can provide extended care for recovering people leaving inpatient treatment to a lower level of care. The goal of a recovery house is to provide a safe environment free of drug and alcohol abuse while building skills needed to advance toward independent living. Many people may need a combination of outpatient treatment and Recovery House services in order to maintain stability and reduce the risk of relapse. Facility services should include relapse prevention, social skills, re-employment and vocational

skills, life skills, and assistance with forming linkages to recovery support systems. We believe that a recovery House with approximately 20-30 beds would provide a critical element to our continuum of care.

2) Recovery Care Coordinators (RCC)

A Recovery Care Coordinator supports people in early recovery by ensuring connections to community services. The RCC provides services for people with difficulty in functioning (such as people with serious mental illness, offenders coming out of the jail, people coming out of the hospital). The RCC's work begins from the moment of the request for services through various phases of treatment. The RCC will maintain contact years after the person has entered into successful recovery to assist with possible relapse and other healthcare issues.

Locations where and high risk populations with whom the RCC's might conduct business could include:

- Addiction Stabilization Center
- Jail (release)
- Hospital
- Pregnant &/or parenting population
- Active Chronic Relapsing Person in IOP/OP
- Heroin addicted population
- People with serious mental illness

3) Housing with staff support

Whatcom County is in need of housing for people leaving inpatient treatment settings. Staff supported permanent housing is essential for many individuals who suffer from the debilitating effects of long term SUD. Staff support and monitor residents for continued recovery work, including: attendance during outpatient treatment, development of social support, contact with family, and initiating employment or vocational activities.

4) Clean & Sober housing

Whatcom County currently has several clean and sober houses which many residents believe could benefit from structure and oversight. Historically, the primary focus of clean and sober housing has been limited to that which had little structure for ongoing recovery. Services provided, and the soberness of the homes currently in use, is inconsistent at best. The development of more units could function as permanent housing and fit nicely into our "Housing First" model for people who are homeless. "Housing First" is based on the philosophy that when people have their basic needs met, including housing, they can focus on improving their well-being.

5) Enhance capacity for MAT programming

Whatcom County currently experiences a lack of support and infrastructure for Suboxone and Methadone treatment prescribers. It is important to continue providing support for physicians, and possible startup funds to extend programming.

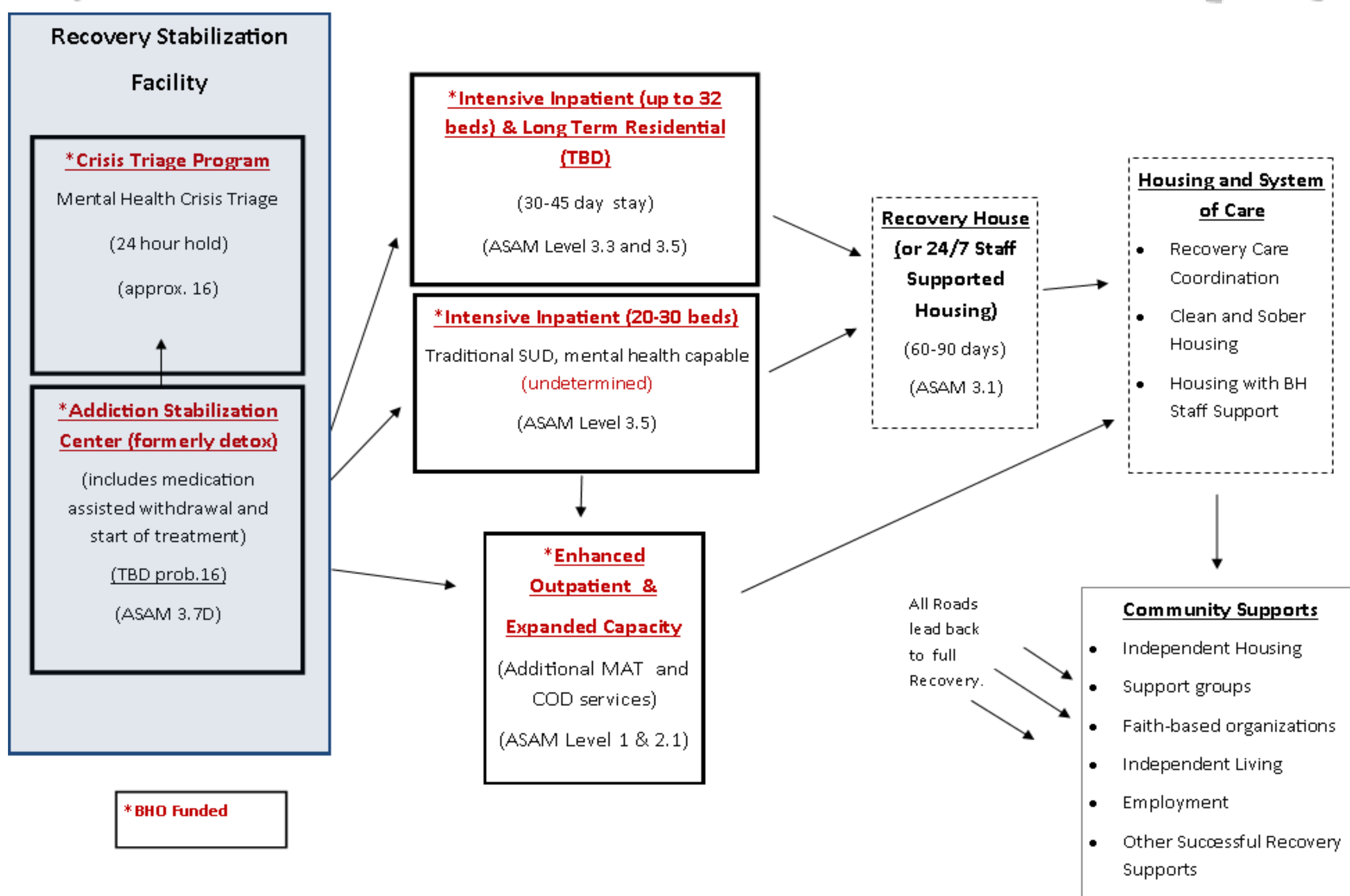
6) Training for Chemical Dependency Professionals & Mental Health Professionals

The dramatic changes in the provision of behavioral health care in addition to ever increasing needs of people with substance use disorders and mental health issues requires that chemical dependency and mental health professionals receive extensive, ongoing education to be effective. Development of regular trainings and workshops focused on the educational needs of today's behavioral health professional will not only enhance the services provided in the community, but will serve to attract additional professionals that are needed to fill current vacancies.

Our prosed new system of care should include Recovery Care Coordination for special populations, housing with and without treatment, plus additional training for CDPs and enhanced Capacity to provide MAT services.

F. *New Proposed SUD System of Care:*

The proposed new model of SUD services is depicted below with red highlights to indicate North Sound BHO supported services and black to indicate possible County supported services. The innovative model begins with a "Recovery Campus" which places an array of vital services in the same location; including a Recovery Stabilization Facility (RSF) to house the Crisis Triage Program and the Addiction Stabilization Center. It also includes two Intensive Inpatient and Long Term Residential programs; one for people with serious mental illness and the other for people with few or no mental health issues. The site includes a "Recovery House" for people transitioning to a lower level of care but who still require structured support while re-engaging with community services. Lastly, the site includes a vast array of housing and other community supports necessary for a person's recovery from SUDs.



Conclusion:

While this new system would address the immediate and escalating needs of our residents with SUD, the new models will also begin to reflect the future of integrated behavioral health care with primary care. Only by doing so, can we step into the future of care in four years and address the still more complex patient who has medical concerns as well as behavioral health issues. Studies show that relapse of behavioral health disorders is less likely and long term recovery is enhanced when treated in conjunction with primary care.[6,7] We leave the full discussion of this topic for another day.

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