



THURSTON COUNTY
WASHINGTON
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**THURSTON MASON
REGIONAL SUPPORT NETWORK**

**ANNUAL REPORT
Calendar Year 2010**

THURSTON MASON REGIONAL SUPPORT NETWORK ANNUAL REPORT 2010



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Thurston County Public Health and Social Services Department Mission Statement

The mission of the Thurston County Public Health and Social Services Department is to make a positive, significant and measurable difference in the environmental, physical and mental health, safety and well-being of our community.

Thurston Mason Regional Support Network Mission Statement

Thurston Mason Regional Support Network (RSN) is dedicated to providing mental health services to persons with severe and persistent mental illness to promote quality tenure in our community.

The Thurston Mason RSN

Thurston Mason RSN is a county program responsible for the administration of publicly-funded mental health services for Thurston and Mason Counties. TMRSN contracts for outpatient, crisis, residential, and inpatient services through licensed mental health agencies called "Providers".

The primary focus of these publicly-funded services is to serve Title 19 (TXIX) Medicaid eligible adults and older adults who have chronic and persistent mental illness and children/youth with severe emotional disturbances. Individuals without Medicaid may receive acute care and crisis services based on the availability of funding, which is monitored by the Thurston Mason RSN. The services provided are a vital part of maintaining the community's overall health, safety, and quality of life.

Introduction

Washington's Regional Support Networks (RSNs) contract with licensed Community Mental Health Agencies (CMHAs) and private nonprofit agencies and hospitals to deliver mental health treatment services. The RSNs are responsible for ensuring that services are delivered in a manner that complies with all legal, contractual, and regulatory standards for effective care. In 2010, the Department of Social and Health Services (DSHS) contracted with thirteen (13) RSNs to deliver mental health services for Medicaid enrollees through managed care. In 2010, the average number of covered individuals in Thurston and Mason Counties was approximately 41,730; of this, approximately 7,906 were engaged in mental health services.

All RSNs are required to contract with an independent Ombuds service to advocate for enrollees by informing them about their rights and helping them to resolve complaints and grievances. A Quality Review Team (QRT) for each RSN represents consumers of mental health services and their family members. The QRT may monitor consumer satisfaction with services and work with consumers, service providers, the RSN, and DSHS to improve services and resolve identified problems.

Table 1 below displays each of Washington State’s Regional Support Networks, the acronym for the RSN, and the total average number of Title XIX Medicaid enrollees for 2010.*

Regional Support Network	Acronym	Number of Medicaid Enrollees - 2009	Number of Medicaid Enrollees - 2010	Increase (Decrease)
Chelan-Douglas RSN	CDRSN	20,714	21,605	+891
Clark County RSN	CCRSN	62,757	65,103	+2,346
Grays Harbor RSN	GHRSN	15,057	14,917	-140
Greater Columbia Behavioral Health	GCBH	148,938	147,910	-1,028
King County RSN	KCRSN	201,795	209,270	+7,475
North Central Washington RSN	NCWRSN	50,040	53,877	+3,837
North Sound Mental Health Administration	NSMHA	137,161	141,544	+4,383
Peninsula RSN	PRSN	42,784	42,414	-370
OptumHealth Pierce RSN	OPRSN	115,203	120,098	+4,895
Southwest RSN	SWRSN	20,420	21,042	+622
Spokane County RSN	SCRSN	83,024	82,302	-722
Thurston-Mason RSN	TMRSN	39,489	40,671	+1,182
Timberlands RSN	TRSN	19,176	19,869	+693
Totals		964,312	980,622	+16,310

Table 1 - Mental Health Regional Support Networks and enrollees, October 2010

***Data includes a twelve month average for Categorically Needy, Disabled, Medically Needy, CHIP, and SCHIP.**

Source: Washington Mental Health Performance Indicator System / Division of Social and Health Services

The Work of the TMRSN

TMRSN is responsible for many different functions. Currently, this includes:

- Contract development & management
- Network coordination
- Management Information System (MIS) & IT coordination
- Quality management
- Utilization management
- Customer service coordination
- Inpatient care management
- Children’s mental health care management
- Adult and Older Adult mental health care management
- Fraud and abuse compliance coordination
- Resource management
- Compliance with Federal and State Requirements for mental health managed care

In 2010, TMRSN and Thurston County Public Health and Social Services Department (PHSS) underwent an organizational restructuring. The TMRSN Administrator assumed new duties as the Director of all Social Service programs, including Chemical Dependency, Housing and Community Renewal, and Developmental Disabilities. The previous Quality Manager stepped in to manage the day to day

operations of the RSN as the new TMRSN Manager. In June 2010, TMRSN hired a new Quality Manager. Also in 2010, TMRSN hired a new Ombuds, filling a vacancy left by the outgoing Ombuds. The staff of the Thurston Mason Regional Support Network are responsible for:

- Developing and maintaining a provider network for the delivery of mental health services according to the requirements of the Prepaid Inpatient Health Plan (PIHP) and State Mental Health contracts
- Strategic planning and allocation of state and federal mental health funds
- Monitoring and analyzing the unmet needs of Thurston and Mason Counties and developing strategies to meet those needs in the future
- Collaborating with local, state and federal partners for the purpose of consultation, process improvement, exploring new evidence based practices, and developing new services to meet unmet needs
- Developing and monitoring contracts with Community Mental Health Agencies (CMHAs)
- Provision of Medicaid and State-Funded psychiatric inpatient services for residents of Thurston and Mason Counties
- Authorizing all outpatient, residential and voluntary/involuntary inpatient services, and responding to appeals of authorization decisions
- Provision of Involuntary Treatment Act (ITA) Services in involuntary settings, to include investigations and detentions, involuntary court, individual treatment services, monitoring of Least Restrictive Alternatives (LRAs) and completion of continuity of care plans to meet the State Waiver and Medicaid plan
- Provision of services in residential settings for mental health enrollees
- Creating and maintaining a complaint and grievance system for clients and/or their authorized representatives who are dissatisfied with services provided
- Developing policies, procedures and operational guidelines for CMHAs that reflect state and federal regulations and contract requirements
- Financial monitoring of resource allocation against budgeted expenditures and collection of third party revenue
- Maintaining a clinical chart review and administrative audit process to ensure compliance with state and federal regulations and contract requirements
- Engaging with CMHAs in a vigorous continuous quality improvement program to ensure compliance with state and federal regulations and to promote quality care and services to consumers

In addition to the functions listed above, TMRSN employs two (2) individuals responsible for Ombuds Services and the Quality Review Team (QRT). Ombuds Services is responsible for addressing client complaints and grievances. QRT position is responsible for collecting satisfaction with services and quality improvement data from consumers in the form of personal interviews and surveys. Both positions summarize their work and submit it to the TMRSN Quality Manager and the TMRSN Advisory Board Quality Management Committee. These positions are paid through the TMRSN, yet are functionally independent so as to maintain neutrality.

2010 in Review

2010 continued to be a challenging time for everyone working within the publically-funded mental health system. The effects of the expansive recession continued to be felt by all Washingtonians during 2010. These challenges forced TMRSN and its Network Providers to make many difficult decisions and refocus on its core mission of bringing mental health services to Thurston and Mason County's most vulnerable populations. Although it was a year of watchful stewardship over resources, it was also an opportunity to plan for the future and strengthen its overall quality management program. Some of the highlights of 2010 included:

Focus on Recovery Services

TMRSN implemented a Consumer Council in 2006 to provide valuable feedback and input into TMRSN delivery system and policies. The Council recommended revisions to the TMRSN Benefits Handbook and the Ombuds brochure to make them more client friendly and culturally competent. As highlighted in Acumentra's Washington Q-News Newsletter, TMRSN developed a Healthcare Passport – a small booklet put together by consumers to include healthcare information that can be carried with them and to encourage them to be more proactive in their healthcare. TMRSN also implemented a Wraparound program, which is coordinated through the founder of the Family Alliance for Mental Health parent network and uses parent partners to provide family/child interventions, education and cross systems coordination. TMRSN also funded NAMI trainings, support groups, education and outreach efforts, and the TMRSN Advisory Board sponsored a free annual mental health forum focused on recovery.

Decreased Inpatient Hospitalization and Readmissions

Thurston Mason's Evaluation and Treatment Center (E&T) has provided diversion from community hospitalization since opening in 2006, reducing the need for community inpatient admissions while saving costs. An E&T inpatient bed saves approximately \$400 dollars per day over the average psychiatric inpatient daily bed rate at community hospitals. As part of our Crisis System services at the E&T, a step-down stabilization unit with 10 beds also gives clients longer periods of supervised treatment as an alternative to an inpatient level of care. This has facilitated better placements into the community with a reduction in inpatient recidivism.

Treatment Sales Tax (TST)

Revised Code of Washington (RCW) 82.14.460 stipulated that one tenth (1/10) of one (1) percent of collected sales tax dollars would go towards services that would reduce the negative impacts of mental health and substance abuse on children, families and adults with an emphasis on those individuals involved with, or at risk of, involvement with the jail/correctional system. In 2009, the Thurston County Board of County Commissioners adopted Ordinance #14138 that further defined how this revenue should be spent. After a lengthy cross-departmental collaborative process and public review, TMRSN secured funding for several programs during this period, looking to either offset state funding reductions for services or to fund services not otherwise covered by Medicaid. Some of these programs included:

- The Mentally Ill Offender Program (MIO) – MIO is a program that provides mental health and crisis services to incarcerated adults in the Thurston County Jail. MIO services include: 1)

identifying incarcerated adults who are mentally ill and in need of mental health services, 2) on-site crisis services, 3) referrals to other key services such as outpatient mental health treatment, 4) enrollment in publicly-funded benefits when the participant is released from jail, and 5) diversion alternatives to incarceration (i.e. Thurston County Mental Health Court), if appropriate.

- Multisystemic Therapy (MST) – MST is a program used with severely behaviorally challenged and substance-abusing juvenile offenders (age 11 – 17). Therapy focuses on promoting positive social behavior while decreasing antisocial behavior and can occur in the home, school, or other community setting. MST is family-oriented, based on the philosophy that the most effective and ethical route to help youth includes helping their families.
- Thurston Wraparound Initiative (TWI) - TWI provides high-fidelity wraparound supports modeled after the principles of the national wraparound model. TWI is **not** a treatment program; rather, it is a community-based family planning process that shows promise in reducing the number of children placed in more restrictive settings (e.g. therapeutic foster care, psychiatric hospitals) due to improvements in behavior and functioning. TWI is voluntary; however, the approach is highly participatory as the family or caregiver of the child must be committed to engage in team development, goal setting, and implementing the strategies and/or services identified by the team.
- Mentally Ill Juvenile Offender Program (MIJOP) – Similar to the adult MIO program, MIJOP provides on-site services to youth in the Thurston County Juvenile Justice system. Services emphasize support of the family to help the adolescents re-engage successfully in the community.
- Co-occurring Treatment Services (COD) – COD services are for clients with a dual diagnosis of chemical abuse and mental illness. Services emphasize the need to cross over care for both disorders with staff trained to do so.
- Mental Health Court – An evidence based practice that combines a specialized court docket with mental health care coordination and treatment for individuals whom can be diverted from jail or have their length of stay in jail reduced.

Access Program

The TMRSN approach to care management and service utilization is to provide services in the least restrictive environment that meets the unique treatment needs of the individual. The authorization criteria for each level of care are determined by Medicaid eligibility and medical necessity that is based on an individual client's needs.

TMRSN identifies three (3) distinct Outpatient Levels of Care (LOC), depending on intensity and length of stay. TMRSN also authorizes additional levels of care when medically necessary depending on the individual's acuity and level of need. These include residential services, crisis stabilization services and inpatient services.

The TMRSN Level of Care Guidelines were developed as a framework when considering the request for and authorization of medically necessary services for children, youth, adults and older adults who are eligible to receive treatment for covered psychiatric/mental disorders. In order to guide and facilitate appropriate care management, the guidelines define each level of care and the service expectations for that level. Criteria for admission are described for each LOC and are based on the initial presenting

problem(s) and treatment needs. The TMRSN Level of Care Guidelines take into account the differences in the treatment needs for adults and children/adolescents and their families and are separated accordingly.

The Level of Care Guidelines are based on published or peer reviewed standards and meet all DSHS Access to Care Standards (ACS). Access to Care Standards are considered the eligibility requirements for authorization into services. Conversely, Level of Care Guidelines are considered the least restrictive guidelines for the level of service that the consumer will receive **after** they have met Access to Care Standards.

In 2010 TMRSN revised its Level of Care Guidelines with the intent of improving “front end” services for the consumer. It was recognized that, in many cases, the length of time from the initial request for service to an intake appointment was taking longer than the requirement of fourteen (14) days. In addition, TMRSN wanted to create a new system that would provide short term, solution-focused intervention services at front end of the service delivery system – as opposed to enrolling the consumer into longer lasting services.

The newly revised Level of Care Guidelines lays the foundation for a new Access Program that will do the following:

- Reduce the amount of time a consumer has to wait from initial request for services to intake evaluation;
- Create a system whereby consumers can receive short-term, solution-focused therapeutic services from the same Mental Health Professional that conducted the intake evaluation;
- Reduce the no-show rate typically found for initial intake evaluation appointments; and
- Eliminate lengthy service authorizations for consumers who only require brief, solution-focused intervention services.

The Level of Care Guidelines were approved in November of 2010. The Access Program was fully operational by February 2011.

External Quality Review (EQR)

Federal law requires that the State of Washington – and all of the Regional Support Networks – undergo an annual, independent external quality review (EQR) for health care services delivered to Medicaid enrollees. Acumentra, Washington State’s External Quality Review Organization (EQRO), reviews various performance areas on a yearly basis. Some of these topics include consumer rights, grievance systems and the RSN’s responsiveness to complaints and grievances, data security and confidentiality, and the RSN’s quality assessment and performance improvement (QAPI) programs. In addition, each RSN must create two (2) Performance Improvement Projects (PIPs) to improve clinical and non-clinical services provided to Medicaid enrollees. In 2010, TMRSN had its PIPs reviewed and met the rigorous standards set forth by the Centers for Medicaid and Medicare Services (CMS). The topic areas for TMRSN’s two (2) PIPs are:

- Clinical PIP: Multisystemic Therapy – This PIP strives to improve mental health outcomes for youth who are served by multiple systems through the use of Multisystemic Therapy. The 2010 Acumentra review noted significant improvement “in the indicators for school attendance,

substance abuse, and arrests, and a trend toward a reduction in suicide attempts.” Overall, TMRSN received an “87” (fully met) score for this PIP.

- Non-Clinical PIP: Increasing the percentage of Medicaid clients who receive an intake service within fourteen (14) days of (initial) service request. This is a new PIP for TMRSN, and as such, has not had an opportunity to be fully evaluated. Thus far, it has received a score from Acumentra of “50” (partially met). This PIP will be heavily influenced by the anticipated success of the newly-created Access Program (see description above in this section).

PIPs are generally projects that have been identified in the community, and strive to address particular gaps or problems in the mental health system. They are generally two (2) year projects and are evaluated by Acumentra on an annual basis. TMRSN will continue to work on the Performance Improvement Projects in the coming years and develop new PIPs to meet community needs.

Evidence Based Practice (EBP)

TMRSN continues to explore opportunities to bring more evidence based practices into Thurston and Mason Counties. Evidence Based Practices (or, EBPs) are treatments or services whose effectiveness are well documented. Such treatments and services generally have to undergo rigorous research and have a substantial body of documentation to be considered an EBP. Other treatment modalities that are in the midst of clinical research are oftentimes referred to as Emerging Best Practices. These treatments and services are generally less thoroughly evidence based, but show some positive treatment response. Currently, TMRSN is engaged in the following EBPs:

- Cognitive and Interpersonal Therapies for Depression
- Multisystemic Therapy
- Thurston Wraparound Services
- Positive Parenting Program (Triple P)
- Family Psychoeducation
- Assertive Community Treatment (PACT)
- Supported Employment
- Psychosocial Rehabilitation (Capital Clubhouse)
- Jail Diversion and Community Re-entry Programs (MIO, MIJOP)
- Trauma Focused Cognitive Behavior Therapy through the Skokomish Tribe
- Steps to Respect school-based intervention through the Skokomish Tribe

Community Involvement

In 2010, TMRSN continued its tradition of involving community stakeholders in reviewing quality and performance measures, program design, and the production of consumer-focused materials. Some of the ways that TMRSN utilized community members in 2010 included:

- **Treatment Sales Tax** – Community stakeholders were involved in reviewing the plan for how Treatment Sales Tax money would be used in Thurston and Mason Counties. As mentioned above, Treatment Sales Tax dollars are intended to fund mental health services that strive to reduce the negative impacts of mental health and substance abuse on children and families and reduce risk of criminal justice involvement.

- **Thurston Wraparound Initiative (TWI)** – Community members participated in many of the startup activities for the Thurston Wraparound Initiative. TWI provides intensive, individualized care planning and support for high risk children/youth and their families.
- **Thurston Mason Mental Health Advisory Board** – The Advisory Board is a body of community volunteers that meet monthly to provide input on service delivery and quality improvement initiatives. The Board consists of consumers and family members of consumer and organizations that have a stake in mental health delivery and quality. TMRSN representatives attend each meeting as staff.
- **Consumer Council** – TMRSN’s Ombuds Representative leads a council of clients that review published materials (policies, brochures, handbooks, benefits booklets, etc.), meet with clients on a regular basis to provide education and support, report to the TMRSN and represent clients at the Thurston Mason Mental Health Advisory Board.
- **Family Alliance for Mental Health** – TMRSN pays a stipend for a community member (TMRSN Parent Network Contractor) to lead a parent/caregiver-driven network dedicated to providing support services and education for parents and caregivers of children with mental health challenges.
- **Children’s Community Consensus Teams (CCCT)** – The CCCT is an on-going team, represented by child-serving agencies and community members, whose purpose is to implement the principles of individualized care and to support children with mental health issues and their families. The CCCT also is the local gatekeeper and referral source for Thurston and Mason County residents seeking voluntary admission into the Children’s Long Term Inpatient Program (CLIP).
- **Conference participation and scholarships** – Each year, staff from TMRSN attend training specific to their specialty (i.e., child mental health specialist certification). TMRSN has a tradition of involving as many community stakeholders as is possible in these various trainings and conferences. In 2010, several consumers received scholarships to attend conferences in Yakima and Vancouver.
- **Sponsorship of the Annual Mental Health Forum** – Developed collaboratively by the TMRSN staff, Mental Health Advisory Board, consumers, providers and other interested community members. The 2010 Forum focused on “Working towards Recovery” and featured three guest speakers and an expert in Yoga-based relaxation techniques. The event also included an opportunity to complete a Health Care Directive, Mental Health Advance Directive, and Durable Power of Attorney for Health Care, and to register these Living Will documents, if requested, with the Department of Health’s State Registry.

Improved / Strengthened Clinical Chart Review system

In 2010, a revised clinical chart review program was initiated at TMRSN. Although clinical chart reviews have always been a part of TMRSN’s quality management system, the newly revised program ensures that clinical chart reviews become part of the on-going, continuous quality improvement system for both TMRSN and Network Providers. Many changes were made to the clinical chart review process, including:

- Yearly review schedules that incorporate regular and consistent TMRSN reviews;
- Quarterly summaries by TMRSN that identify areas of strength, areas in need of further improvement, and record of compliance according to cited requirements;

- Creation of performance improvement plans, for use by Network Providers, that focus on agency strengths, resources, and compliance standards; and
- Development of targeted review instruments and instructions specifically for unique focus areas such as:
 - ◆ Request for Services and Intake Evaluation
 - ◆ Individualized Treatment Planning
 - ◆ Client Rights and Service Provision
 - ◆ Psychiatric, Medical and Crisis Planning and Services
 - ◆ Level of Care / Access to Care Standards
 - ◆ Schizophrenia – Practice Guidelines
 - ◆ Evaluation and Treatment Unit (ETU)
 - ◆ Crisis Stabilization and Transitional Unit (CSTU)
 - ◆ Crisis Resolution Services (CRS)
 - ◆ Mentally Ill Offenders Program (MIO) and Mentally Ill Juvenile Offenders Program (MIJOP)
 - ◆ Program of Assertive Community Treatment (PACT)

Clinical chart reviews of ten (10) percent of all unduplicated mental health charts in a given year, using a standardized review instruments, was initiated on October 1, 2010. The review instruments included either a Comprehensive Outpatient Services Review instrument or one of several targeted review instruments. During the first year (October 2010 – September 2011), roughly 375 charts were identified for review. This represents the ten (10) percent requirement set forth by the Prepaid Inpatient Health Plan (PIHP) contract between the Department of Social and Health Services (DSHS) and TMRSN.

Improved / strengthened grievance and complaint system

Questions, concerns, and complaints about mental health services in Thurston and Mason Counties are addressed by the TMRSN Ombuds. 2010 continued to see an improved complaint and grievance system at the Thurston Mason Regional Support Network. During the year, TMRSN improved tracking, response time, and the resolution process for all complaints coming into the RSN. One of the guiding principles explicitly stated in the TMRSN Grievance Policy is that all complaints should be resolved at the lowest level possible. This means complaints should be immediately resolved and formal grievances avoided, if possible. In 2010, there were 201 calls to the Ombuds. These calls included questions, concerns and complaints about mental health services. There were no formal grievances filed at TMRSN during 2010; in addition, there were no appeals or fair hearings during the calendar year.

Generally, the TMRSN Ombuds answers the questions and investigates any complaints. In some circumstances, the TMRSN Quality Manager must also investigate complaints and grievances and create corrective action plans for Network Providers, if required. TMRSN responds to and tracks all consumer complaints, grievances, appeals and fair hearings. TMRSN also logs and tracks all “information and referral” contacts when clients, family members or other community members inquire about available services within the RSN.

Figures 1 and 2 below summarize the types of calls received by TMRSN in 2010, and the various types of resolutions:

Categories of Complaints and Inquiries

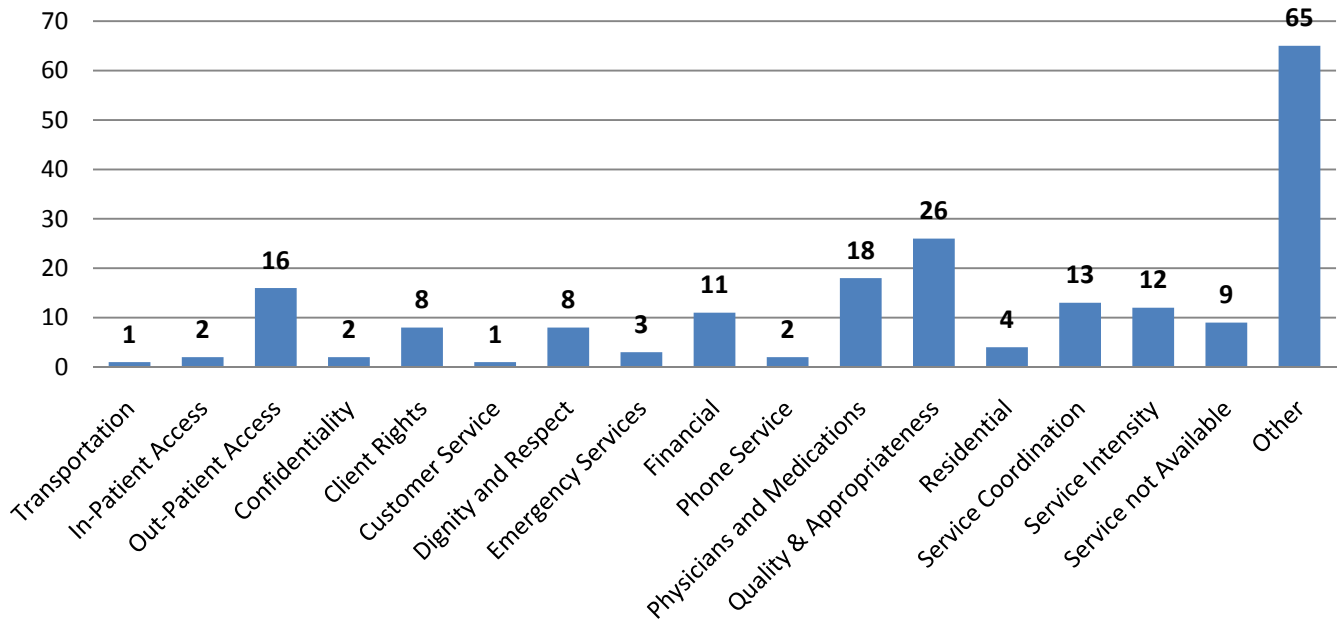


Figure 1 – Types of Inquiries / Complaints / Grievance: CY 2010
 *"Other" indicates primarily inquiries that were not complaints.

Types of Complaint & Inquiry Resolutions

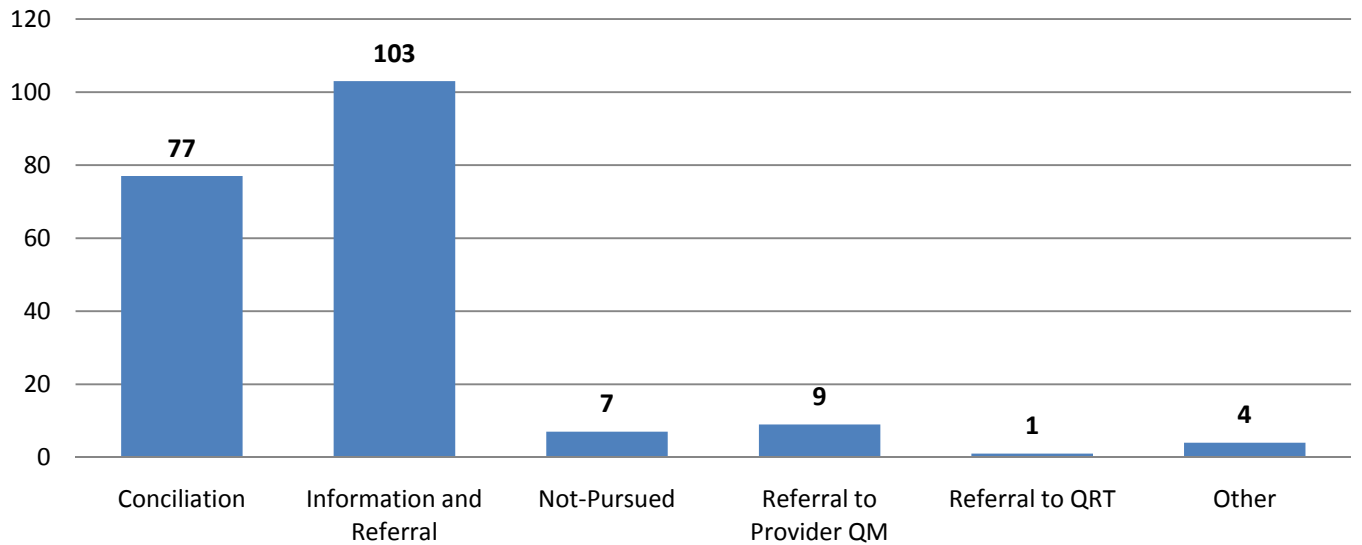


Figure 2 – Types of Resolution to Inquiries / Complaints / Grievances: CY 2010

Program Descriptions

OUTPATIENT SERVICES

Outpatient programs are designed to bring forth a wide range of mental health services to enrolled clients. TMRSN must consider the capacity of current available services and work towards making the

full range of contracted services available – in sufficient number, mix and geographic distribution - to all current and anticipated Medicaid enrolled individuals. This includes closely monitoring population trends, anticipated Medicaid enrollments, and the feasibility of current Mental Health Care Providers (MHCPs) to expand to meet unmet needs, if warranted.

Core Outpatient Services

Core services are outpatient services which are mental health services provided in Community Mental Health Agencies (CMHAs) or by other community providers. Core outpatient services are provided in the TMRSN Provider Network by Mental Health Professionals (MHPs) or other trained mental health providers. Core outpatient services include, but are not limited to:

- ◆ Case management
- ◆ Individual therapy
- ◆ Group therapy
- ◆ Psychiatric evaluation
- ◆ Medication monitoring
- ◆ Medication management
- ◆ Crisis services

Access/Entry

Access and Entry refer to the “front door” of service provision. It is the point at which most individuals come into services. After a client requests mental health services, initial services are offered to provide an intake assessment and a screen for eligibility. Clients are then enrolled into appropriate services or referred to other community services. These services also include outreach to hospitals and liaison with Western State Hospital to facilitate entry into outpatient services.

Medication Management and Monitoring

The prescribing, administering, and/or reviewing of medications and their side effects is a critical medication management core service and is provided by licensed Mental Health Care Providers. Medication monitoring involves face-to-face, one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. It also includes working closely with the persons licensed to provide medication management services for the direct benefit of the individual.

Community Support Services

Community Support Services refers to outpatient services provided to clients on a less restrictive alternative (LRA) court order when involuntary treatment services are necessary, consistent with statutory regulations.

Community Support Services also refers to the core case management program that provides individual, group and/or family treatment services along with case management, medication evaluation and monitoring. Many of these services are provided in the community or in the client’s home.

In addition to regular outpatient therapy treatments and programs (Core Services), there are a variety of TMRSN-funded programs that offer value to clients’ lives. Some major outpatient programs are briefly described below.

Washington Program of Assertive Community Treatment (WA-PACT)

PACT is a program intended as an appropriate treatment approach for individuals with a current diagnosis of a severe and persistent mental illness who are experiencing severe symptoms and have significant impairments. These individuals must also have demonstrated a combination of continuous high service needs and functional impairments and have not shown to benefit significantly from other outpatient programs currently available.

High Intensity Treatment

High Intensity Treatment services are services intended to support client who require daily living skills training and a high volume of treatment team contact and crisis services to remain stable in the community.

Children’s Mental Health Specialist – Joint Position

The Joint Program is a joint project between the Division of Child and Family Services (part of DSHS) and TMRSN. The purpose of this program is to enhance cross system collaboration and to assure early linkage and intervention for acute or severely emotionally disturbed children. The program funds one individual whose responsibility include triage, assessments, next day appointments, crisis case management, home/community outreach, consultation, cross system coordination, medication referrals, and referral/linkage to other local resources.

Multisystemic Treatment (MST) / Children’s Evidence Base Practice

TMRSN is always looking at Evidence Base Practices (EBPs) and ways to incorporate them into the milieu of offered services. EBPs are treatment modalities, or approaches, that have been extensively studied and have demonstrated success in the field. In 2009, TMRSN was actively engaged in four (4) children’s EBPs designed to work with specific populations of children. MST is one of the EBPs, and is a grant and Medicaid-funded specialized program that follows national standards on who is served, what services are provided, and the level of clinical skills required to provide the services. The MST program is specifically concerned with youth who are considered at-risk and/or who have had involvement with the juvenile justice system.

Thurston Wraparound Initiative (TWI)

The Thurston Wraparound Initiative is one of Thurston and Mason County’s newest programs. TWI provides high-fidelity wraparound supports and services modeled after the principles of the national wraparound model. It is a community-based program that relies on utilizing identified family to assist in the planning process in order to reduce the number of children placed in more restrictive settings (e.g., therapeutic foster care, psychiatric hospitals). TWI is voluntary, however the approach is highly participatory as the family or caregiver of the child must be committed to engage in team development, goal setting, and implementing the strategies and/or services identified by the team.

Projects for Assistance in Transition from Homelessness (PATH)

PATH is a federally funded outreach program that focuses on the homeless and resistant clients to try and link them with services.

Capital Clubhouse

The Capital Clubhouse – while not a community mental health agency – plays an integral role for many clients in Thurston and Mason Counties. The Capital Clubhouse is the consumer-run agency that provides employment, housing, and life-skills training to many mental health consumers in Thurston

and Mason Counties. The Clubhouse seeks to function in a “work-ordered” or “normative setting”. The Clubhouse currently has 160 active clients – clients who participate in Clubhouse activities on a regular basis.

Services to At-Risk Seniors (STARS)

STARS is a program designed for older adults. It is a day-program that strives to assist disabled adults live as independently as possible in their own homes – with family members or caregivers. The service is designed to enhance the physical, mental, cognitive and social well being of seniors with chronic, mental health issues and progressive diseases such as Alzheimer’s or other forms of dementia.

Services and Supports in Residential Settings

A wide range of services and supports for clients in residential settings exist in Thurston and Mason counties. These may involve a facility, designated parts of a facility or housing complex, or services which support community (independent) living for acutely or chronically mentally ill adults, or seriously disturbed adults at risk of becoming acutely or chronically mentally ill. Supervised and supported living services may include services provided in residential beds within a facility, licensed boarding homes, or adult family homes.

Mentally Ill Offender Program (MIO)

This service provides cross-system coordination and services between Thurston County Jail, Olympia City Jail, Mason County Jail and mental health agencies with identification and referral, intake assessments, diversion, crisis intervention services, transitional case management and discharge planning, training, and consultation for incarcerated individuals who meet the criteria for “priority population” due to acute/chronic mental illness.

Mentally Ill Juvenile Offender Program (MIJOP)

This program provides mental health diversion services for adjudicated and at-risk juveniles who are severely mentally ill in Thurston and Mason Counties. These services include identification, diversion, referral, staff and family support, consultation and training provided by a Child Mental Health Specialist.

Supported Employment

This is a program that provides an assessment of work history, skills, training, education, and personal career goals. Information about how employment income will affect the benefits the client is receiving because of their disability is also assessed. Preparation skills such as resume development and interview skills are taught. Supported Employment provides assistance in locating employment opportunities that are consistent with the client’s strengths, abilities, preferences, and desired outcomes, and may also include job coaching and employer consultations.

Peer Support

Peer Support services are provided by certified peer counselors to individuals under the consultation, facilitation or supervision of a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

CRISIS SERVICES

Crisis Information and Referral Services

This program maintains complete, accurate and current information on mental health and human service resources in data banks, published materials and directories, and provides information, referral and crisis telephone services to residents of Thurston and Mason Counties 24 hours a day, seven days week by trained adult and teen volunteers.

Crisis Resolution Services (CRS)

This is a service whereby crisis interventionists and Designated Mental Health Professionals (DMHPs) provide crisis evaluation and intervention anywhere within Thurston and Mason Counties. If, after careful evaluation, the client can demonstrate enough insight, self-care ability, and/or community and family support to remain safely in their primary residence, they are encouraged to do so. If the client can remain safely in their primary residence, CRS staff will work with the client to provide information on other community resources and will provide follow up services, as necessary. If a client is unresponsive to CRS intervention, declines voluntary services, appears to present a risk of harm to self or others, or appears gravely disabled, the DMHP may evaluate the client for involuntary treatment if found to be medically necessary.

Crisis Stabilization and Transitional Unit (CSTU)

The CSTU is a voluntary, short-term (generally not over 30 days) program designed to provide observation, evaluation and brief treatment for adults in crisis. In addition, it provides voluntary transitional care for adults who require a more structured therapeutic environment than cannot be provided in an outpatient setting alone. The CSTU is oftentimes used as a step-down program for those transitioning out of Western State Hospital (WSH), coming out of the ETU, or a community inpatient setting. The CSTU provides a place for clients to rest, sleep, eat and recover – with a minimum of auditory and visual stimulation. Authorizations for the CSTU must come from the TMRSN. The CSTU is located at the Evaluation and Treatment Center (E&T) in Olympia and has a total of ten (10) available beds.

INPATIENT CARE

Evaluation and Treatment Unit (ETU)

The TMRSN funds the Evaluation and Treatment Unit (ETU) within the Evaluation and Treatment Center (E&T) – housed in a county-owned building on Mary Elder Way in Olympia. The ETU, while **not** considered a hospital, is the only location in Thurston or Mason Counties where individuals may be involuntarily detained. If, in the opinion of specially trained Designated Mental Health Professionals (DMHPs), a person presents as a danger to him/her self or the public at large or is determined to be gravely disabled, he/she may be detained at the ETU. Clients in the ETU receive acute psychiatric care that is comprehensive and individualized. Authorizations for placement in the ETU must come from the TMRSN. There are a total of fifteen (15) available ETU beds.

The ETU staff are only able to treat individuals that do not have major medical or physical problems, as they are not considered a hospital. Clients are generally required to have a medical/physical evaluation prior to admission into the ETU. Clients that are brought to the ETU by law enforcement for a misdemeanor crime as a result of a mental illness may receive services. For those with a felony charge, law enforcement presence may be required during an assessment. Clients who are under the

influence of recreational (street) drugs or alcohol may receive mental health services at the E&T Center. However, for those who require medically monitored detoxification, the client may be transferred to a suitable drug and alcohol program.

Community Hospitals

In Thurston and Mason Counties, Providence St. Peter's Hospital has an inpatient psychiatric facility where individuals may temporarily (and voluntarily) stay in order to stabilize a crisis episode. Oftentimes, a person will transition into the E&T or the CSTU from community hospitalization. When space is not available in Thurston County, other available community hospital settings are sought. Community inpatient hospitalizations must be pre-authorized by TMRSN.

Western State Hospital

Western State Hospital (WSH) is one of two state-operated mental health hospitals in the State of Washington. Individuals residing at WSH are there voluntarily or involuntarily. Due to the high cost of hospitalization (both at WSH and in community hospitals) and requirements around Least Restrictive Alternatives, the goal is always to move people out of hospital-settings and into more community-based programs and services. Authorizations for placement at Western State Hospital must come from the TMRSN.

Beds at Western State Hospital are paid for by the Department of Social and Health Services (DSHS). TMRSN was allotted twenty-six beds at any given time in 2010. If utilization goes over the allotted number of beds, TMRSN must cover the additional costs. In addition, TMRSN purchases additional bed space for the Program for Adaptive Living Skills (PALS). This program is considered a step-down program for those transitioning out of Western State Hospital or for those who are having a difficult time finding permanent housing options. In 2010, TMRSN purchased an average of three (3) PALS beds per day.

Providers in the TMRSN Network

Thurston Mason Regional Support Network welcomed a new community mental health agency (CMHA) into its network during 2010. Catholic Community Services joined the Network's three (3) other primary providers. Of TMRSN's network of providers, Behavioral Health Resources (BHR) is the largest provider in both Thurston and Mason Counties.

Behavioral Health Resources (BHR)

Behavioral Health Resources provided mental health services for over ninety-five (95) percent of the Medicaid and State-Funded eligible clients (who sought mental health services) in Thurston and Mason Counties during 2010. BHR offers a large, comprehensive package of mental health services including:

- A comprehensive list of options for adult outpatient mental health services, including a Program of Assertive Community Treatment (PACT) team, a Client Accessed Support Team (CAST), a supported employment program (Pathfinders), and a residential program that owns and operates three (3) apartment complexes in Thurston County, and supports clients in other residential settings.
- A full array of children's outpatient mental health services, including a co-occurring disorders program, Mentally Ill Juvenile Offender Program (MIJOP), Multisystemic Therapy (MST)

program, and an integration program for children transitioning back into their home of origin after a facility detention.

- Crisis services – including the Crisis Stabilization and Transitional Unit (CSTU) and Crisis Resolution Services (CRS).
- Inpatient services – including the Evaluation and Treatment Unit (ETU).

BHR operates at six (6) locations in Thurston and Mason Counties. These include:

Office Name	Address	City / State
Adult Services and Administration	3857 Martin Way E	Olympia, WA
Medical Services	4422 Sixth Avenue	Lacey, WA
Children Services	3773-A Martin Way E	Olympia, WA
Recovery Services	6128 Capitol Blvd	Tumwater, WA
Adult and Children Services	110 West K Street	Shelton, WA
Evaluation and Treatment Center	3436 Mary Elder Road	Olympia, WA

Table 2 - Behavioral Health Services Thurston and Mason County locations

Providence St. Peter’s Hospital

Providence St. Peter’s Hospital (PSPH) is primarily a health care facility and hospital – treating the full spectrum of physical health maladies. The hospital is located at 413 Lilly Road in Olympia. The hospital also provides mental health services, including:

- An 18-bed voluntary acute care unit for inpatient psychiatry. Treatment is provided to adults eighteen (18) and older who are experiencing a mental health crisis. The treatment team includes a psychiatrist, social worker, psychiatric nurses and occupational and recreational therapists.
- A program of partial hospitalization that serves as a transition and/or alternative to traditional hospitalization. It is an intensive weekday program that includes group therapy and activities, family support, education and links to community resources. Flexible scheduling encourages an early return to independent living.
- Older adult services that specialize in working with adults age 55 and older who are seeking diagnosis and treatment for mental health problems and support for maintaining tenure in the community. Services are designed to provide symptom management and to facilitate social integration in the community.

Sea Mar

Sea Mar is a health and human services provider that began in Seattle in 1978. Their primary focus is working with low income, underserved and uninsured populations in Western Washington – with a primary emphasis on work with Latino populations. Sea Mar is a Federally Qualified Health Center (FQHC) that provides medical care for these populations. The Tumwater clinic of Sea Mar offers the following mental health services:

- English and Spanish outpatient mental health services – including case management, individual and family counseling, and psychiatric medication assessments and management for adults. Sea Mar also offers chemical dependency and substance abuse outpatient treatment for both English and Spanish speaking clients, including intensive outpatient and after care.

Sea Mar has two locations in the Thurston Mason catchment area. This includes the primary location for mental health services at 409 Custer Way in Tumwater and their new location at 669 Woodland Square Loop in Lacey.

Catholic Community Services

Catholic Community Services (CCS) is TMRSN's provider for the Thurston Wraparound Initiative (TWI). Catholic Community Services and Catholic Housing Services have been in Western Washington for more than ninety (90) years. The mission of CCS and CHS is to serve as an advocate for "individuals, children, families, and communities struggling with poverty and the effects of intolerance and racism." Catholic Community Services is located at 2940 Limited Lane NW, Olympia, WA 98502.

Budget and Expense Review

Information about the expenses of the TMRSN can be found in **Figure 3** below. This information represents Calendar Year 2010 (January 1, 2010 through December 31, 2010). The graph includes percentages of the overall costs on actual expenditures for 2010 in the eight (8) largest categories. **Figure 4** displays a comparison on these eight categories between 2009 and 2010.

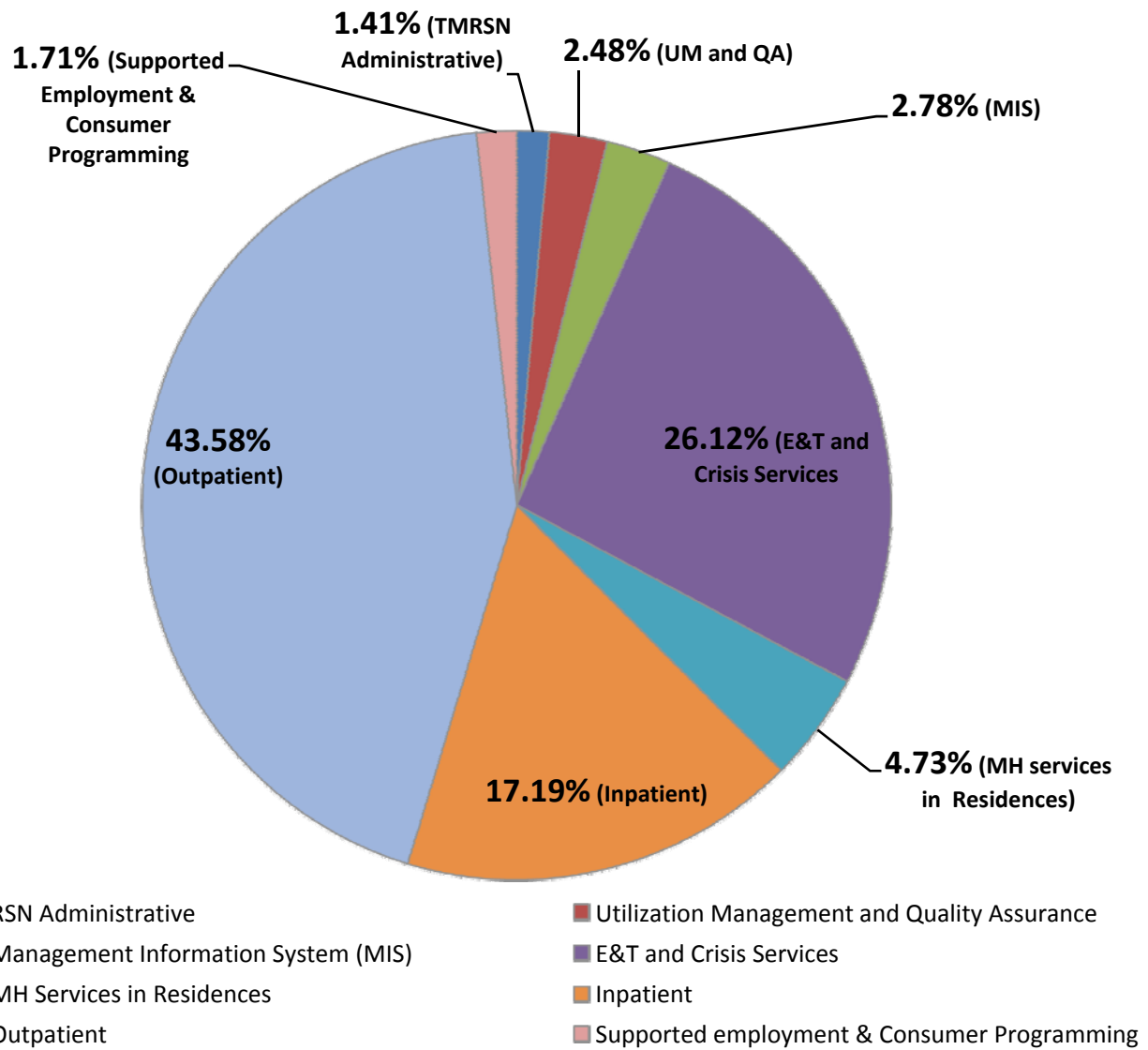


Figure 3 – CY 2010 Expenses

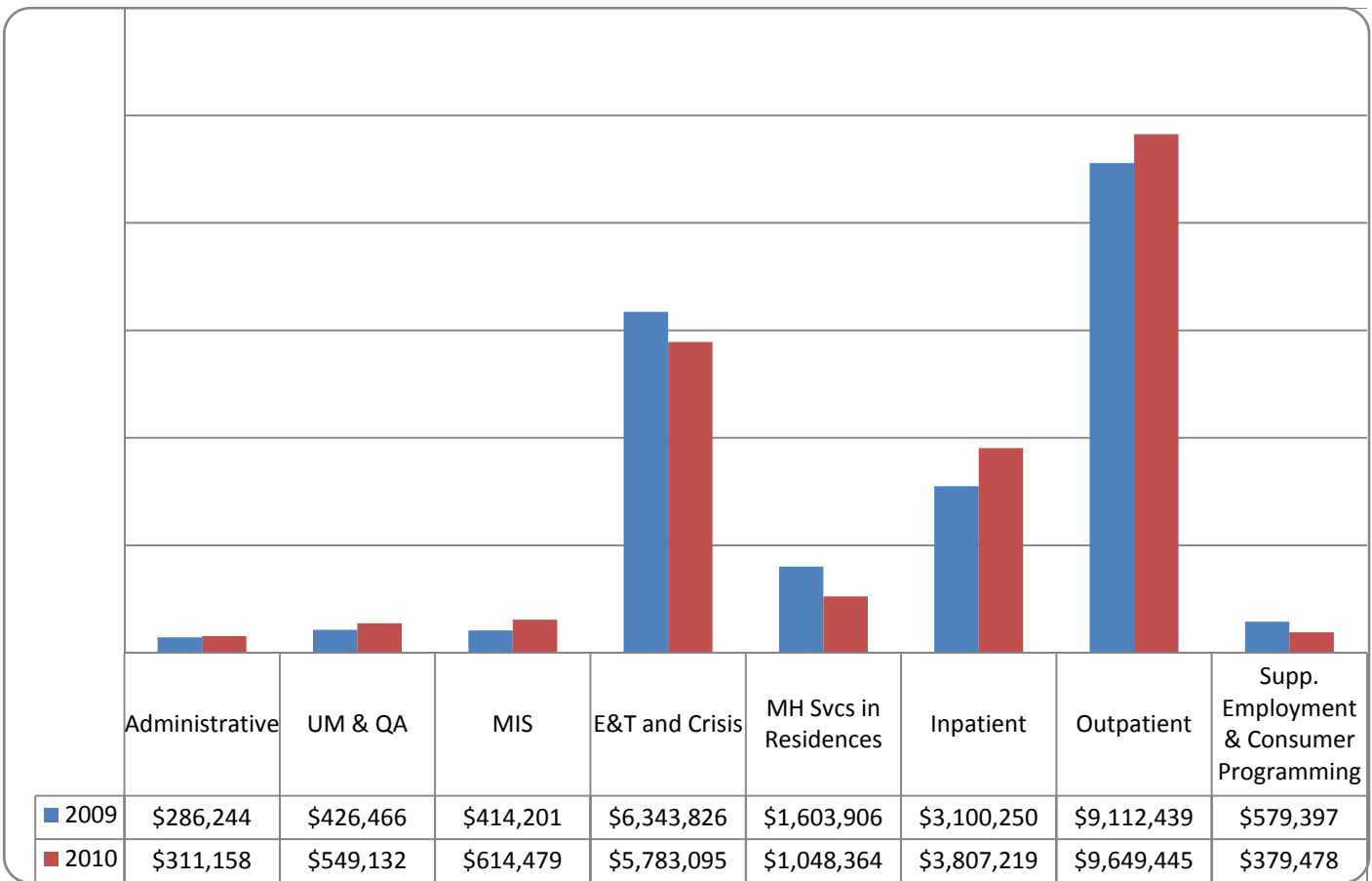
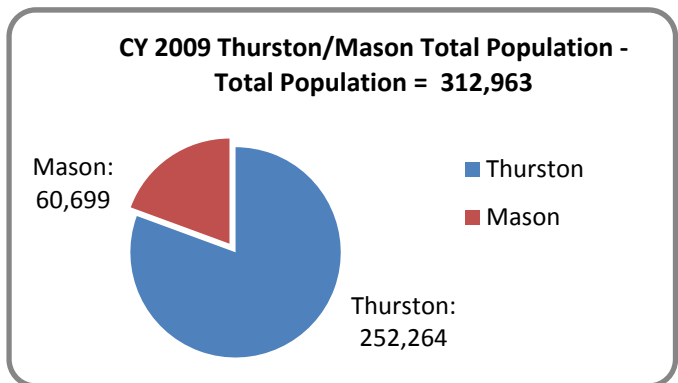


Figure 4 – Budget Expenditures: 2009 and 2010 Comparison

Populations Served

The overall population of Thurston and Mason Counties in 2010 – according to the newly released US Census Bureau figures – was 312,963 residents. Thurston County alone had a population of 252,264 residents. Seventy-five percent of these residents lived in an urban setting, while only twenty-five percent lived in rural settings. The average wage for a Thurston County resident in 2010 was \$34,583. Mason County had a population of 60,699 residents in 2010 – with only twenty-five percent living in an urban setting. The average wage for a Mason County resident in 2010 was \$27,927.



The population of Thurston and Mason Counties grew by some 56,203 residents between 2000 and 2010 (Thurston gained 44,909; Mason gained 11,294), according to the 2000 and 2010 Federal Census. This represents a 21.7% growth rate for Thurston County, and a 22.9% growth rate for Mason County.

Figure 5 – Thurston and Mason County, Total Population

Medicaid and Non-Medicaid Populations

Out of the 312,963 Thurston Mason Residents, approximately 41,730 had Medicaid eligibility in 2010. In other words, 41,730 citizens of Thurston and Mason Counties met the criteria to become Medicaid eligible. According to the Centers for Medicare and Medicaid Services (CMS): *Medicaid is health insurance that helps many people who can't afford medical care pay for some or all of their medical bills... Medicaid is available only to people with limited income.*

You must meet certain requirements in order to be eligible for Medicaid. **Figure 6** below demonstrates that the 41,730 Medicaid-eligible residents represent roughly **13.3%** of the total population of Thurston and Mason Counties.

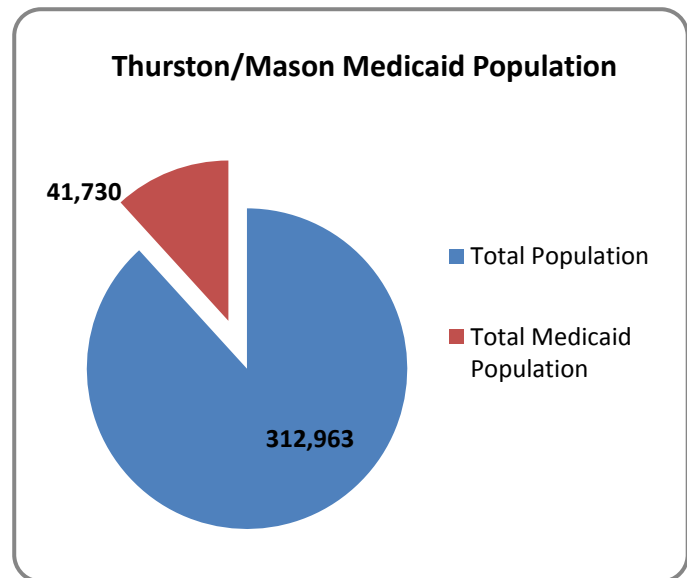


Figure 6 – Medicaid-Eligible Population versus Total Population

Figure 7 below demonstrates that of the 41,730 Medicaid-eligible residents, **7,906** eligible and unduplicated individuals (**18.95%**) utilized and received services through the publically-funded mental health system in calendar year 2010.

It is important to note that **not** all consumers of publically-funded mental health services are Medicaid consumers. There are a significant number of Thurston and Mason County residents who do not qualify for Medicaid – for a variety of reasons – who still qualify for publically-funded services. Funding for these services are referred to as “state-funded.” Consumers of state-funded mental health services must meet criteria under the Priority Populations definition as found in the Revised Code of Washington (RCW) 71.24, 71.05, and 71.34. The number of Medicaid versus non-Medicaid mental health consumers for 2009 is shown in **Figure 8** below:

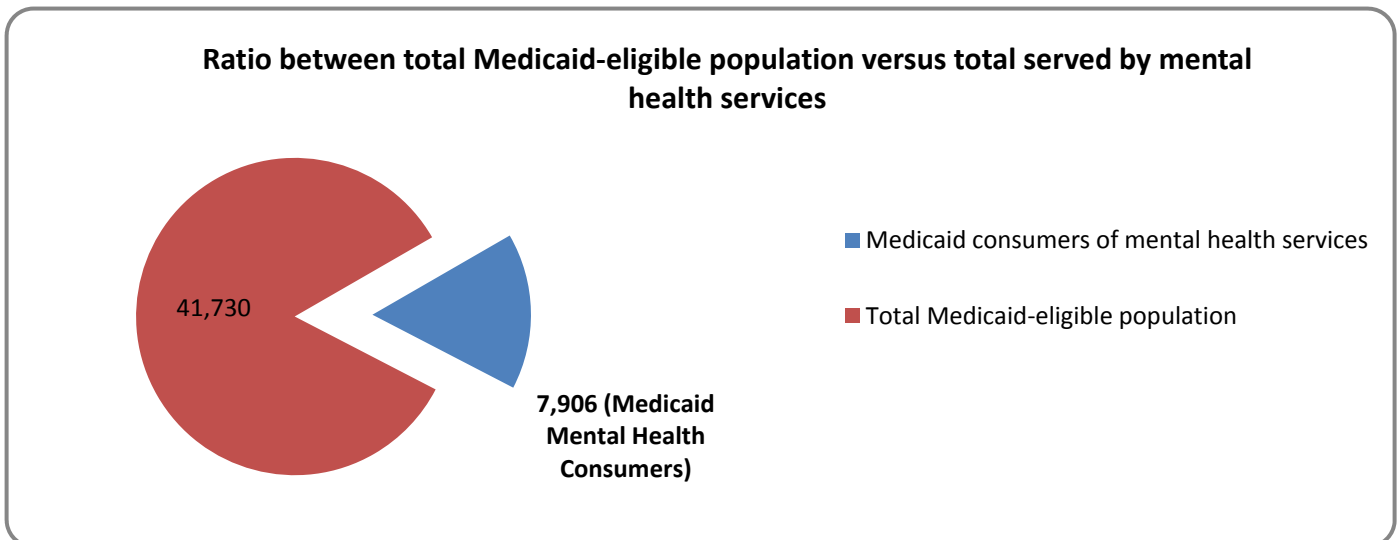


Figure 7 – Medicaid consumers of Mental Health Services

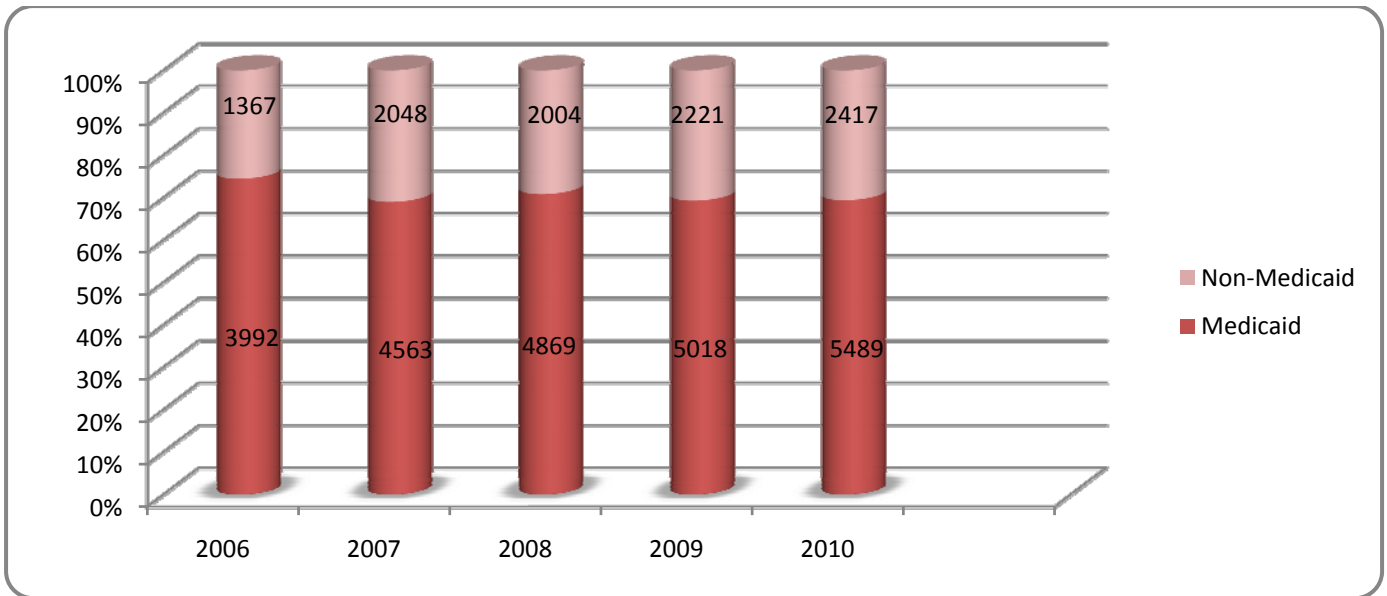


Figure 8 – Medicaid (Title XIX) versus Non-Medicaid Utilization

Age

The penetration rate of children in the publically-funded mental health system is roughly equal to the total number of residents within the two-county catchment area. Meaning, a similar ratio existed between the total number of children living in the region as compared to the total number of children who utilized mental health services. For example, in 2010 approximately 21.7% of the population in Mason and Thurston Counties were under the age of 18. Youth who engaged in publically-funded mental health services represented 24.7% of all participants. Adults, however, over the age of 64 represented 15.1% of the total bi-county population, yet represented only 6.7% of the overall population of those engaged in publically-funded mental health services. As **Figure 9** below demonstrates, the ratio of youth, adults and older adults has remained fairly consistent over the past five (5) years:

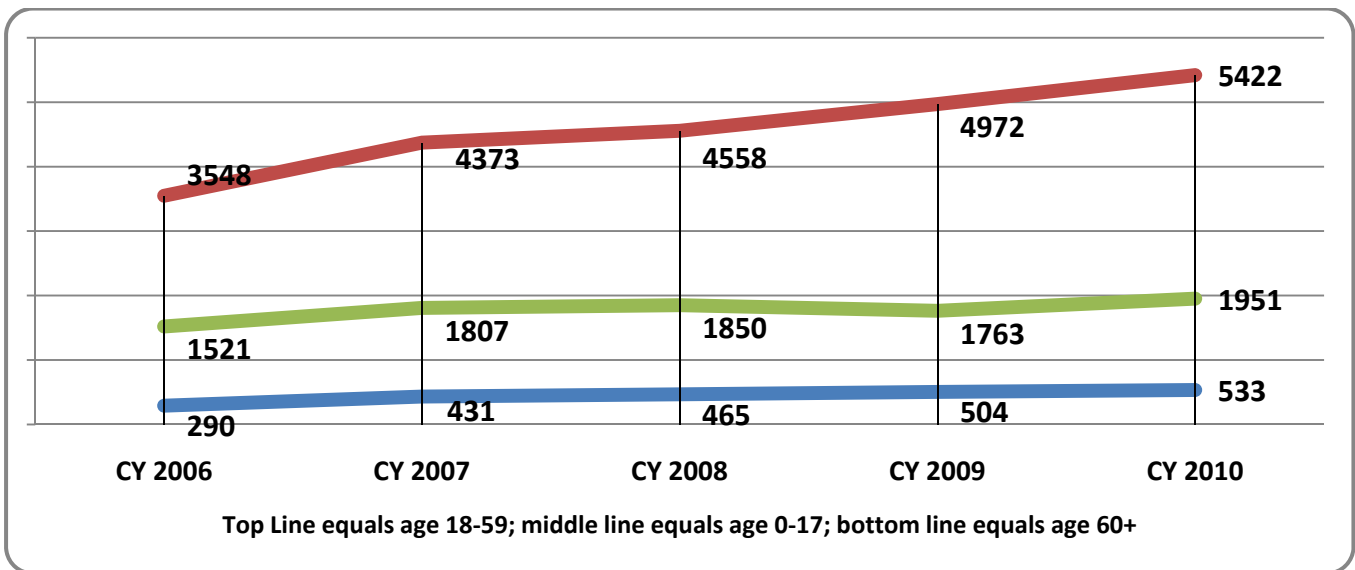


Figure 9 – Utilization of Publically-Funded Mental Health Services by Age

Ethnicity

Figure 10 below demonstrates the ethnic makeup of those consumers involved in publically-funded mental health services. **Table 3** that follows demonstrates the ethnic diversity in the overall Thurston and Mason County population. Furthermore, it compares the percentage of a given ethnicity in the general population of Thurston and Mason counties to the percentage of those engaged in mental health services. For example, one can see that in 2010 the percentage of Caucasian mental health consumers was roughly **70.12** percent of all consumers. However, Caucasians make up a total of **83.12** percent of the total general population in Thurston and Mason Counties, indicating that Caucasians were **under-represented** in 2010 by **13** percent. Similarly, one can see that individuals who represented themselves as multiethnic (or, more than one ethnicity), were **over-represented** by **3.92** percent.

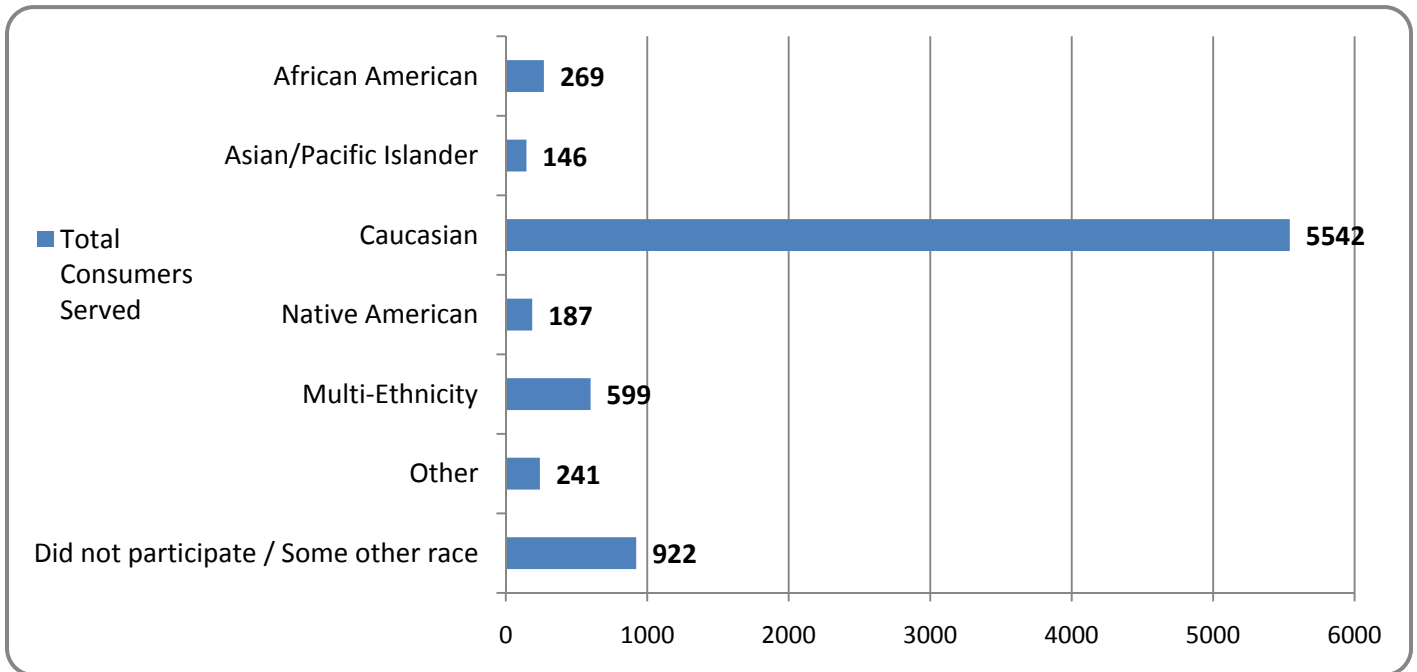


Figure 10 – Utilization of Publically-Funded Mental Health Services by Ethnicity

	2010 US Federal Census (number / percent)	2010 Mental Health Utilization by Ethnicity	Percent Mental Health Utilization	Proportionality
African American	7,411 / 2.37%	269	3.41%	+ 1.04
Asian/Pacific Islander	15,956 / 5.1%	146	1.85%	- 3.25
Caucasian	260,137 / 83.12%	5542	70.12%	- 13.00
Native American	5,754 / 1.84%	187	2.37%	+ 0.53
Multi-Ethnicity	16,008 / 5.11%	599	7.58%	+ 2.47
Some Other Race	7,697 / 2.46%	922	11.66%	+ 9.2
Hispanic Origin	22,631 / 7.23%	319	4.03%	- 3.2

Table 3 – Proportionality between ethnic demographics and Mental Health utilization

Total Client Visits and Hours

In 2010, there were a total of 179,516 client visits to publically-funded mental health facilities and 80,426 hours of service provided. There was an unduplicated count of 7,906 clients in 2010. This translates to 22.7 visits per client for 2010 with an average of 10.17 hours of service provided. Overall, the number of visits per client has increased since 2009, but the length of time has decreased. Both the number of client visits and the total number of service hours provided are based on the total number of clients seen during 2010.

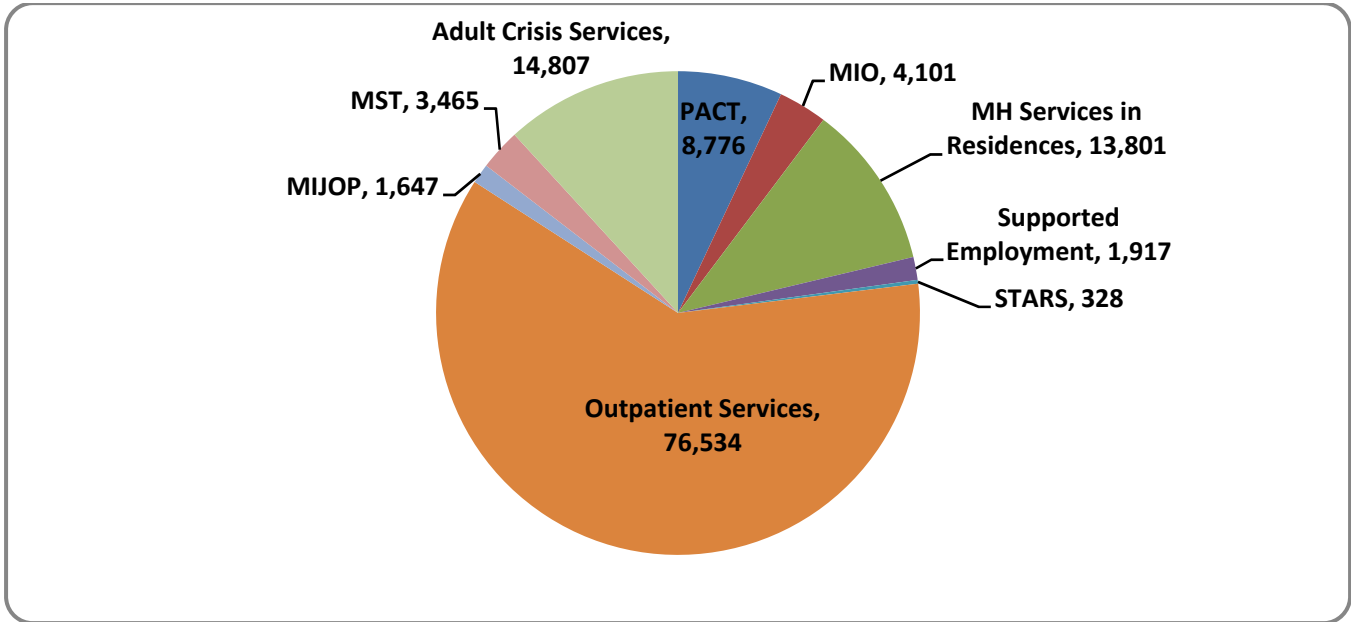


Figure 11 – CY 2010: Total Client Visits

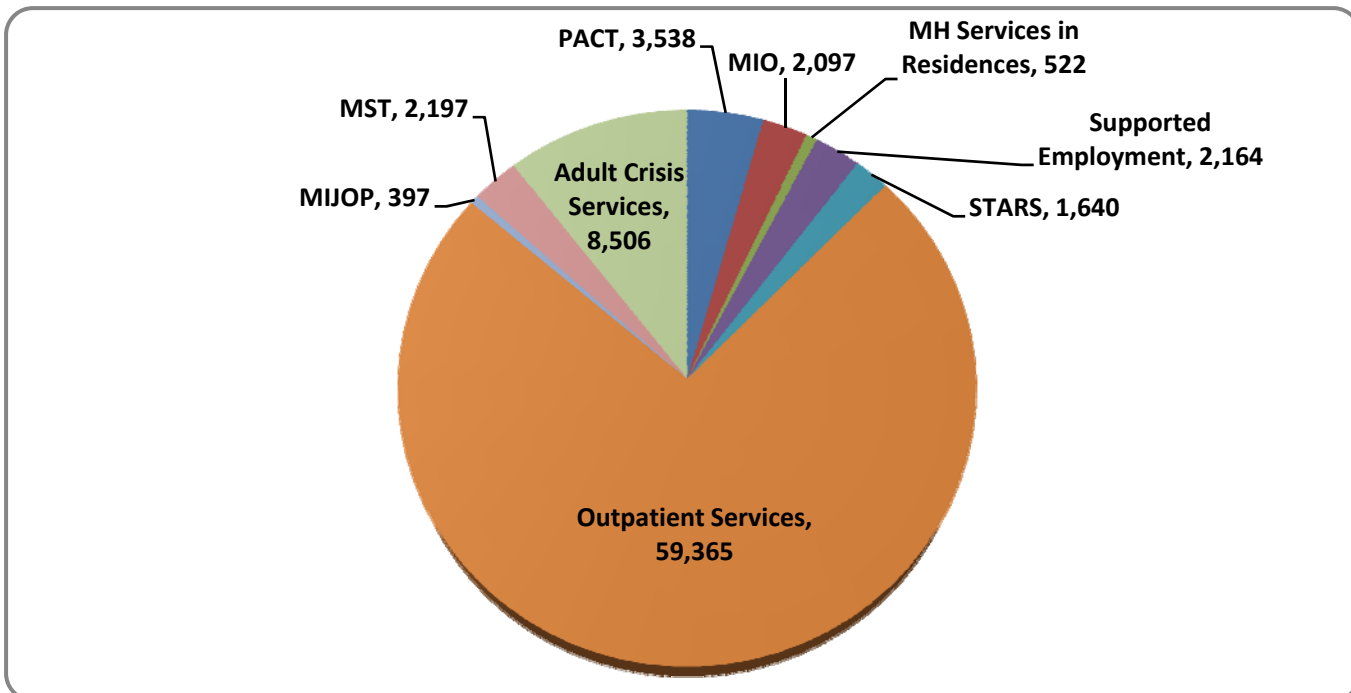


Figure 12 – CY 2010: Total Hours of Service

Services Provided to Adults

Outpatient Programs

Each client enrolled in publically-funded mental health services may be eligible for multiple programs or services. Although the majority of clients are enrolled in only one program, i.e., outpatient case management, many others may be enrolled in multiple programs. When examining the actual number of clients enrolled in the publically-funded mental health system, it is important to remember the difference between a duplicated and unduplicated count. The numbers presented in the figures below represent a **duplicated** count of clients. This means that one client can be counted more than one time. For example, the client may have started out in the Mentally Ill Offender (MIO) program, transferred to Outpatient Services counseling, and ultimately transitioned into the PACT program – all during the course of one year. As mentioned in **Figure 7** above, during 2010 there were a total of 7,906 unduplicated clients who received services through the TMRSN (one person, possibly numerous programs and services).

In addition, all of the programs represented by **Figure 13** below are considered “outpatient programs.” The large number of clients represented by the **outpatient services** section below (3507) are clients who were engaged in traditional outpatient mental health services. The other categories represent specialized outpatient programs. **Figure 13** demonstrates various outpatient programs in 2009, while **Table 4** demonstrates an historical view of several specialized programs over the past five (5) years:

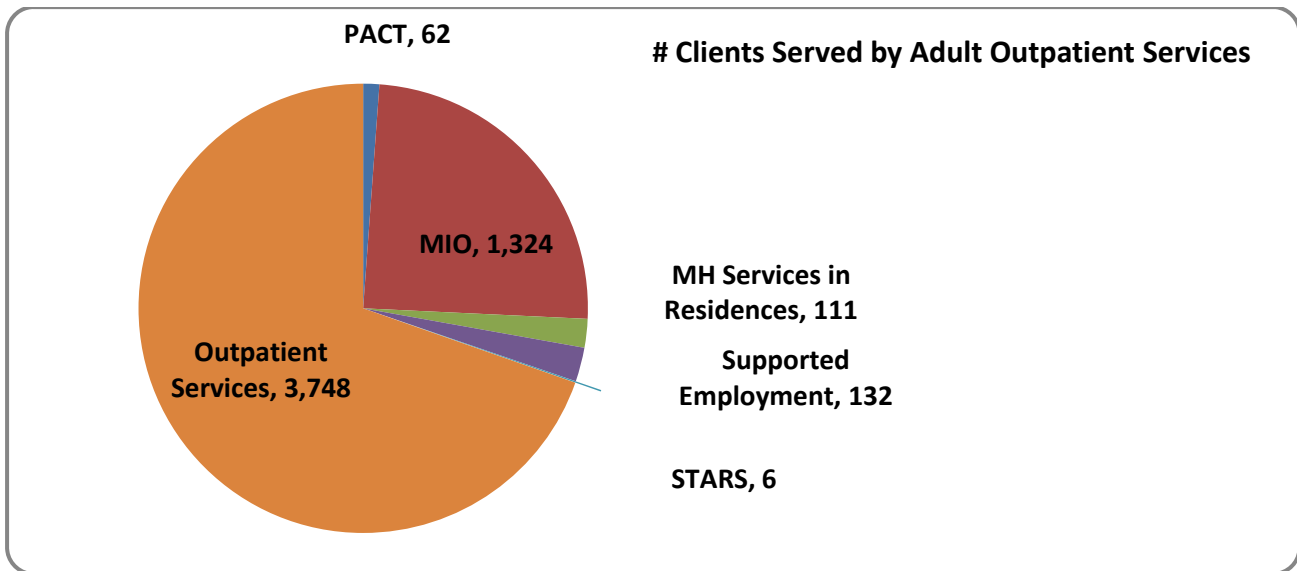


Figure 13 – Adult Outpatient Services, by Client

Adult Mental Health Program/Service	2006	2007	2008	2009	2010
PACT	0	19	51	52	62
MIO	939	1048	928	1117	1324
MH Services in Residences	4	8	66	115	111
Supported Employment	69	84	95	100	132
STARS	12	12	9	10	6

Table 4 – Adult Outpatient Services, by Client

Employment

Another piece of information that TMRSN collects is employment demographics of the clients. There are several employment programs offered within TMRSN that prepare clients for seeking employment and/or supports them once they have obtained a job. **Figure 14** below summarizes how adult clients reported their employment profile, while **Table 5** demonstrates an historical view of several specialized programs over the past five (5) years:

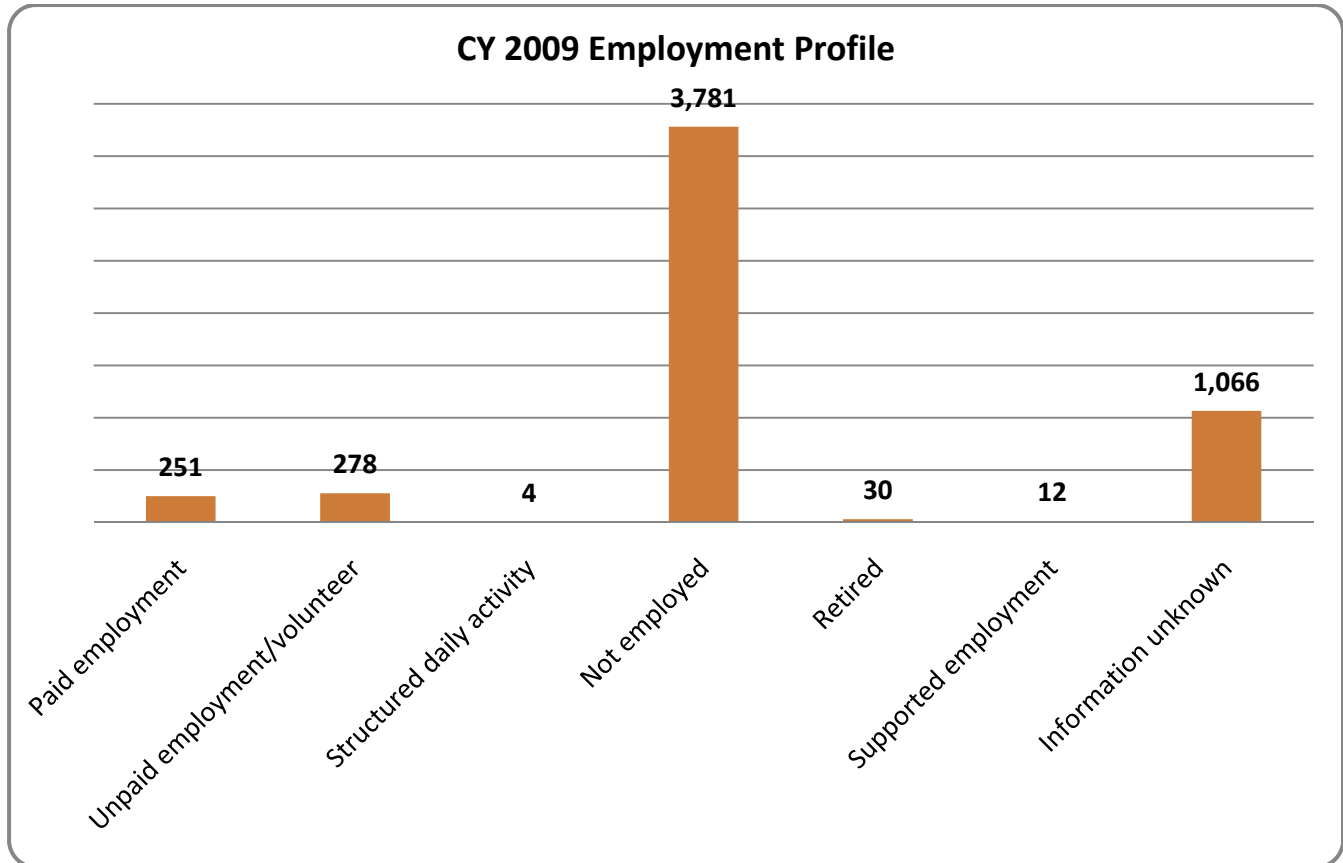


Figure 14 – CY 2010: Consumer Employment Profile

Activity	2006	2007	2008	2009	2010
Paid employment	254	279	290	254	251
Unpaid employment/volunteer	118	107	126	189	278
Structured daily activity	8	10	7	7	4
Not employed	3328	3637	3886	3873	3781
Retired	30	40	36	28	30
Supported employment	14	13	19	17	12
Information unknown	74	639	703	789	1066

Table 5 –Consumer Employment Profile, Historical Comparison

Crisis Services / Hospitalization / Correctional Institutions

Crisis services for adults are designed for people who are experiencing acute symptoms of a mental disorder. Access to services may come from referrals from friends and family, mental health professionals in the community, primary care physicians, law enforcement, or from the consumer.

Figure 15 below summarizes the number of consumers who have accessed crisis services in Thurston and Mason counties during 2010. **Figure 16** demonstrates the number of clients that were involuntarily and voluntary detained due to concerns for their own safety, or the safety of others.

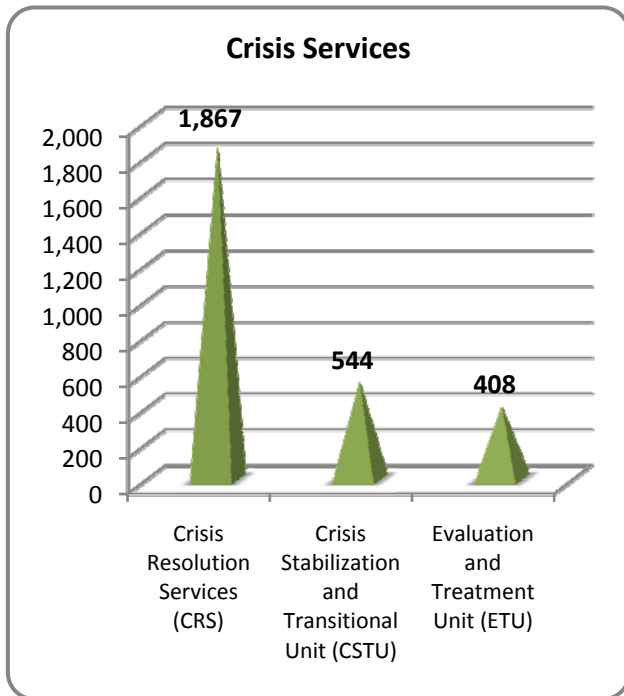


Figure 15 – CY 2010: Adult Crisis Services, by Client

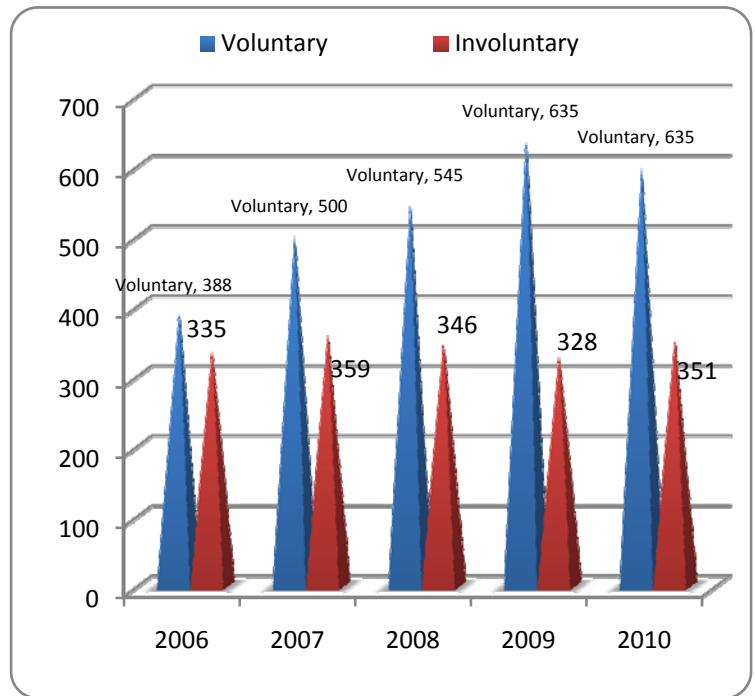


Figure 16 – Voluntary and Involuntary Utilization, Historical Comparison

Figure 17 shows the regional breakdown of where these consumers resided at the time of their involvement in crisis services. It is important to note that the category marked as “other counties” represent those consumers who utilized E&T services from the TMRSN, but were from counties outside of Thurston or Mason Counties. Several other Regional Support Networks do **not** have E&T facilities, psychiatric beds, or community psychiatric hospitals within their own geographic area, therefore several have an agreement with TMRSN to use its resources. These include Gray’s Harbor and Timberlands Regional Support Networks.

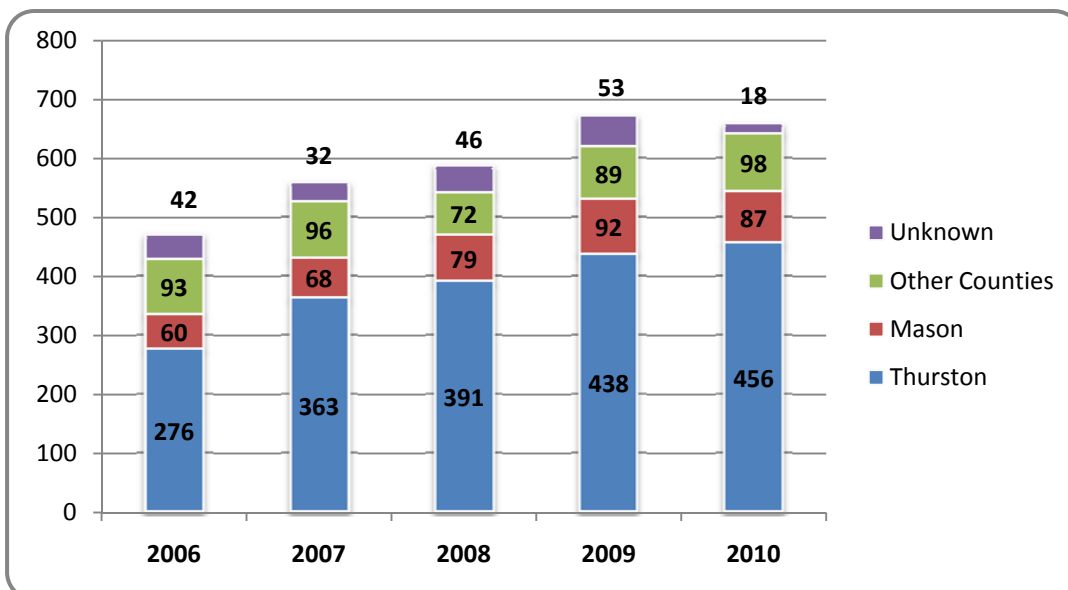


Figure 17 – Adult Crisis Services Historical Comparison, by County

Western State Hospital

Western State Hospital (WSH) provides hospitalization services for some of the most chronically mentally ill adults in the community. Thurston Mason Regional Support Network was allocated twenty-six (26) hospital beds to use during the 2010 calendar year, meaning, the State will pay for up to 26 beds per day for use by the TMRSN. If the daily census goes over this amount, TMRSN must pay for these additional beds.

Over the past decade or so, the length of stay at WSH has steadily declined as outpatient and step-down services, including intensive residential support services and PACT, have increased to provide services to those who would otherwise be hospitalized. As **Figure 18** below demonstrates, the number of admissions to the hospital has remained fairly consistent over the past five (5) years.

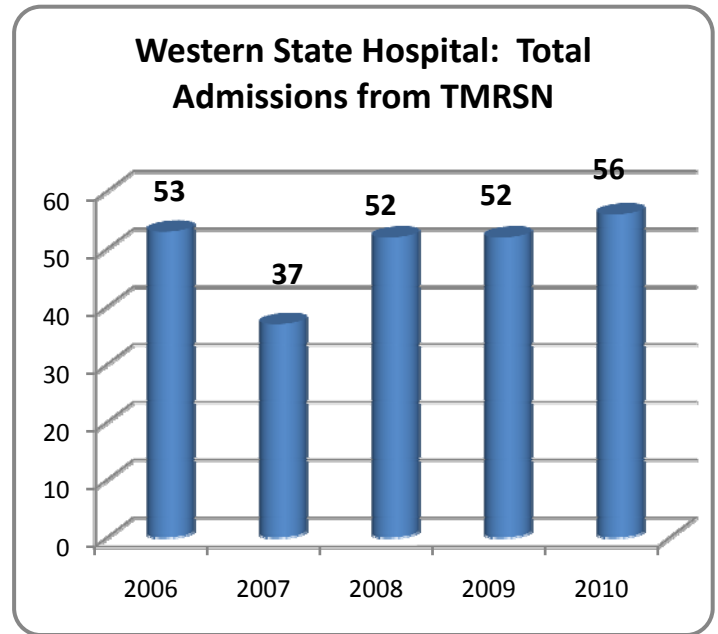


Figure 18 – Western State Hospital TMRSN Unduplicated Admissions, Historical Comparison

Figure 19 and **Figure 20** demonstrate, however, that the average daily census (the number of TMRSN consumers utilizing a bed at Western State Hospital on any given day) and the total number of bed days utilized by TMRSN, increased from 2009 to 2010.

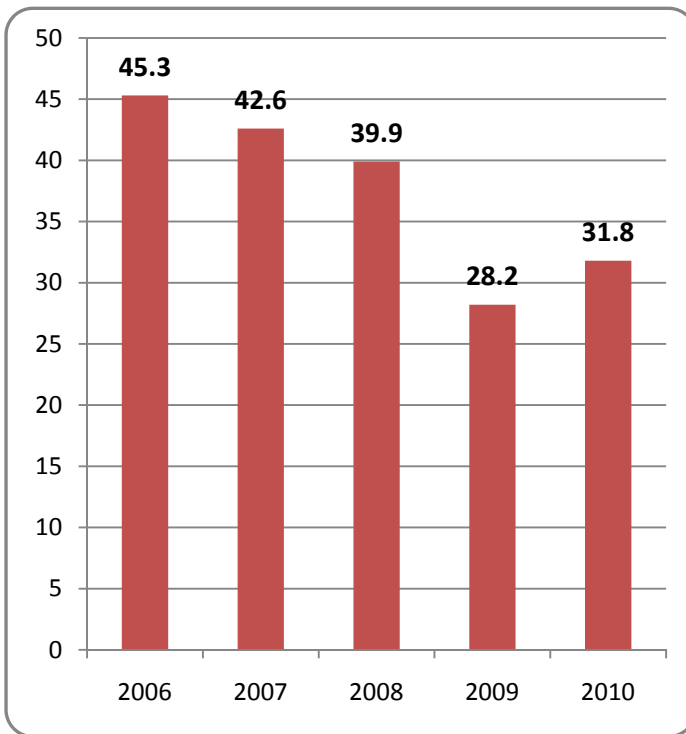


Figure 19 – WSH Average Daily Census, Historical Comparison

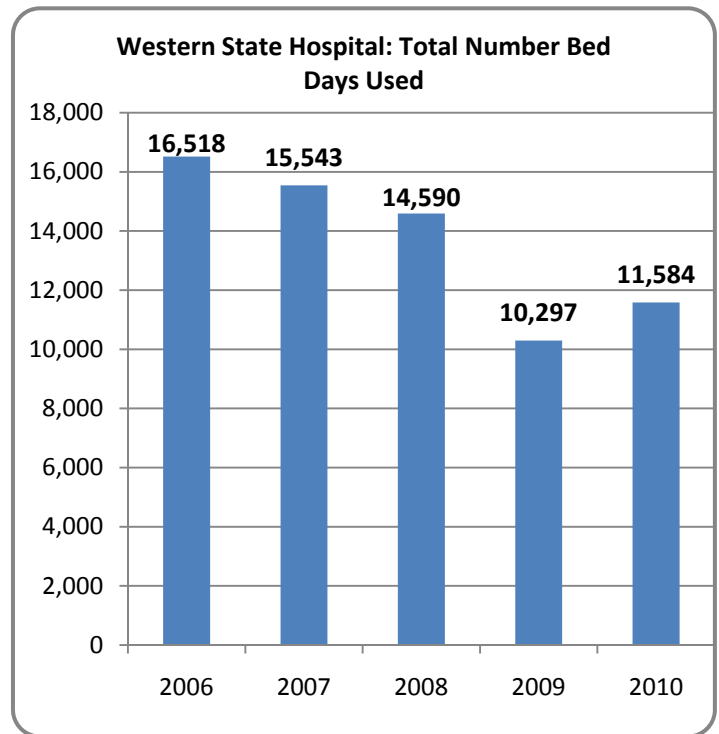


Figure 20 – WSH Total Utilized Bed Day, Historical Comparison

Thurston - Mason Jail Facilities

Figure 21 below represents individuals who were residents of one of the three (3) jail facilities in Thurston or Mason counties **and** who were engaged in the TMRSN-funded Mentally Ill Offender (MIO) program. In 2005, the MIO program was not yet well established in the Olympia City Jail or the Mason County Jail, but as the figure below demonstrates, utilization has greatly increased in these facilities in the past six (6) years.

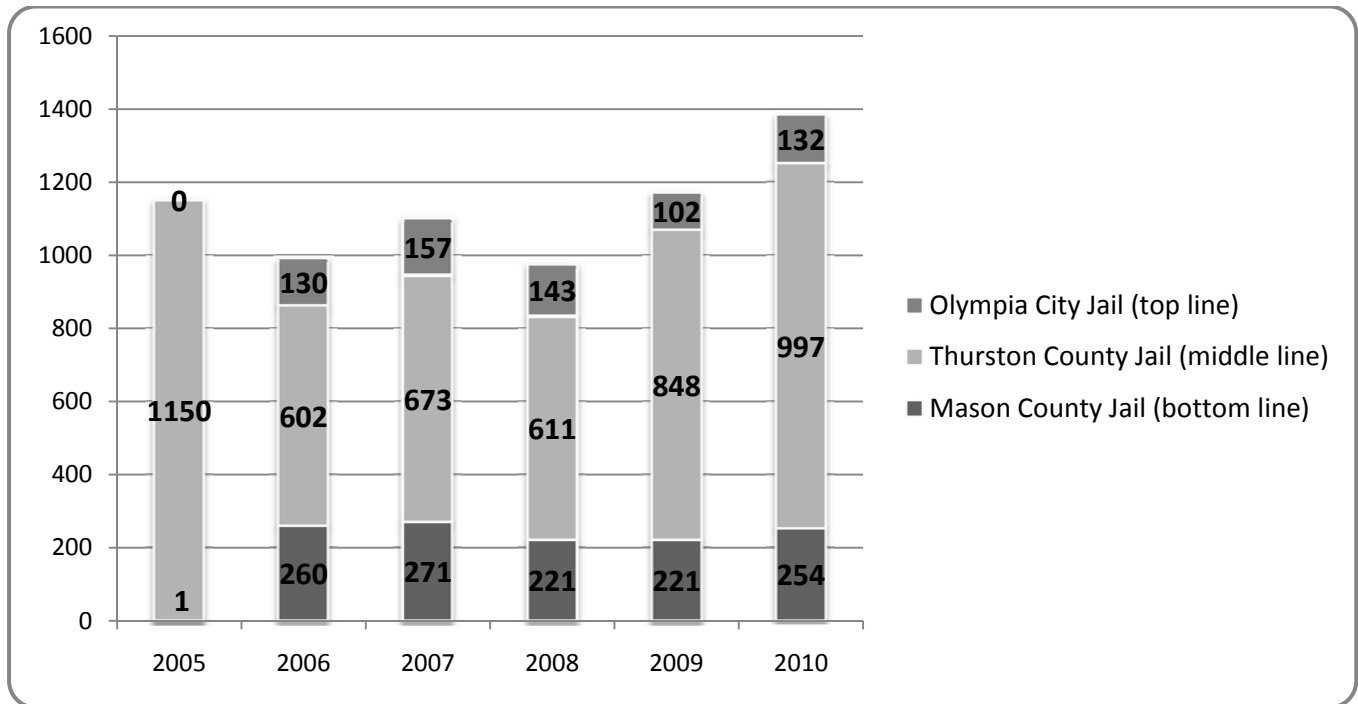


Figure 21 – Correctional Institutions MIO Utilization, Historical Comparison

Services Provided to Children

As with the adult consumers discussed above, each child enrolled in publically-funded mental health services may be eligible for multiple programs or services. It is important to note the numbers presented in **Figure 22** below represents a **duplicated** count of children. This means that one client can be counted more than one time. As mentioned in **Figure 7** above, during 2010 there were a total of 7,906 unduplicated consumers who received services through the TMRSN; of that, 1,951 (24.7%) were children. In 2009, 1,763 (24.4%) of consumers were children

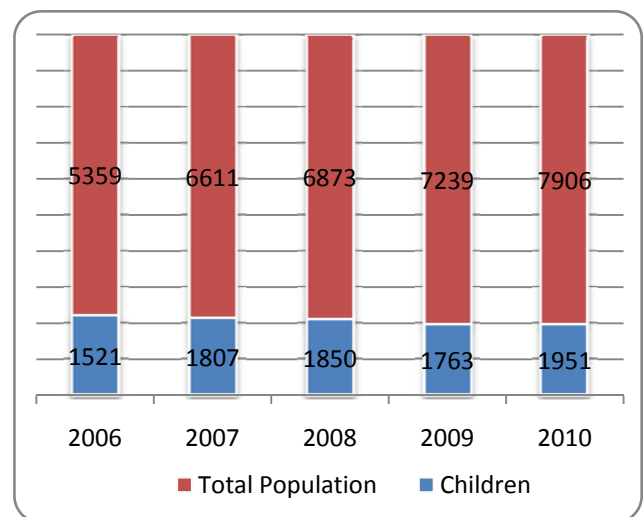


Figure 22 – Youth Engaged in Publically-Funded Mental Health System, Historical Comparison

Figure 22 demonstrates the total population of all persons engaged in services over the past five (5) years and the percent of those that were children under the age of eighteen (18).

In 2010, there were three (3) primary categories for publically-funded children’s mental health services in Thurston and Mason Counties. The Mentally Ill Juvenile Offender Program (MIJOP) and the MST program were both described in the Program Description section above. The Outpatient Services category is the largest service category. It is comprised of many smaller services and programs depending on the needs of the client.

Figure 23 summarizes the number of youth consumers involved in three (3) categories of outpatient programs. As with the adult population, it is important to note that some client are involved with more than one program; therefore, the total number of youth involved in these programs exceed the “unduplicated” count of children (1,951) presented earlier.

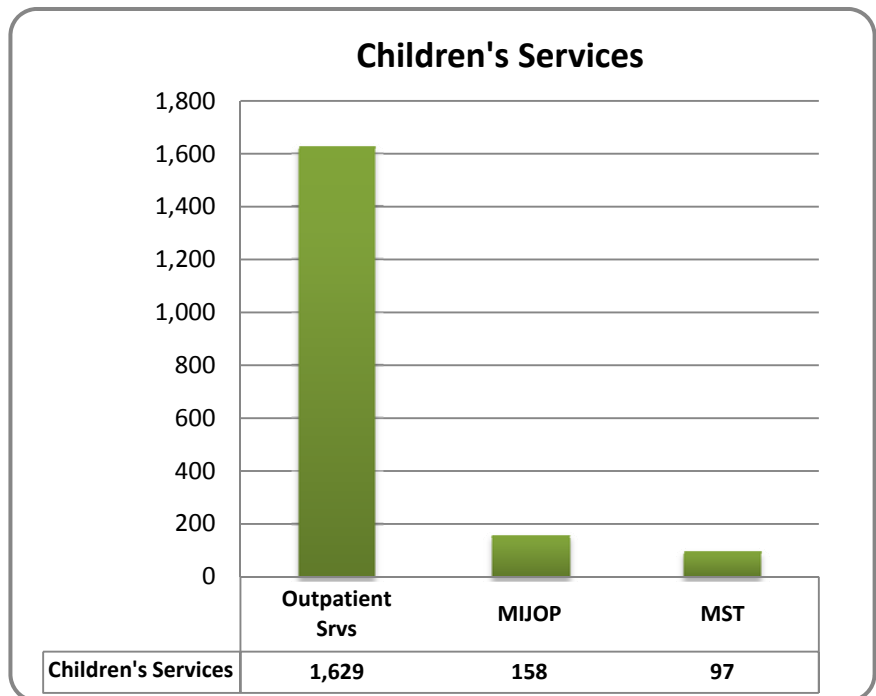


Figure 23 – CY 2010: Children Outpatient Services, by Client

Figure 24 below presents an historical overview of children’s mental health programs at TMRSN.

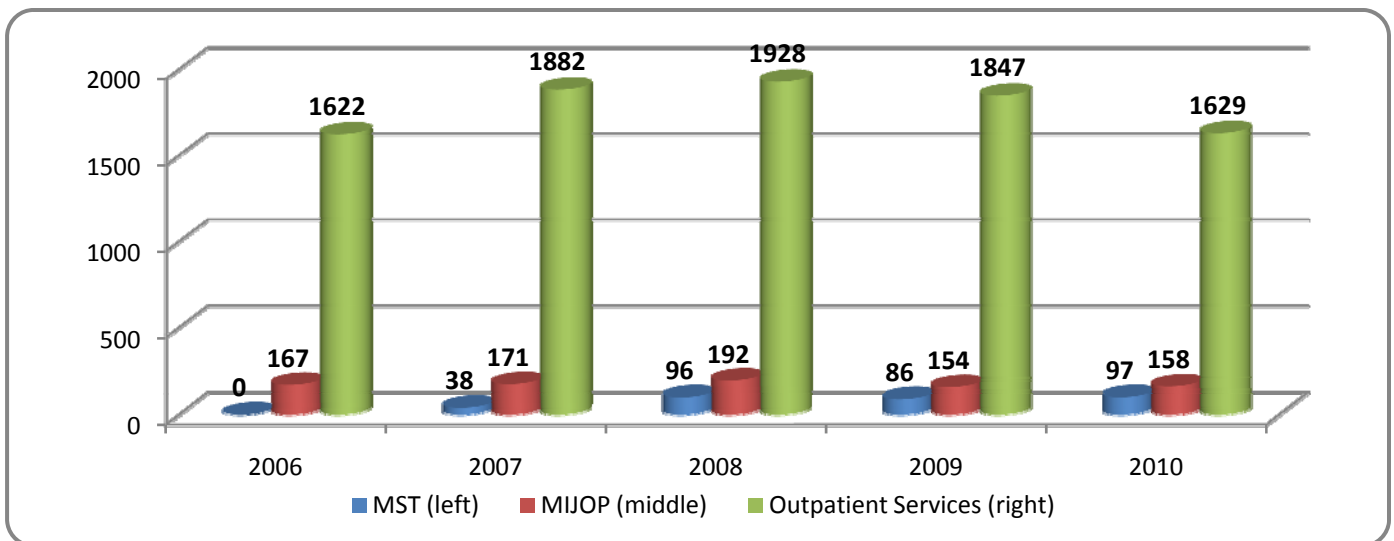


Figure 24 – Children’s Outpatient Services Historical Comparison, by Client

2010 saw the continuance of many new and exciting programs and initiatives in support of mental health services for children. In addition to the four (4) Evidence-Based Practice (EBP) projects currently underway, TMRSN added a fifth during 2010.

- **Thurston Wraparound Initiative (TWI)** – As described above in the 2010 in Review, TWI is an initiative that strives to provide intense, individualized care planning and services to high risk

children and youth, and their families. As part of the design model, community members and professionals alike collaborate to “wrap” the individual consumer with individualized services that best fit the needs of the consumer and their family.

- **Multisystemic Therapy (MST)** – also described above in the 2010 in Review, MST is an evidence-based practice designed to serve severely behaviorally challenged and substance-abusing juvenile offenders (age 11 – 17). Therapy focuses on promoting positive social behavior while decreasing antisocial behavior and can occur in the home, school, or other community setting.
- **Skokomish Project** – This project trained mental health professionals from the Skokomish Nation Tuwaduq Family Services Program trauma-focused – cognitive behavioral therapy, Positive Parenting Program (Triple P) training and motivational interviewing.
- **Positive Parenting Program (Triple P)** – The Triple P process of positive parenting is a comprehensive, research-based program that demands rigorous fidelity to its model. In 2010, over fifty (50) parents received Triple P services. The program has now been adopted as one of BHR’s programs.
- **Parent Empowerment Program (PEP)** – The Parent Empowerment Program began forming in late 2009. The program consists of parents helping parents and involves extensive PEP training. Five (5) parents from Thurston and Mason Counties participated in the initial training with all agreeing to the required twenty (20) hours of consultation.

Interestingly, the Multisystemic Therapy Program (MST) started in 2007 as a two-year test program, but has demonstrated such positive results that it is now on its second extension and will be entering its fifth year in 2011. **Figure 25** below demonstrates the results of the most recent evaluation of MST, and the impact it is having on the lives of youth:

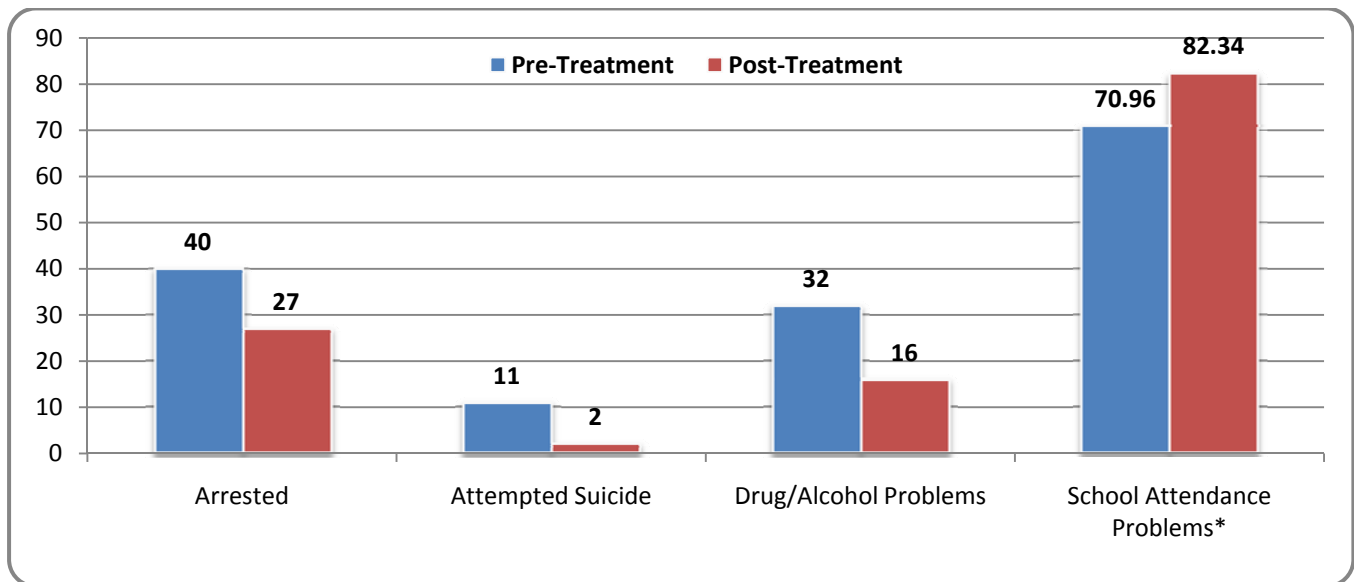


Figure 25 – Pre-Post outcomes for MST Youth (n=104)

Note: School attendance was measured in terms of percent of increase in overall school attendance. For the study period, one can see that school attendance increased over eleven (11) percentage points.

Crisis Services

In 2010, TMRSN implemented the Children’s Crisis and High Intensity Program in response to a growing need in the community to better serve children with more intensive, timely, and preventative services. Specialists in the program provide crisis response and adjunctive high-intensity outpatient service for children/youth experiencing acute or severe emotional and mental health symptoms that cannot be managed with traditional outpatient mental health services alone or in a timely manner. Services are provided to children, families and others involved in the support of the child, and include crisis response, crisis intervention, same day appointments, high-intensity supports, and follow-up care for crises, and include coordination and linkage with outpatient and/or cross-system supports, such as the collaborative Joint Position project with DCFS, as part of the service continuum.

In addition, services are based on an intensive treatment and crisis response model and may be provided in the client’s home, outpatient children’s program, school, Thurston County Evaluation and Treatment Center, hospital emergency rooms, or in the community. The primary target population for these services is TMRSN-enrolled/eligible children/youth who are experiencing a serious and/or acute mental health episode.

The new program has designated specialists that provide immediate crisis care and coordination of services. The staff are all credentialed Children’s Mental Health Specialists and are supervised by a licensed Mental Health Professional. TMRSN is currently in the process of developing outcome measures and quality standards for this program.

The number of clients served in traditional outpatient services in 2010 included a significant number of children who were seen in crisis. These children were served in existing outpatient settings and programs – and counted in the overall outpatient numbers (see **Figure 23** above).

Figure 26 below demonstrates the overall number of children who were seen due to a crisis episode for the past five (5) years, and the corresponding number of service hours spent with the youth. Note that there was a significant increase in the overall number of youth who were seen for crisis visits between 2009 and 2010. It is still too early to tell whether or not this is a result of the new Children’s Crisis and High Intensity program:

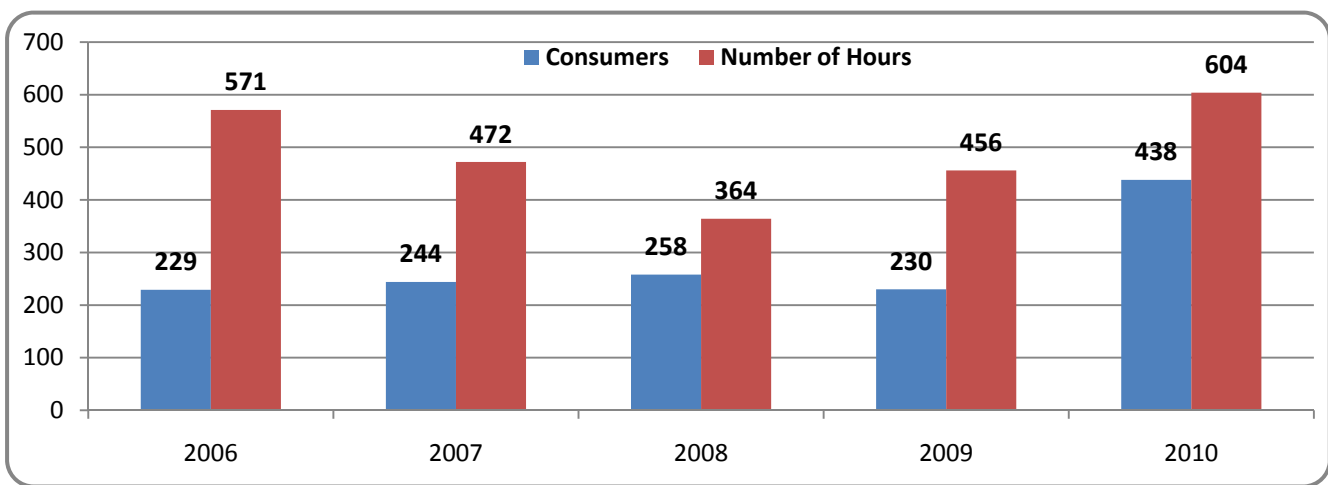


Figure 26 – Children’s Outpatient Crisis Services, Historical Comparison

Conclusion

TMRSN was faced with many new and existing challenges and opportunities at the start of 2010. As 2011 began, many of those same challenges and opportunities remained. At the front of everyone's mind were the lingering effects of the Great Recession – the worst economic downturn since the Great Depression. While there was a lot of celebrate in 2010 – especially the many new and exciting initiatives within children's mental health – many still worried about how shrinking budgets would affect those populations most in need.

2010 was a year that allowed TMRSN to continue reviewing programs and services and to evaluate possible gaps in the overall service delivery system. It was a year that saw a newly invigorated clinical chart review system come to fruition – and along with it, the many possibilities that come from a lively continuous quality improvement system. A new program for youth, Thurston Wraparound Initiative, was launched in 2010, and existing children's programs were strengthened. Work was also finalized on a new Access Program, which will greatly reduce the length of time from a request for service to an actual intake.

The State of Washington and all RSNs remain concerned, however, over the critical issue of State and Federal budget reductions and their impact on social and health services. Funding for the TMRSN is entirely subject to the fluctuations in State and Federal levels of funding. Expectations are that TMRSN maintain current levels of service, regardless of any reduction in budget or increase in expense. The TMRSN will, by necessity, examine ways to be more efficient and reduce non-required programming in order to maintain essential service delivery. The first priority of TMRSN will continue to be funding for acute care needs. Other services, and those priority populations we serve, will have to be evaluated over the next year for continued funding and support.

The second critical issue over the next several years is the impact of Health Care Reform on the health care service delivery system. Issues such as integrated models of care between behavioral health and primary health, "affordable care homes" and "health care homes" are all being discussed to try and understand how service delivery care models will change and what the role of TMRSN and Thurston County will be as a result of these changes. Planning is already underway so that TMRSN will be well positioned to make decisions in response to health care reform – due to occur at least by 2014.

In addition to the critical issues discussed above, TMRSN has other continuing initiatives, including:

1. Implementation of a gap analysis to study the mental health needs of children in Thurston and Mason counties – especially in the area of crisis services provided by community mental health agencies.
2. Partnering with community stakeholders and contracting with a new Medical Director to better manage inpatient resources and assess the medical necessity for community inpatient level of care. Potential revision of the State's Access to Care system that providers use to determine eligibility for services to clients. TMRSN to implement an "Access Program" in early 2011 where consumers can get many of their urgent mental health concerns addressed promptly. The current TMRSN Level of Care (LOC) Guidelines were revised in 2010 in preparation for this significant change.
3. Managing the shift of fund source for the PACT program services from a State proviso funded program to a program funded primarily with Medicaid dollars, without sacrificing quality or capacity. Research into local resources to assist consumers with transitional services after they leave an inpatient setting.