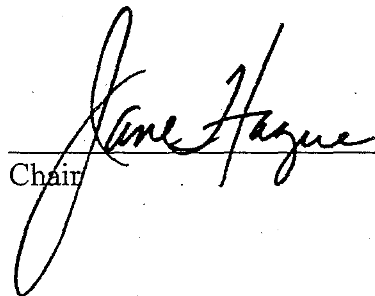
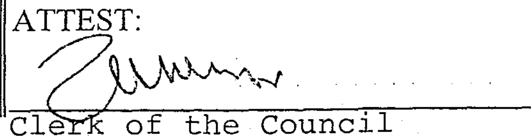
1 WHEREAS, the creation of a unified services initiative called "No Wrong Door"
2 offering multiple portals of entry into both the mental health and substance abuse treatment
3 systems such that every doorway in each system becomes the "right" door, regardless of a
4 client's presenting problems, can begin to address the goals of systems integration, and
5 WHEREAS, the target population for "No Wrong Door" shall include individuals and
6 families with limited financial resources who present problems and/or a level of disability
7 which indicate the need for publicly funded mental health or substance abuse services, and
8 WHEREAS, priority for initial care and linkage to ongoing services shall be given to
9 individuals who are homeless or at imminent risk of homelessness, and/or individuals with a
10 history of repeated or chronic use of public services providing acute care and/or more
11 restrictive environments.
12 NOW, THEREFORE, BE IT MOVED by the Council of King County:
13 The attached response to the council proviso calling for a Unified Services Initiative
14 and the creation of "No Wrong Door" be hereby approved, and, furthermore, be implemented
15 immediately by the executive and the directors of the departments of community and human
16 services and public health.
17 PASSED by a vote of 11 to 0 this 13th day of October, 1997
18
19 KING COUNTY COUNCIL
20 KING COUNTY, WASHINGTON
21
22
23
24

25 Chair
26
27 ATTEST:
28

29
Clerk of the Council

10336

"No Wrong Door"

A Unified Services Initiative for the Mental Health and Substance Abuse Systems In King County

Barbara J. Gletne, Director
King County Department of Community and Human Services

Alonzo Plough, Director
Seattle/King County Department of Public Health

Joanne Asaba, Manager
Mental Health Division

Patrick Vanzo, Manager
Division of Alcoholism and Substance Abuse Services

David Wertheimer
Unified Services Project Manager
Mental Health Division

Richard Andrews
Unified Services Project Manager
Division of Alcoholism and Substance Abuse Services

June, 1997

10336

Executive Summary

At the encouragement of then King County Councilman Ron Sims (now the County Executive), language was attached by County Council to 1997 ordinances calling for the development of a plan for the creation of a new behavioral health program combining at least portions of existing mental health and alcohol and substance abuse programs.

The Directors of the Seattle/King County Department of Public Health and the King County Department of Community and Human Services have articulated a commitment to the goal of promoting systems integration between the two departments to improve services to King County residents experiencing mental health and/or substance abuse disorders. The Managers of the Division of Alcoholism and Substance Abuse Services and the Mental Health Division have prioritized activities in this area. In order to more effectively pursue these goals, County staff from each Division were assigned to temporary, parallel positions as Unified Services Project Managers.

In order to better understand and define systems integration, four key indicators of this type of integration are being used to identify desired goals and outcomes and to guide current staff efforts. These indicators are:

1. **Shared Information:** Information about programs, services, treatment models, and clients all moves across the traditional, categorical lines of service delivery systems
2. **Shared Planning:** Multiple systems engage in conjoint processes to plan integrated services to multi-problem clients
3. **Shared Clients:** Multi-problem clients that traditionally receive services in only one system or receive uncoordinated care in multiple systems are shared by appropriate treatment systems and treated in a coordinated fashion (e.g. single treatment plans, multi-disciplinary teams, etc.)
4. **Shared Resources:** The resources available to multiple systems are blended and/or shared to ensure that services are configured in a way that meet the individualized and tailored treatment needs of clients rather than the needs of the systems or providers offering care.

Utilizing these key indicators (which also contain the basis for the development of measurable outcomes), the two departments have identified three key areas for current systems integration efforts. These areas are:

1. Information Management

The exchange of client-specific information between the mental health and substance abuse systems is currently highly cumbersome at best. Legal difficulties rooted in a range of statutory and regulatory concerns are frequently encountered. Meaningful and effective integration efforts between these two systems will require a careful review and analysis of existing statutory and regulatory issues, and very possibly the design and

implementation of mechanisms to facilitate enhanced information sharing. The two Departments are committed to fully exploring the issues that exist in this area, utilizing the County's existing legal counsel and, if required, additional outside expertise.

2. Prevention Efforts

Both the Departments of Public Health and Community and Human Services maintain community-based prevention efforts related to alcohol and drug abuse. These programs currently target at-risk populations including youth, pregnant and parenting women, and others. The two Departments are committed to exploring ways to integrate and/or conjoin these prevention efforts to ensure the County maximizes its reach to those who are among our most vulnerable populations.

3. Service Delivery

The area of service delivery presents both the most promising and most challenging area for integration activities. Both Departments assign significant resources to the provision of services to County residents in need of mental health and/or substance abuse treatment, including those with multiple disorders and diagnoses. County staff have begun to develop a model of care called "No Wrong Door" which would integrate services in the areas of provision of information, referral and initial care (including outreach, engagement and assessment activities).

The Unified Services Initiative: Activities and Timeline

The Departments of Community and Human Services and Public Health have developed proposed activities and timelines for implementation of the unified services initiative:

1. Current Unified Services Planning Activities

- Creation of inter-departmental staff team work products
- Creation of design and implementation timeline for Bureau of Unified Services (BUS)
- Regular meetings of BUS Advisory Council
- Meetings with mental health and substance abuse provider agencies
- Briefings of other key stakeholders (e.g. Health Care for the Homeless Network Advisory Council, ACCESS Systems Design Work Group, neighborhood and community planning bodies, etc.)
- Linkages to related planning efforts (e.g. Health Status/Health Systems Work Group, Chronic Public Inebriate Systems Solution Work Group)

2. Proviso Response -- Stage 1: No Wrong Door/BUS Activities (For mobilization 4/1/97-6/30/98)

- Jail Alternative Services (Operational as of 4/97)
- Enhancement of CHAT services by DASAS (CROP Contracts implemented as of 5/97)
- Resolution of confidentiality issues/information sharing
- Co-investment on helplines
- Co-location of involuntary treatment services
- Stimulation of dual licensure by vendor agencies (e.g. CPC, HWSMH, CSRC, HMC, SRC)
- Development of shared language for mental health and substance abuse providers
- Voluntary hospital (MH) diversion for intoxicated, suicidal clients through expansion of mental health capacity at locations providing Detox services
- Coordination of 1999 SKCDPH and DCHS (MHD and CSD) contracting and funding processes, including linkage/coordination with appropriate City of Seattle DHHS contracts

3. Proviso Response -- Stage 2: Future Potential Proviso-Related Activities (preliminary and partial list of possible No Wrong Door/BUS activities for mobilization as of 7/1/99)

- Expanded differential diagnosis services (conjoining of Detox and E&T services)
- Expansion of ESP Van to County-wide service
- Conjoining of mental health and substance abuse involuntary treatment services
- Development of conjoint intake and assessment instruments (e.g. use of LOCUS, ASAM as part of No Wrong Door)
- Symptom-based diagnosis of neurochemical dysfunction for primary care, mental health and substance abuse systems (c.f. SKCDPH Naturopathic Clinic in Kent)
- Development of plan for Triage Center and/or triage functions in King County (c.f. Pierce County Triage Center model)
- Development of shared outcome measurement and evaluation toolbox (including clinical, fiscal and customer satisfaction)

Integrating Mental Health and Substance Abuse Services in King County: Some Background Information

The mental health and substance abuse treatment systems in King County are large and complex. In 1994 (the last year for which comprehensive data is available from DSHS):

- The substance abuse system served 12,300 individuals
- The mental health system served 18,500 individuals
- More than 1,300 of these clients were served by both systems simultaneously. This number represents only a fraction of those individuals with co-occurring disorders
- An unknown, but significant, number of these individuals were also incarcerated in the King County Correctional Facility

The effectiveness of the mental health, substance abuse and correctional systems are significantly limited by the lack of coordination across service system lines. The absence of integrated activities that conjoin these (and other) systems creates a service environment that is not conducive to recovery for the large proportion individuals with co-occurring substance abuse and mental health problems. Although national estimates suggest that up to 50% of persons with a mental health disorder also have a drug or alcohol problem[1], the absence of integrated systems contributes to the fact that it is impossible to determine the precise extent of this problem within King County.

We do know that, in 1994, the 1,320 clients who utilized services in both the mental health and substance abuse services did so without the benefit of coordinated, integrated treatment plans. Many of these individuals used extremely expensive services in both systems. For example, 179 individuals utilized *both* voluntary inpatient hospitalization and medical detoxification services. We also know that separating the mental health and chemical dependency needs of individuals with co-occurring disorders and treating the illnesses serially, sequentially or without deliberate integration of service systems consistently fails to promote individual recovery.[2] And yet, this is precisely what we do in King County.

Among the many unfortunate outcomes of this lack of systems integration is that many individual clients are rejected by *both* the mental health and substance abuse treatment systems because of the presence of a dual diagnosis. Because of the lack of an integrated information system, it is impossible to track the number of persons experiencing co-occurring disorders who are unable to access needed services in either system. It is these individuals, as they fall between the cracks created by our service systems, who contribute to the swelling ranks of homeless men and women visible throughout the region, whether on our streets or in our jails.

[1] Federal Task Force on Homelessness and Severe Mental Illness, 1992.

[2] Drake, Robert, *et al.*, "Treatment of Substance Abuse in Severely Mentally Ill Patients, *The Journal of Nervous and Mental Disease*, October 1993.

During the past year, several county-level work groups have been seeking to address various dimensions of this problem. These groups include the Chronic Public Inebriate Work Group (chaired by Ron Sims), the Health Status and Health Systems Project (Health Department), the ACCESS Systems Integration Strategic Planning Team and BUS Advisory Council (Mental Health Division/Division of Alcoholism and Substance Abuse Services). The principles, values and recommendations contained in this document are congruent with the work of all of these different planning efforts.

Principles and Core Values of Systems Integration

Promoting integration of the provision of information, referral and initial services (including outreach, engagement and assessment activities) which can effectively serve clients with co-occurring disorders in the King County mental health and substance abuse systems is rooted in the following principles and core values:

- **Services should be user-friendly:** Access to needed services should be driven by individual client needs rather than by the structures of service systems or the categorical funding which supports them.

- **Integrated services should be available for clients with multiple problems:** Clinical research indicates that integration of services greatly increases service effectiveness and positive treatment outcomes. Shared planning and implementation of services across the mental health, substance abuse and correctional systems should be the norm, not the exception.

- **Integration of information systems should be a goal for the mental health and substance abuse systems:** Although complex regulatory issues currently prevent the sharing of information across service systems, individuals with co-occurring disorders are poorly served when the systems responsible for their treatment are unable to communicate.

- **Blended funding is a effective and efficient means to service and systems integration:** Conjoined design, funding and management of services through practices such as the single purchase of services can promote systems integration while creating administrative efficiencies that reduce overhead costs.

Unified Services Initiative: System Design Recommendations

The proviso language attached by County Council to 1997 ordinances pertaining to the Departments of Public Health and Community and Human Services provides impetus for the integration of services provided by the mental health and substance abuse systems. The proviso states:

> *"(B)y June 30, 1997, the executive shall submit for council review and approval a proposal to create a new behavioral health program which combines at least portions of, if not all of the existing mental health and alcohol and substance abuse programs"*

In response to this proviso, staff from the Mental Health Division and the Division of Alcoholism and Substance Abuse Services have developed a plan for a unified services initiative called "No Wrong Door" which will integrate the "front-end" activities in King County involving the provision of information, referral and initial care (including outreach, triage and assessment) to individuals with mental illness and/or substance abuse problems. From a functional perspective (see **Chart # 1**, attached), "No Wrong Door" addresses the key activities pertaining to accessing services in the mental health and substance abuse systems: Provision of information, enabling of referrals, sorting of referrals, provision of initial services and linkage to ongoing care.

Through the blending of resources, the various funding streams and the key functions of the mental health and substance abuse systems identified above can be forged into a seamless network of services to individuals seeking or needing access to treatment in either or both systems. The integration of provision of information, referral, sorting of referrals and provision of initial care (including outreach, triage and assessment services) offers the potential of a system capable of responding to the full range of substance abuse and mental health needs presented at the front end of treatment by King County residents without creating a new County Division of Behavioral Health or compromising the authority of the existing mental health and substance abuse systems. Additionally, if "No Wrong Door" proves effective as its activities and outcomes are measured, it can serve as an invitation to expand collaborative and integrated efforts across systems to ongoing, long-term treatment services.

Since December of 1996, an Advisory Council of concerned citizens and stakeholders has been advising the process of proviso response development. This Council, with significant input from County staff, has developed the following definition of the target population for the unified services initiative:

> *"The Bureau of Unified Services/No Wrong Door shall target individuals and families with limited financial resources who present problems and/or a level of disability which indicate the need for publicly funded mental health or substance abuse services. Priority for initial care and linkage to ongoing services shall be given to individuals who are homeless or at imminent risk of homelessness, and/or individuals with a history of repeated or chronic use of public services providing acute care and/or more restrictive environments."*

As currently envisioned, the integrated system would maintain the following components and functions:

1. **The Bureau of Unified Services:** This entity (see **Chart # 2**, attached), is comprised of a limited number of County staff provided by both the Mental Health Division and the Division of Alcoholism and Substance Abuse Services. This entity manages the resources of the two systems dedicated to provision of information, referral and initial care (including outreach, triage and assessment) which have been blended together. The Bureau maintains formal linkages with other relevant departments and divisions, such as the Department of Adult Detention, the Division of Developmental Disabilities, etc. The Bureau is responsible for writing and managing Requests for Proposals and contracts for services as well as oversight of any County personnel involved in the delivery of direct "front door" services. The Bureau coordinator would report directly to the Managers of the Mental Health and Alcoholism and Substance Abuse Divisions. A formal Advisory Council to the Bureau would provide input, feedback and support to help insure the success of the endeavor.

2. **Entity or Network Providing Coordinated Information, Referral and Initial Care:** The integration of the activities of providing information, enabling of referrals, sorting of referrals and provision of initial care could be accomplished either through the creation of a single entity or the careful linking of multiple points of entry into both systems. This entity or network would serve as the locus of integrated service delivery across the two service systems and carry responsibility for management of the incoming requests for information, referral, sorting of referrals and provision of initial care currently being handled independently by each service system. Under the management of the Bureau of Unified Services, this entity or network would operate with the existing County and contractual resources allocated by each system to the core functions of information, referral and initial care (including outreach, triage and assessment).[3] Services would, where possible, be co-located and/or linked electronically. This would improve the "reach", efficiency and effectiveness of services, providing increased capacity to serve greater numbers of individual clients. The entity or network would maintain the requisite relationships with service providers for making timely referrals to existing services throughout the County that offer ongoing treatment to persons with mental illness and/or substance abuse issues. Where linkages between the entity/network and publicly funded services are involved, the entity/network must have the authority to secure necessary services for eligible individuals.

Conclusion: The Benefits of Reconfiguration

The reconfiguration of services proposed above could offer the following benefits to consumers, providers and system administrators:

- "Front-end" services to individuals requesting assistance for mental health and/or substance abuse treatment are coordinated and improved

[3] Startup costs related to the creation of the entity or network comprise a separate, additional expense.

- An increased number of clients are able to access needed mental health and substance abuse services, as well as services provided in other systems
- Individuals with co-occurring disorders are not referred back and forth from system to system and left without assistance and/or ongoing services
- Integrated services are provided efficiently and flexibly within existing resources
- Administrative activities and costs related to current service configurations in each system are consolidated

CHART 1
BUREAU OF UNIFIED SERVICES NO WRONG DOOR FUNCTIONAL ANALYSIS

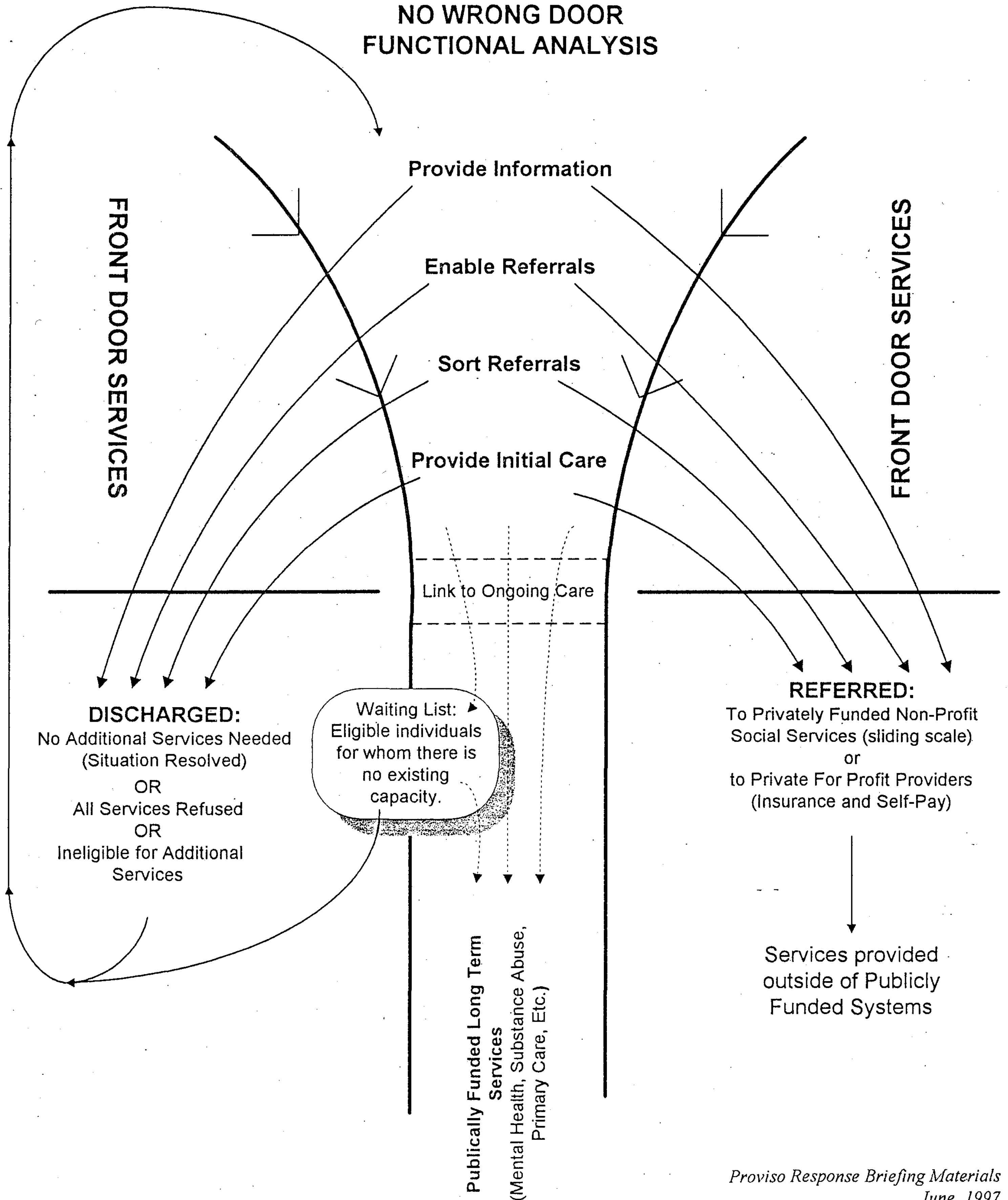
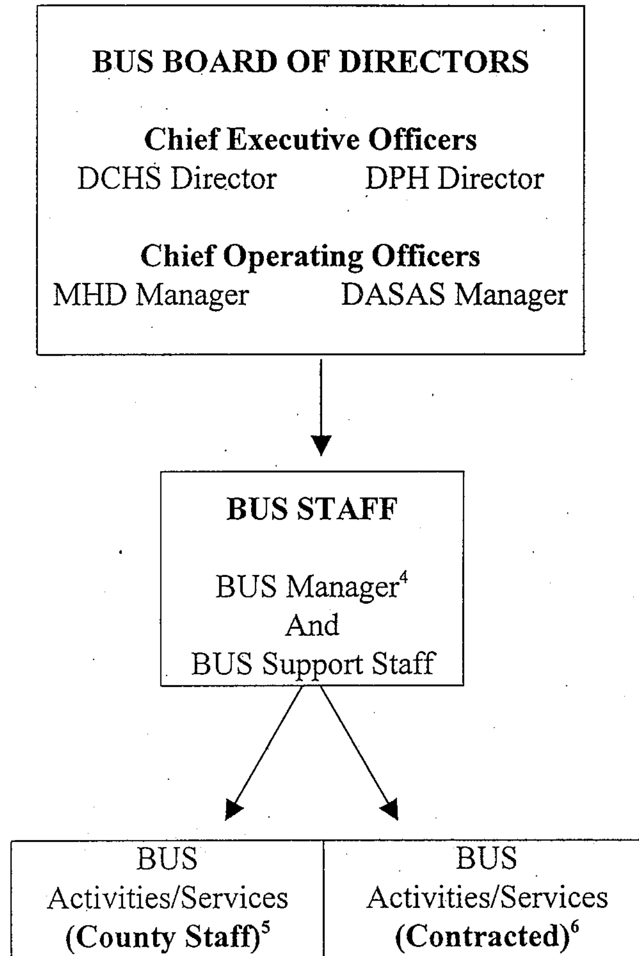


CHART 2

Bureau of Unified Services (BUS) Organizational Chart

(Proposed, 6/97)



[4] The BUS Manager is hired by the BUS Board of Directors and supervised by the BUS Chief Operating Officers.

[5] The precise nature of the County staff to be included within the BUS is yet to be defined, but could include "front end" service providers who are County employees of the Departments of Public Health and Community and Human Services.

[6] The precise nature of the contracted services to be included within the BUS is yet to be defined, but could include the "front end" service contracts held by the Departments of Public Health and Community and Human Services.