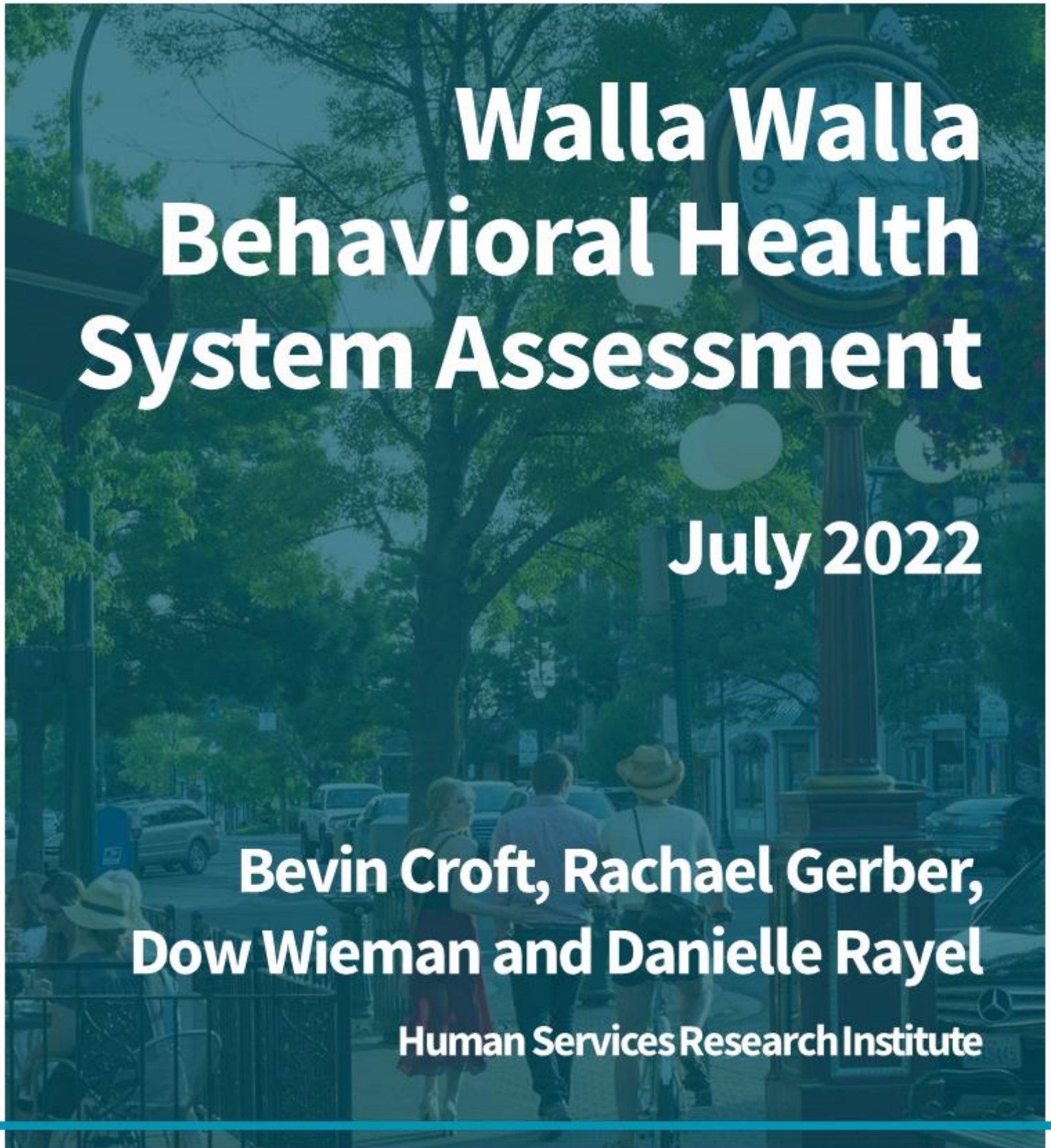
Human Services Research Institute



Walla Walla Behavioral Health System Assessment

July 2022

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Human Services Research Institute

1. Contents

Executive Summary

Beginning in the summer of 2021, the Human Services Research Institute engaged in comprehensive, mixed methods research to understand the Walla Walla County behavioral health system. Funded by the Walla Walla County Board of County Commissioners and in partnership with the Walla Walla County Department of Community Health (DCH), the project team gathered insights from the widest array of health and human services data available, complemented by listening sessions and stakeholder interviews, to identify strengths of the community and shed light on gaps between existing and needed services.

FACTS AT A GLANCE

Average Number of Crisis Contacts per 10,000 People

Walla Walla County: 39
Surrounding Counties: 25 or fewer

Percentage of People with 3+ Crisis Contacts per Month

Walla Walla County: 20%
Regional Average: 13%

Prevalence of Binge Drinking Among 12th Grade Students

Walla Walla County: 21%
Statewide Average: 12%

The scope was broad, examining intersections between the behavioral health system and other health and social service systems used by members of the Walla Walla County community, including health, education, justice, and housing.

The County has a long-standing commitment to population-level health, as demonstrated by passage of the 1/10th of 1% tax to strengthen behavioral health services and an extensive infrastructure of well-established non-profit organizations led by people dedicated to community wellbeing. This commitment to whole-person health and the large number of stakeholders who eagerly participated in interviews and listening sessions made our work possible.

And yet, despite a clear commitment to behavioral health, there remain areas of deep need. Many of the challenges uncovered in this research are not uncommon to regions of similar size, demographics, and resources, and data reveals critical areas for improvement. There are more Crisis Response Team (CRT) contacts per capita and more high utilizers of crisis services in Walla Walla County than in other counties in the region, while at the same time broad dissatisfaction with the CRT due to negative experiences and misunderstanding of the CRT's mandate. People who have interacted with the County's service infrastructure cite confusing points of entry to health systems and crisis support. Young people in Walla Walla County report higher rates of binge drinking than the state average, and one in four high school seniors reported seriously considering suicide in 2021. Walla Walla County is a health professional shortage area for mental health providers, with particularly acute unmet needs for bilingual and bicultural providers and those who serve children and youth. Individuals and families are experiencing these access challenges as they grapple with the social determinants of health that exacerbate behavioral health conditions, including unstable housing, income inequality, education and language barriers, and the persistent impacts of racism and anti-immigrant discrimination.

The COVID-19 pandemic was an accelerant of the combined health and social crisis for many across Walla Walla County. People and families already experiencing instability found themselves in severe need of resources, with little clarity on availability and access. Meanwhile, a shortage of clinical providers is among factors leading to untenably long wait times and avoidable emergency intervention. These hardships were particularly evident in data on the use of crisis services, provider-initiated appointment cancellations, as well as prevalence of depression, suicidal feelings and actions, and drug and alcohol use in youth populations in Walla Walla County.

Against these substantial challenges, stakeholders nevertheless expressed appreciation for and satisfaction with resources available in Walla Walla – particularly those organized by community and civic groups whose missions are grounded in equitable, whole-person care across the lifespan. Our recommendations take these insights into account and urge the expansion of community-led initiatives, informed by the wisdom of people who have engaged with behavioral health systems, providers, and community groups.

We recommend the creation of a behavioral health leadership position at the Walla Walla County DCH. Our research underscored both the need – and interest – in furthering an inclusive, comprehensive behavioral health strategic plan. This is important momentum that the County can leverage now. With behavioral health leadership at the municipal level, there is an opportunity for greater transparency and accountability in the 1/10th of 1% funding, further investments in wellness promotion and prevention, and open channels for more community engagement in the behavioral health system.

At the community level, we offer a series of recommendations that require collaboration and resources from local, regional, and state healthcare stakeholders. These focus on lowering barriers to access for people experiencing need – from voluntary options for people experiencing urgent distress, to the use of more community health workers and promotores, expansion of peer support and community paramedicine, strengthening of the behavioral health workforce, and improvements in data collection practices and data sharing.

There has never been a more important time to elevate behavioral health in our communities. With the tireless dedication of Walla Walla County stakeholders and the continued commitment of County leadership, areas of need identified in this research come with meaningful paths to progress. As one interviewee challenged aloud, “How can we as a community say, ‘yes,’ as soon as a person steps forward with courage to change the situation?” These data-driven recommendations support a behavioral health system that can more effectively, sustainably say *yes*.

The primary audience for this report is the Walla Walla County Department of Community Health. We welcome its broad distribution to those across the community whose participation in this research and continued promotion and use of community health is invaluable.

Human Services Research Institute

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Background and Approach

In August 2021, at the behest of the Walla Walla County Board of County Commissioners, the Walla Walla County Department of Community Health (DCH) retained the Human Services Research Institute (HSRI) to conduct an in-depth assessment of the County's behavioral health system.

The project had four interrelated aims:

Aim 1: Understand behavioral health needs and assets in Walla Walla County
Aim 2: Examine available behavioral health system resources
Aim 3: Identify gaps between existing and needed behavioral health services
Aim 4: Provide recommendations for closing gaps and maximizing community resources

HSRI used a mix of quantitative and qualitative methods to develop recommendations based on the fullest consideration of community assets and needs. We gathered quantitative data from a range of public use sources and provider organizations, hosted two community listening sessions with a total of 51 attendees, and conducted 98 interviews with 158 stakeholders representing varied perspectives. Of these stakeholders, 32 had lived experience in the behavioral health system. More detail on data sources and methods, interviews, and listening sessions can be found in the report appendices.

This behavioral health system assessment is designed to guide behavioral health system stakeholders in strategic planning for improved outcomes through a comprehensive, evidence-based continuum of care. Our goal is to support a behavioral health system driven by quality, efficiency, and scientific merit; effective in coordinating services over levels of care and with intersecting systems; and focused on outcomes that lead to recovery with minimal barriers to access.

Scope and Audience

We believe a behavioral health system does more than treat; it promotes wellbeing across the population. Therefore, our scope included all behavioral health services that foster wellness and provide prevention, treatment, and recovery support for mental health and substance use disorder (SUD) across the lifespan. Our scope also included intersections between the behavioral health system and other health and social service systems used by members of the Walla Walla County community, including health, education, justice, aging, disability, and housing.

The primary audience for this report is the Walla Walla County DCH, whose mission is to *improve the quality of life and wellbeing of our communities within Walla Walla County through prevention, promotion, and protection.* We are also presenting this report to the Walla Walla County community in recognition and appreciation of the many stakeholders, including and especially those who use behavioral health services, whose engagement and partnership is essential for a well-functioning behavioral health system.

Organization of the Report

Our report is organized as follows:

Section 2 focuses on the county, regional, and state system structures, with an overview of key healthcare reform initiatives and entities that pay for and oversee behavioral health services in Washington State.

Section 3 provides a detailed description of the Walla Walla County community as it relates to behavioral health, with an emphasis on social determinants of behavioral health, prevalence of behavioral health conditions, and the impact of the COVID-19 pandemic. Because understanding strengths and assets is essential for system change efforts, they are documented herein.

Section 4 includes details from available data about services currently available in Walla Walla County along with stakeholder feedback about those services.

Section 5 outlines key system considerations that emerged in stakeholder interviews, including workforce, cultural and linguistic responsiveness, forums for community education and engagement, access barriers and facilitators, data sharing, sustainability, and collaboration.

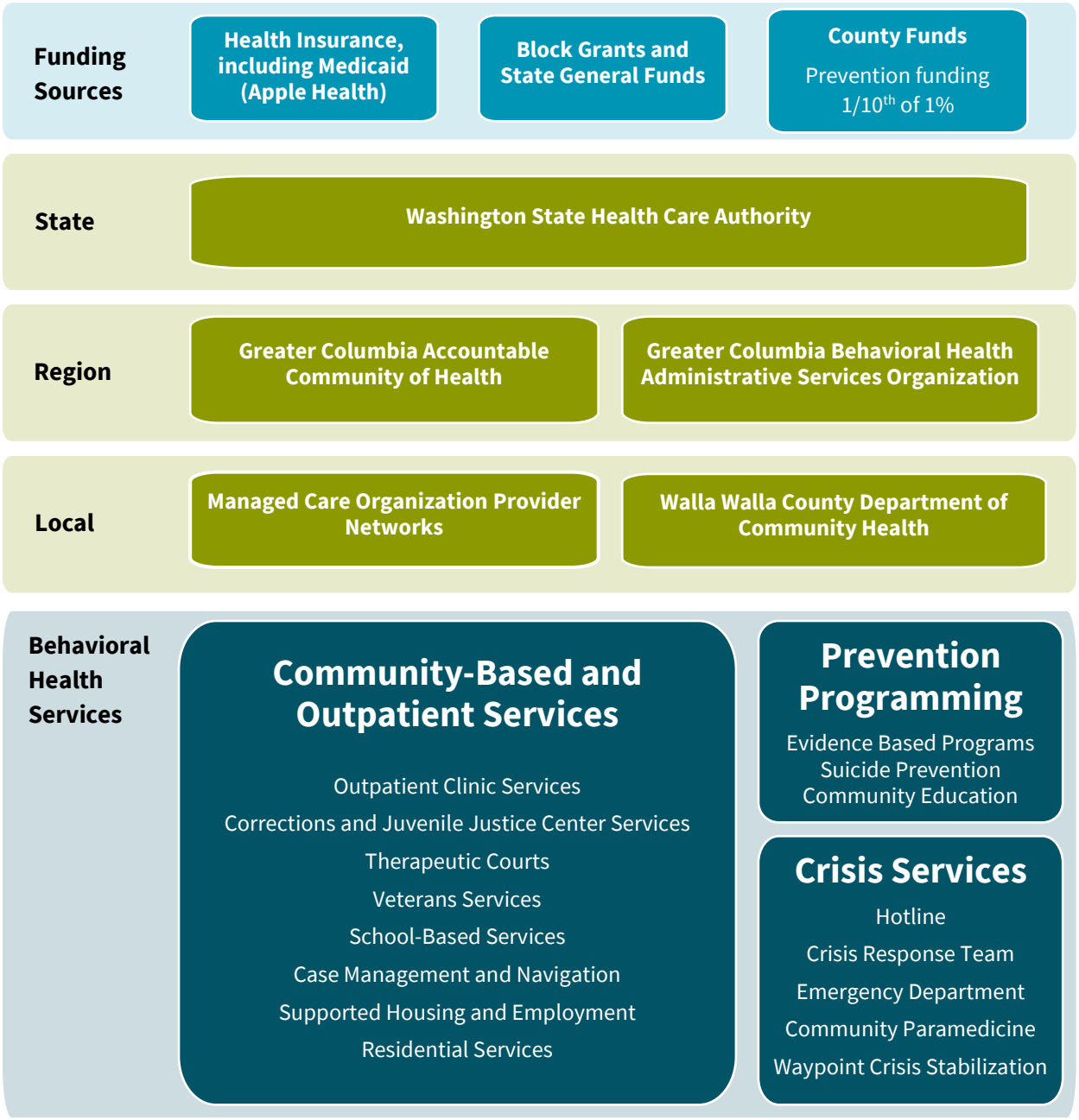
Section 6 offers two sets of recommendations – one for the Walla Walla County DCH and another set of community recommendations that require coordinated action across a range of stakeholders in the County and beyond.

2. System Structure and Financing

Figure 1 is an overview of components of the behavioral health system most relevant to this report, including primary funding sources, state/regional/local entities that administer and oversee the system, and behavioral health services and programming.

Figure 1

Overview of Behavioral Health System Components in Walla Walla County



For at least four decades, Washington State has been on the forefront of healthcare reform. A strong focus of these reforms is to ensure behavioral health is integrated into overall healthcare. Behavioral health services are funded through a mix of public and private health insurance and state, county, and federal funds. Approximately 20-25 percent of the Walla Walla County population is enrolled in Medicaid, which also funds the public crisis service system for all people in Walla Walla County and numerous initiatives to support public health. A more detailed summary of Washington State's healthcare reform initiatives is provided in Appendix G.

> "I'm really proud of our County for having the 1/10th of 1% tax. I'm glad for the way our County stepped up to the plate on that. I don't think there was a big effort or problem for getting this established. Every five years it needs to be renewed, but the County commissioners have renewed it every time. It doesn't seem to be a controversial thing."
>
> *Community stakeholder*

The current Medicaid structure involves five managed care organizations (MCOs) contracted by the Washington State Health Care Authority to oversee provider networks. The MCOs active in Walla Walla County are Amerigroup Washington, Coordinated Care of Washington, Community Health Plan of Washington, Molina Healthcare of Washington, and UnitedHealthcare Community Plan.

A Behavioral Health-Administrative Services Organization (BH-ASO) is responsible for the crisis service system. Greater Columbia Behavioral Health, LLC (GCBH) is the BH-ASO for the nine-county region that includes Walla Walla County. BH-ASOs are nonprofit entities that contract with the state to perform several distinct functions, including management of crisis services (the only services not provided by the MCOs), services funded by block grants, and ombudsmen programs. In addition, the BH-ASO oversees non-crisis behavioral health services, such as outpatient SUD and/or mental health services, to low-income individuals not eligible for Medicaid.

An Accountable Community of Health (ACH) is funded by Medicaid and pursues maximum integration of healthcare – including behavioral healthcare – at the regional level. The local ACH is the Greater Columbia Accountable Community of Health (GCACH).[1] The GCACH serves as a coordinating body to support multi-sector collaboration, develop regional health improvement plans, jointly implement or advance local health projects, and advise state agencies on how to best address health needs within the Greater Columbia region. The ACH also supports Local Health Improvement Networks (LHINs) to coordinate and collaborate on activities to address health issues and disparities. The LHIN for Walla Walla and Columbia counties is the Blue Mountain Region Community Health Partnership (BMRCHP). The County DCH is a partner in the GCACH efforts, supports some prevention programming, and oversees one-tenth of 1 percent of funding.

1/10th of 1%

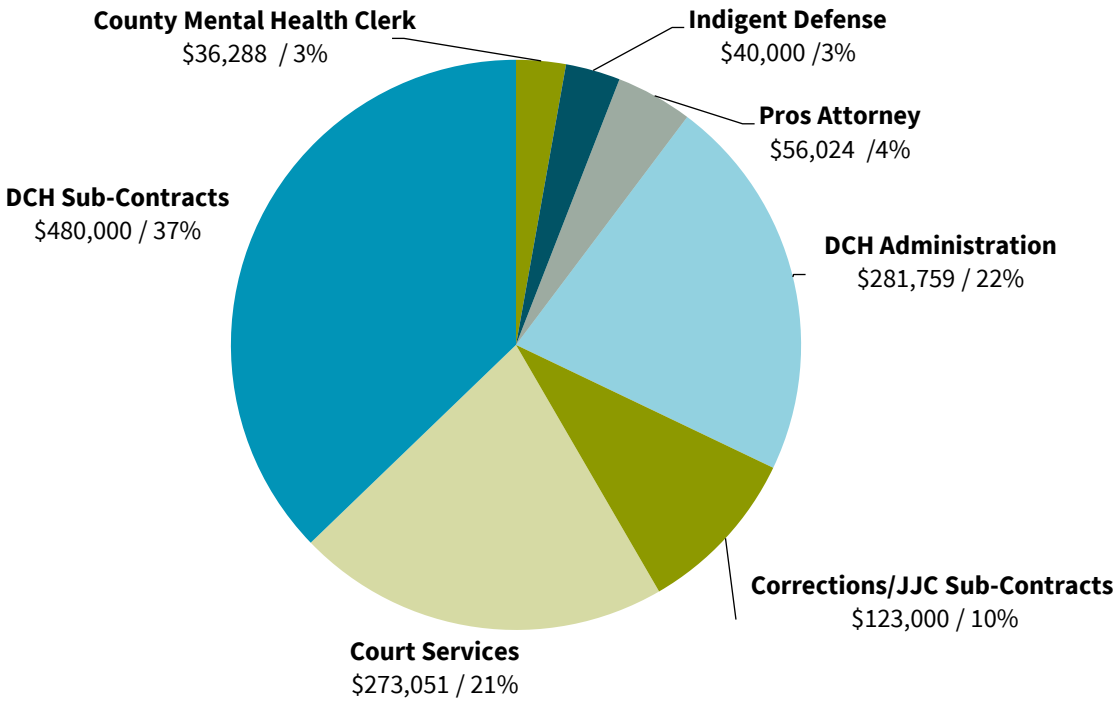
In 2005, Washington's legislature passed the Omnibus Mental Health and Substance Abuse Act (E2SSB 5763) that authorized counties to levy a one-tenth of 1 percent (hereafter 1/10th of 1%) sales and use tax to fund new mental health, chemical dependency, or therapeutic court services – a significant

[1] Greater Columbia Accountable Community of Health. (n.d.).

demonstration of residents' commitment to addressing needs for behavioral health services. Walla Walla County adopted the tax in 2011. Revenue from the sales tax has increased each year, from $670,337 in 2012 to $1,296,888 in 2020. Figure 2 shows the 2022 budget appropriations for the funding, the largest portion of which goes to DCH subcontracts to community providers for behavioral health services, which are awarded each year through a competitive grant process and are described in detail in Figure 3. The funding also supports the Department of Court Services for the Adult Recovery Court and Family Treatment Court, and the County Corrections Department for behavioral health services delivered in the Walla Walla County Corrections Facility and Juvenile Justice Center (JJC).

Figure 2

Walla Walla County's 2022 Budget Allocation of the 1/10th of 1% Funding Totaling $1,290,122



Source: Walla Walla County DCH, 2022 One Tenth Expenditure Budget

Figure 3

Summary of DCH Subcontracts for 1/10th of 1% Funding in 2022

Department/Organization	Services/Programs	Funding
Comprehensive Healthcare	A full-time therapist working at Prescott and Dixie schools and a part-time therapist at Touchet school; therapists serve walk-ins, accept referrals, and conduct assessments and brief interventions	$100,000
Blue Mountain Health Cooperative (BMHC)	An executive director, Walk-In Clinic Manager, and paid student interns	$66,000
The Successful Transitions and Reentry (STAR) Project	A STAR case manager, administrative support, client group activity expenses, SUD testing services	$61,503
Walla Walla Fire Department	Expanded capacity of the Community Paramedic and ideally add an additional paramedic	$50,000
Hope Street	Recovery advocate, executive director, and staff training	$45,000
Joe's Place	Social worker, admin/bookkeeper, and facilitator	$38,500
Catholic Charities	LOFT Care Coordinator, Intake Specialist, and Youth Services Administrator (Supervisor)	$31,411
The Health Center	Mental Health Counselor and Care Coordinator in the school clinic	$20,000
Veterans Affairs (VA)	Doctor of Nursing provider to provide mental health services to the residents of Walla Walla Veterans Home	$12,000
Trilogy Recovery Community	Executive director, to support accreditation from the Council of Accreditation of Peer Recovery Support Services	$8,500
Walla Walla Valley Academy (WWVA)	Sources of Strength training for WWVA and Rogers Adventist School 7th and 8th graders	$7,760

Source: DCH-provided details from grantees' 2022 applications. Note: some amounts may differ due to carry over or other budget adjustments.

3. Walla Walla County Community Context

Walla Walla County was formed in 1854, named for the Walla Walla people who first inhabited the area with the Cayuse, Umatilla, and Nez Perce tribes. Walla Walla County covers 1,271 square miles of land, ranking 26th in size among Washington's 39 counties.[2] In this section, we outline characteristics of Walla Walla County as they relate to the behavioral health of the community.

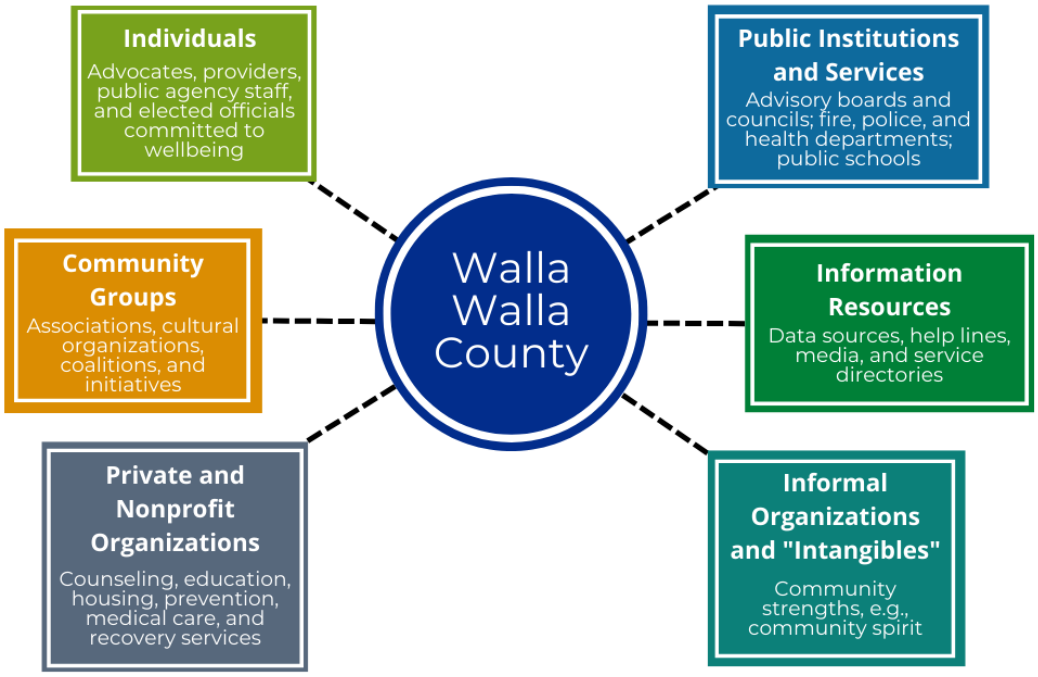
Community Strengths and Assets

> "Our community is rare when it comes to helping people, and I hear it from people who move in. People are nice to each other. They would give their shirt off their back."
>
> *Elected official*

Embracing an Appreciative Inquiry approach, we first outlined the considerable assets within the Walla Walla County community. To do so, we created an Asset Map, detailed in Appendix F, describing the many individuals, community groups, private and nonprofit organizations, public institutions, information resources, informal organizations, and "intangibles" in the county. Taken together, our impression is that Walla Walla County is a vibrant community composed of passionate and skilled stakeholders who embody a spirit of community service and care for one another. These community strengths were immediately apparent in our interviews.

Figure 4

Walla Walla County Asset Map



[2] Washington State Employment Security Department. (2020). *Walla Walla County profile*.

Commitment to Behavioral Health

> "There's passion, drive, and individuals who want to help. That's the biggest strength we have."
>
> *Provider*

First and foremost, the County's investment in a behavioral health system assessment of this type speaks to the importance of community wellbeing on the part of the Board of County Commissioners and the DCH. This commitment is also evident in Walla Walla County's adoption of the 1/10th of 1% tax.

> "There are a lot of really committed people in our community to making change, and I feel like that's a big strength. There are people willing to do the work to see that people get the care in the region."
>
> *Provider*

Moreover, the volume of people who came forward to engage in listening sessions and interviews for this study is a testament to a shared dedication to behavioral health among a range of stakeholders.

Stakeholders we interviewed also noted the following evidence of support for behavioral health:

- Collaborative relationships to advance common goals of community wellbeing, including cooperation between political groups and parties.
- Law enforcement departments, the County Sheriff, and the County Prosecutor are supportive of behavioral health programming and see the value of collaboration with community providers to promote behavioral health in the population.
- A multitude of social service organizations with a long history of working together on a range of issues, staffed by leaders who care deeply about the community. Because of their history and experience, leaders from these organizations are "able to make things happen that might not happen in other communities."

Spirit of Volunteerism

We observed a multitude of community organizations and events, often staffed by volunteers or funded through charitable giving. Stakeholders celebrated this "spirit of volunteerism" as a defining characteristic of Walla Walla County.

> "I think there is a really strong sense of community here. There are a lot of events, a lot of free events, which I appreciate it, since not everyone can afford to pay, I appreciate free events that happen."
>
> *Service user*

Positive Experiences with Services

Although much of this report outlines challenges and gaps with the behavioral health system, we observed – and service user and family stakeholders endorsed – programs, services, and organizations that have had a positive impact on peoples' lives, as well as supported recovery in powerful ways. These include all the organizations listed in the Asset Map. Below are selected quotes from service users that illustrate these experiences.

- "The Y[WCA] is so supportive. I wouldn't have made it if I hadn't had the Y. Those ladies over there, they are so supportive. They make sure that nobody's going to get you when you're in your crisis mode. When I was moving over there, they just make sure that you're safe."
- "I feel like the pediatricians are really great [at the] Walla Walla Clinic Pediatric Office. They've been a good resource for me, I really trust all of the providers there."
- "There was a clinic that opened up, BMHC, they've been very helpful. That's been a huge benefit to the community."
- "I've gotten a lot from Comprehensive. I'm glad people are here to witness it."
- "I've been doing Illness Management and Recovery (IMR). It makes a world of difference … I haven't missed any groups. It's been helping out."
- "The Program of Assertive Community Treatment (PACT) team was really helpful, when I kept relapsing. Comprehensive has been a huge part of my sobriety."

Social Determinants of Behavioral Health

In recent years, researchers, policymakers, and healthcare professionals have been shifted from the dominant model of behavioral health consisting of individual therapy and pharmacological treatment provided by highly trained professionals, to a broader conceptualization of care. Focus has expanded from individual care to population health, addressing structural factors that increase the risk of behavioral health conditions and contribute to outcome disparities.[3]

To that end, in this section we present information about social determinants of health (SDOH) in Walla Walla County, identifying areas behavioral health and community organizations can address collaboratively.

The World Health Organization (WHO)[4] provides the following list of social determinants that influence health equity in positive and negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities, and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality

[3] Alegría, M., Zhen-Duan, J., O'Malley, I. S., DiMarzio, K. (2022). A new agenda for optimizing investments in community mental health and reducing disparities. *American Journal of Psychiatry, 179*(6), 402-416.
[4] World Health Organization. (2022). *World mental health report: Transforming mental health for all.*

Because of the robust research on social determinants, we emphasize the importance of taking a population health approach for behavioral health system planning. The traditional funding sources for behavioral health services – Medicaid, general revenue, and private insurance – offer few resources for addressing population-level social determinants; however, policymakers are increasingly finding innovative strategies using less restricted sources of funding and capitalizing on opportunities to collaborate with public and private entities that support population health and wellbeing, such as social service agencies, physical healthcare systems, and educational settings.

Population Demographics

Figure 5 shows the demographic characteristics of Walla Walla County residents compared to Washington State and the United States as a whole. Walla Walla County has a higher proportion of Hispanic[5] residents compared to the State (22 percent vs. 13 percent). Walla Walla County also has a higher proportion White residents (87 percent) and a lower proportion of Black or African American (3 percent) or Asian (3 percent) residents compared to the statewide and national averages.

Figure 5

Demographic Characteristics of Walla Walla County Residents Compared to Characteristics of Washington State Population and US Population, 2020

	Walla Walla County		Washington State	U.S.
	N	%	%	%
Total	60,785	100.0%	100.0%	100.0%
Gender				
Female	29,659	48.8%	50.0%	50.8%
Male	31,126	51.2%	50.0%	49.2%
Age				
Under 18	12,831	21.1%	22.0%	22.4%
18 and over	47,954	78.9%	78.0%	77.6%
Ethnicity				
Hispanic of any race	13,115	21.6%	12.9%	18.2%
Race alone or in combination with one or more races				
White	53,117	87.4%	80.0%	75.1%
Black or African American	1,701	2.8%	5.7%	14.2%
American Indian or Alaska Native	1,581	2.6%	3.0%	1.8%
Asian	1,740	2.9%	11.4%	6.8%
Native Hawaiian or Pacific Islander	298	0.5%	1.3%	0.4%
Other Race	6,191	10.2%	6.6%	7.4%
Two or More Races	3,670	6.0%	7.1%	5.2%

[5] In this report, we refer to members of the Latino/a/e/x and Hispanic communities as "Hispanic," recognizing that this term may not be preferred for all. We have chosen "Hispanic" after consultation with members of the community, who recommended this term because the majority of members of these communities in Walla Walla County are of Mexican descent.

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table DP05; generated 05/02/2022 from: https://data.census.gov/cedsci/table?g=0100000US_0400000US53_0500000US53071&tid=ACSDP5Y2020.DP05
Notes: Race categories (except for "Two or More Races") are alone or in combination with one or more races, therefore percentages do not add to 100%.

Overall, Walla Walla County's population increased by 7 percent since 2010, with higher growth in communities of color. The size of the Hispanic population grew by 23 percent, and the non-Hispanic Asian population similarly increased by 25 percent. The size of the population identifying as more than one race nearly tripled, a trend also seen at the national level that is attributed in large part to changes in the question items and coding of race and ethnicity allowing for more thorough and accurate descriptions of how people prefer to self-identify.[6]

Figure 6

Communities of Color Have Grown Much More Rapidly than the White Population in Walla Walla County Since 2010

	Population in 2010	Population in 2020	% Change
Overall	58,781	62,584	6.5%
Non-Hispanic White	43,604	42,580	-2.3%
Non-Hispanic Black	1,004	981	-2.3%
Non-Hispanic Asian	733	918	25.2%
Non-Hispanic Native American	452	418	-7.5%
Hispanic	11,593	14,206	22.5%
Multiple Race	1,182	3,067	159.5%

Source: U.S. Census Bureau; Decennial Census, 2010 and 2020. Data accessed 9/17/2021 from: https://data.census.gov/cedsci/table?q=Race%20and%20Ethnicity%20in%20Walla%20Walla%20County,%20WA&tid=DECENNIALPL2010.P2&hidePreview=true

The proportion of the population with health insurance coverage in Walla Walla County is similar to the state and national average, at 92 percent. Those identified as Hispanic have a significantly lower rate of coverage (81 percent).[7] A smaller percentage of adults (ages 19-64) in Walla Walla County have health insurance coverage compared to the statewide average (88 percent vs. 91 percent), a difference that is likely driven by lower coverage among Hispanic residents in the County.

Income Inequality

> "There are vastly different ways to experience living in Walla Walla."
>
> *Service user*

According to the quantitative and qualitative data we gathered for this assessment, Walla Walla County has high levels of economic and social inequality. Stakeholders emphasized that poverty exacerbates behavioral health concerns and limits resilience factors for children and families. They also noted that multi-generationally under-resourced families have complex

[6] U.S. Census Bureau. (2021). *Improved race and ethnicity measures reveal U.S. population is much more multiracial.*
[7] U.S. Census Bureau, American Community Survey 5-year estimates.

behavioral health needs with additional needs related to poverty alleviation and connection with benefits and entitlements.

One stakeholder described downtown Walla Walla as emblematic of income disparity, where there are large, well-maintained houses alongside smaller houses in disrepair. Other stakeholders noted that Walla Walla County is a community that looks very pretty on the outside to attract tourists, but underneath there are populations struggling with poverty and related needs.

> "[There's a] good reason Walla Walla is the same word twice. [It's a] community with two very different sides, Main Street with tourists and wine, and then other side with immigrants, very different culture."
>
> *Provider*

The County Health Rankings, a program of the University of Wisconsin Population Health Institute, compiles measures from numerous national and state-level data sources to rank counties within states. Of the 39 counties in Washington, Walla Walla County ranks in the higher middle range of counties (50-75 percent); 16th overall in health outcomes and 11th overall in health factors, according to the 2021 County Health Rankings.[8]

Figure 7 shows measures of education, employment, poverty, housing, and other social factors in Walla Walla County compared to national and statewide averages. Values with an asterisk (*) and blue shading indicate the difference between the Walla Walla County value and the state value are statistically significant.

Compared to the state, Walla Walla County has lower rates of high school completion and college attendance. The Walla Walla County median yearly household income is almost $20,000 lower than Washington State's.

[8] County Health Rankings. (2021). *Washington: Overall rank.*

Figure 7

Comparison of Walla Walla County to Averages for the US and Washington State on Social and Economic Factors from County Health Rankings, 2021

Measure	U.S.	Washington	Walla Walla County
High school completion % of adults aged 25 and over with a high school diploma or equivalent	89%	92%	88%*
College attendance % of adults aged 25-44 with some post-secondary education	67%	72%	66%*
Unemployment % of population aged 16+ unemployed but seeking work	8.1%	8.4%	6.9%
Median household income The income where half of households earn more, and half of households earn less	N/A	$80,319	$61,281*
Income inequality Ratio of household income at the 80th percentile to income at the 20th percentile	4.9	4.4	4.5
Children in poverty % of children under age 18 in poverty	16%	11%	15%
Violent crime # of reported violent crime offenses per 100,000 population	386	294	239
Social associations # of membership associations per 10,000 population	9.2	8.5	7.7
Homeownership Percentage of occupied housing units that are owned	N/A	63%	64%
Severe housing problems % of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities	17%	17%	18%
Broadband access % of households with broadband internet connection	N/A	90%	88%

Source: County Health Rankings, 2022, Accessed 05/02/2022 at: https://www.countyhealthrankings.org/app/washington/2022/rankings/walla-walla/county/outcomes/overall/snapshot

Notes:

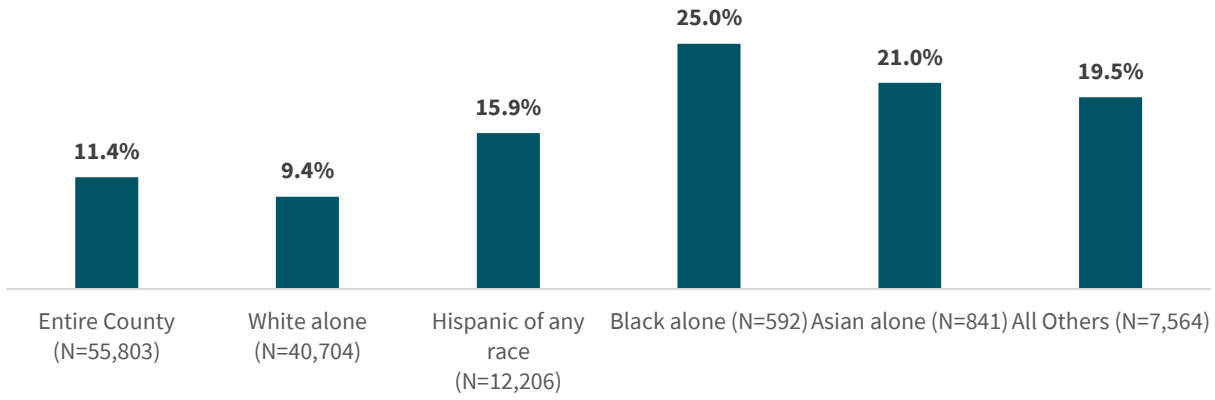
** = Indicates the state average falls outside of the margin of error for the county, suggesting a meaningful difference; margin of error was not available for the following measures: unemployment, income inequality, violent crime, and social associations*

N/A = Data are not available at the national level due to methodological differences across states

There are important differences in SDOH by race and ethnicity in Walla Walla County. Overall, 11 percent of the County population is under the federal poverty threshold, yet the proportion is 16 percent among Hispanic residents and 25 percent among Black residents (Figure 8). White families have higher incomes and are less likely to live in poverty than communities of color. The median household income among Hispanic households is $45,619 compared to $63,559 among White households.[9]

Figure 8

Families of Color in Walla Walla County are More Likely to Live in Poverty than White Families



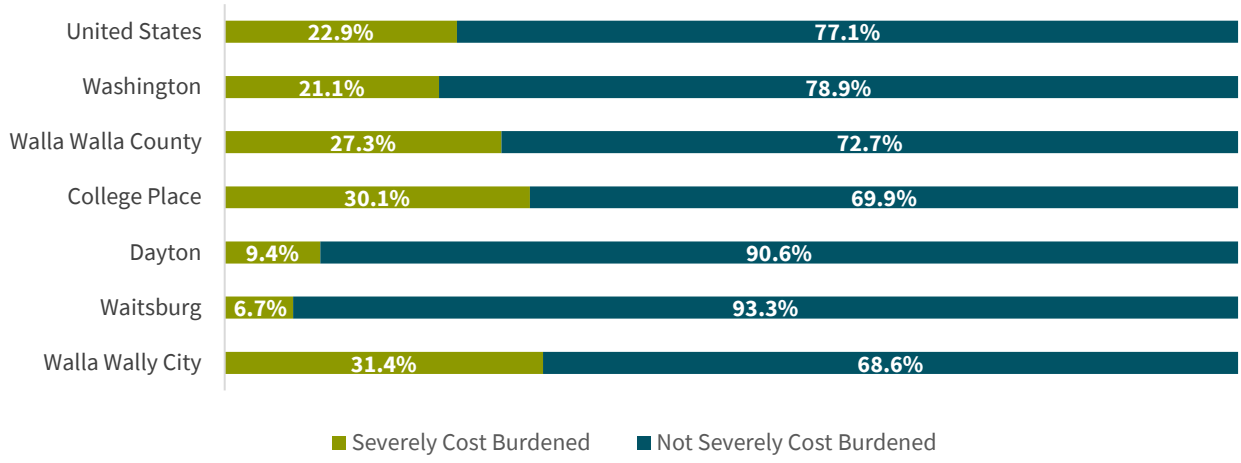
Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table S1701; generated 03/25/2022 from: https://data.census.gov/cedsci/table?q=Poverty%20in%20Walla%20Walla%20County,%20Washington&tid=ACSST5Y2020.S1701

More than one in four (27 percent) of households in Walla Walla County experience severe rent cost burden, defined as spending 50 percent or more of household income on rent in the past 12 months; a rate higher than the statewide or national average (21 percent and 23 percent, respectively). In College Place, 30 percent of households are severely rent cost burdened; in Walla Walla County, the rate is 31 percent. These rates, as well as the percentage of the population under the federal poverty threshold, underestimate the level of economic hardship experienced by many County residents. According to the United Way's measure of economic distress known as "Asset Limited, Income Constrained, Employed (ALICE)," in 2018, 50 percent of residents of College Place and Walla Walla, as well as 42 percent of residents county-wide did not earn enough to afford basic necessities. This is compared to 33 percent statewide.[10]

[9] County Health Rankings. (2022). *Washington rankings data.* Retrieved May 4, 2022. Data are based on 2020 estimates.
[10] United for Alice, Alice Report 2020; data from the Walla Walla Regional Housing Action Plan, 2021.

Figure 9

Percentage of Households Experiencing Severe Rent Cost Burden, 2015-2019



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates (Table B25070)
Note: Severe rent cost burden is defined as spending 50 percent or more of household income on rent in the past 12 months.

Prevalence of Behavioral Health Conditions

The National Survey of Drug Use and Health (NSDUH) is the primary source of statistical information on substance use by the U.S. population ages 12 and older. The survey also includes a series of questions on mental health conditions. Prevalence rates are available for the Greater Columbia region that includes Walla Walla County and 8 other counties (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Whitman, and Yakima). For each measure, we checked if the Greater Columbia region differs from the statewide average when taking the margin of error into account (in other words, if the differences are statistically significant). Across all measures, the differences in prevalence rates between the Greater Columbia region and the state are not statistically significant.

Figure 10 shows the prevalence rate and estimated number of Walla Walla County residents with behavioral health conditions based on NSDUH data and applied to the latest County population estimates from the U.S. Census Bureau. For mental health conditions, the estimates are for adults ages 18 and older; for substance use, the estimates are for ages 12 and older. Nearly one quarter of adults in Walla Walla County (24.2 percent, or over 11,500 residents) experienced any mental illness in the past year and 6 percent (approximately 2,881) experienced serious mental illness (SMI). Nearly one quarter of residents ages 18+ and older engaged in binge drinking in the past month and nearly one in five used marijuana. Approximately 600 adult residents used methamphetamine in the past year and over 250 used heroin. Prevalence rates for students in 8th, 10th, and 12th grades are presented later in this report in the section on School-Based Services.

Figure 10

Prevalence Rate and Estimated Population Size with Mental Health Conditions and Substance Use in Walla Walla County

	Prevalence Rate	Estimated Number of Walla Walla County Residents
Mental Health (ages 18+)		
Any mental illness	24.2%	11,596
Serious mental illness	6.0%	2,881
Major depressive episode	9.0%	4,325
Had serious thoughts of suicide	6.2%	2,984
Made any suicide plans	1.7%	818
Attempted suicide	0.6%	300
Substance Use (ages 12+)		
Marijuana (past 30 days)	18.1%	9,604
Illicit drugs (past 30 days)	4.2%	2,244
Cocaine (past year)	1.9%	1,032
Heroin (past year)	0.5%	272
Methamphetamine (past year)	1.1%	598
Underage drinking (ages 12-20)	19.6%	1,626
Binge drinking (past 30 days)	23.4%	12,377
Tobacco products (past 30 days)	20.0%	10,578

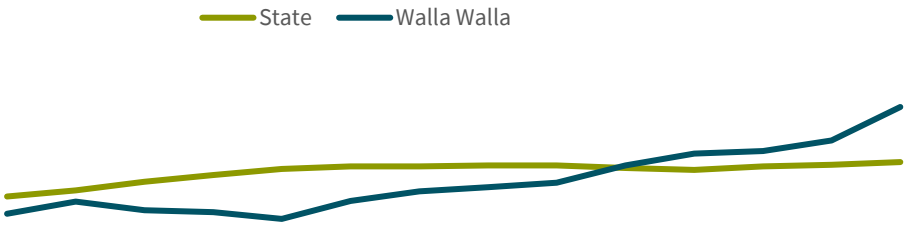
Sources: Prevalence rates are from Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Substate Data, 2018, 2019, and 2020. To estimate population size for mental health conditions among ages 18+, prevalence rates were applied to the County population estimate for ages 18+ from the U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates. To estimate population size for substance use among ages 12+ and ages 12-20, prevalence rates were applied to 2020 Census data for single ages.[11]

Figure 11 shows the trend in the age-adjusted death rate (per 100,000 population) due to drug overdose in Walla Walla County compared to the statewide average. The data are pooled into 5-year time periods and show the annual average rate during that period. Notably, the death rate due to drug overdose has been increasing, surpassing the statewide rate per capita. In the latest period for which data are available (2013-2017), the average annual count of deaths due to drug overdose in Walla Walla County was 12 deaths per year for a rate of 21 deaths per 100,000 population, compared to an average rate of 14 overdose deaths per 100,000 population across Washington State. These data are consistent with stakeholder reports of an increase in stronger and more lethal drugs in the community, underscoring the critical importance of accessible, effective SUD services.

[11] National Center for Health Statistics. Vintage 2020 postcensal estimates of the resident population of the United States (April 1, 2010, July 1, 2010-July 1, 2020), by year, county, single-year of age (0, 1, 2, .., 85 years and over), bridged race, Hispanic origin, and sex. Prepared under a collaborative arrangement with the U.S. Census Bureau. Available from: /nchs/nvss/bridged_race.htm as of September 22, 2021, following release by the U.S. Census Bureau of the unbridged Vintage 2020 postcensal estimates by 5-year age group on June 17, 2021.

Figure 11

Drug Overdose Death Rates Have Increased in Walla Walla County Relative to the Rest of the State Since 2000



	2000-2004	2001-2005	2002-2006	2003-2007	2004-2008	2005-2009	2006-2010	2007-2011	2008-2012	2009-2013	2010-2014	2011-2015	2012-2016	2013-2017
State	10.3	11	12	12.8	13.5	13.8	13.8	13.9	13.9	13.6	13.4	13.8	14	14.3
Walla Walla	8.3	9.7	8.7	8.5	7.7	9.8	10.9	11.4	11.9	13.9	15.3	15.6	16.8	20.7

Source: Washington State Opioid Overdose Dashboard. Accessed on September 20, 2021 at: https://doh.wa.gov/data-statistical-reports/washington-tracking-network-wtn/opioids/county-overdose-dashboard

Behavioral Health Workforce

Nationally, there is a shortage of behavioral health providers. This shortage is particularly acute in rural areas. The national Health Resources & Services Administration (HRSA) designates Walla Walla County as a health professional shortage area for mental health providers, defined as not meeting the threshold of one psychiatrist to a population of 30,000 (the designation is based only on psychiatrists and does not take into consideration other provider types).[12] Such a shortage is not unique to Walla Walla County; all but five counties in Washington State (King, Pierce, Snohomish, Spokane, and Yakima) are designed mental health professional shortage areas.[13] According to the latest HRSA data, Walla Walla County would need 2.76 psychiatrists to achieve the target ratio for its population.[14]

Another source of data on behavioral health workforce is population-to-provider ratios developed by County Health Rankings. In this measure, mental health providers include psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. Figure 12 shows the population-to-mental health provider ratio for Walla Walla County and neighboring counties, as well as the statewide average. Walla Walla County's ratio is similar to that of Benton, Yakima, and Columbia counties, and more favorable than Franklin and Whitman counties.[15] The data for this measure come from the National Provider Identifier (NPI) registry, which may not be current since providers are responsible for updating their own status in the registry. The data, however, are useful

[12] Health Resources and Services Administration. (n.d.). *HPSA find*. Retrieved May 30, 2022. The designation is based on the target ratio of 30,000 population per psychiatrist (20,000 to 1 where high need is indicated).
[13] Rural Health Information Hub. (2022). *Health professional shortage areas: Mental health, by county, 2022 - Washington*. Retrieved June 29, 2022.
[14] Health Resources and Services Administration. (2021, September 10). *Health Professional Shortage Area (HPSA) for mental health*. Retrieved June 30, 2022.
[15] County Health Rankings. (2021). *Washington: Mental health providers.* Data are based on National Provider Identifier (NPI) Registry.

to put Walla Walla County in context compared to the state and other counties for which NPI data have the same limitations.

In summary, Walla Walla County and all but five counties in Washington State suffer from a shortage of psychiatrists. For other behavioral health provider types, there are no established benchmarks to prescribe the optimal number of providers based on the county's population and prevalence rates. Nevertheless, data from the NPI provider registry suggest the ratio of population to mental health providers in Walla Walla County is average for counties statewide and more favorable than neighboring Franklin and Whitman counties.

Figure 12

Ratio of Population to Mental Health Providers in Walla Walla County is Comparable to Counties Across the State and More Favorable Than Some Neighboring Counties

Location	Number of Mental Health Providers	Ratio of Population to Mental Health Providers
Walla Walla County	195	310:1
Benton County	627	330:1
Columbia County	13	310:1
Yakima County	888	280:1
Franklin County	132	740:1
Whitman County	83	600:1
Washington State	33,578	230:1

Source: County Health Rankings, 2022. Data are based on the National Provider Identifier (NPI) registry (based on 2021 data). Accessed 6/30/2022 at: https://www.countyhealthrankings.org/app/washington/2022/measure/factors/62/data

Impact of COVID-19 on Behavioral Health Service Needs

The COVID-19 pandemic has exacerbated behavioral health conditions and increased the need for behavioral health services. More than three in ten adults in Washington reported symptoms of anxiety and/or depressive disorder during the pandemic compared to approximately one in ten pre-pandemic in 2019.[16] In the U.S., one in four young adults seriously considered suicide during the pandemic compared to one in ten pre-pandemic.[17] And in 2020, mental health-related emergency department (ED) visits increased 24 percent for children ages 5-11, and 31 percent for ages 12-17 compared to visits in 2019.

[16] Kaiser Family Foundation. (2021). *Mental health in Washington.*

[17] School Mental Health Assessment Research and Training Center. (2021). *Behavioral health impacts during & after COVID-19: What to expect and ways to prepare for the return to in-person learning.*

"We've seen Black Lives Matter and Make America Great Again signs at houses next to each other, neighbors don't talk to each other anymore, it's sad."

Community stakeholder

"I just know that I worry about the kids, the parents have so much emotion that they can't get out, and kids are taking it. They've carried the burden."

Provider

We heard from stakeholders that the pandemic, combined with national political divisions, have created new tensions in the community that contribute to social isolation. Differences over vaccination, teachers leaving because of the vaccination mandate, and parents trying to control topics taught in the schools are affecting the wellbeing students.

4. Current Service Availability and Utilization

A behavioral health system is a complex constellation of a range of programs and services that promote community wellbeing. In this section we provide a more in-depth discussion of current services, stakeholder input about those services, and opportunities for improvement.

Wellness Promotion and Prevention

Prevention and early intervention in childhood is critical for reducing adult morbidity and mortality from chronic diseases, including mental health and SUD. Leaders are calling on families, educators, health professionals, communities, and government officials to prioritize supporting youth behavioral health and wellbeing.[18] Adverse Childhood Experiences (ACEs), including abuse, neglect, and household challenges, contribute to trauma and toxic stress that negatively impact long-term brain development and gene expression.[19,20] This increases the risk for adult physical, behavioral, and social problems.[21] Preventing ACEs can reduce depression, suicide, substance use, and leading causes of death in adulthood.

> "Prevention is a long-term process. It is embedded and strengthened; it doesn't happen overnight. We have that band-aid or quick fix; we have a fire to put out right now. We don't look at the levels of care all the way through. If we can prevent people from getting to that point, we won't have all the people going to crisis … We can put out the fire, but the next fire's going to come up if we don't go upstream."
>
> *Prevention services provider*

Currently, most prevention programming in Walla Walla County is done through the DCH and select community initiatives, including the Blue Zones Project. Nearly all behavioral health-focused organizations are treatment-based and have little expertise in prevention. And organizations that do prevention work do not appear to be thought of as part of the behavioral health continuum. Stakeholders with expertise in prevention emphasized a need to embed and strengthen a prevention focus across the County.

Suicide Prevention

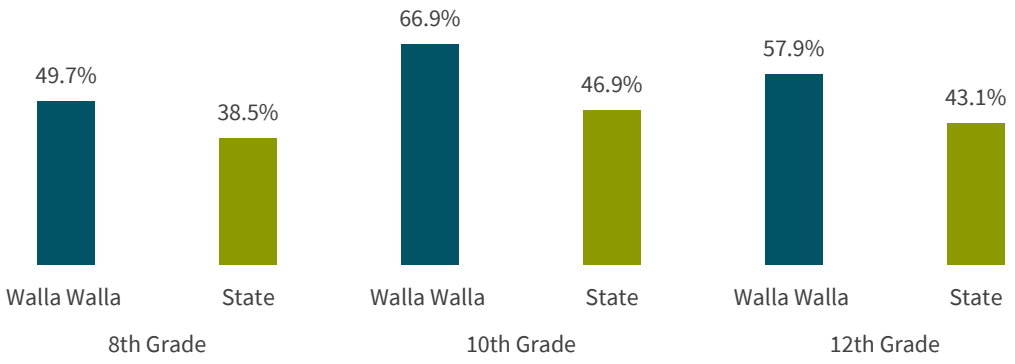
A variety of suicide prevention initiatives have been implemented in Walla Walla County recently, including the Men in the Middle support group, Reach Out Walla Walla, and Sources of Strength, which is being implemented in 11 schools in Walla Walla County, including a new initiative to expand Sources of Strength at WWVA, a Seventh-Day Adventist High School. The latest (2021) data from the Health Youth Survey show a significantly higher proportion of students in grade 10 and 12 in Walla

[18] US Department of Health and Human Services. (2021). *Protecting youth mental health: The US Surgeon General's advisory.*
[19] Centers for Disease Control and Prevention. (2021). *About the CDC-Kaiser ACE study*.
[20] Centers for Disease Control and Prevention. (2019). *Vital signs: Estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention — 25 States*, 2015–2017.
[21] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Walla County reporting that they had seen information at school in the past year about warning signs of suicide and how to get help compared to the state average for these grades (Figure 13).

Figure 13

In Walla Walla County, Students in Grades 8, 10, and 12 had Higher Rates of Suicide Awareness than Peers in the Rest of the State



Source: Healthy Youth Survey, 2021
Note: For 10th and 12th grades, the difference between the County and statewide average is statistically significant.

Community stakeholders applauded these initiatives, particularly those based in schools, seeing them as positively impacting community wellbeing and a reason why there have been no youth suicides in the County since Sources of Strength was implemented in 2017. Despite current efforts, stakeholders still want stronger suicide prevention activities, including more programming in schools, training for primary care and pediatricians, and stronger visibility of avenues for seeking support.

Faith-Based Wellness Promotion

Churches and faith-based organizations offer great potential for promoting wellness in providing substance use prevention, addiction treatment, and mental health services, particularly to underserved communities and culturally diverse populations.[22] Walla Walla County is home to approximately 50 churches and several faith-based service providers the including Christian Aid Center, Walla Walla Rescue Mission, Good Samaritan Ministries, and the Emmaus Counseling Center. Community members that we interviewed voiced opportunities for the County to develop partnerships with churches and other faith communities to promote wellbeing and educate the public about behavioral health issues and services; however, some indicated that faith leaders are not engaged with behavioral health providers, and many pastors and parishioners are hesitant to become involved due to political division. Faith leaders would rather avoid discussing the impact the pandemic has had on wellbeing than "ruffle feathers" among divided

> "I'd like to see a more unified [effort], different pastors joining together to talk about it, and bringing faith communities together. It would be great if they could create something bigger than their church venue and allow people to come and talk."
>
> *Provider*

[22] Substance Abuse and Mental Health Services Administration. (2022). *Faith-based and community initiatives (FBCI).*

parishioners. There was a wish that faith leaders could create more unity among different faith communities to promote wellness.

Building Community Resilience

> "There are trauma-informed people [in Walla Walla County], but not trauma-informed institutions."
>
> *Community stakeholder*

A particularly unique Walla Walla County asset is the Community Resilience Initiative (CRI), a nationally recognized organization that provides training and technical assistance to promote community resilience through education on the science of trauma and trauma-informed practices. Additionally, Walla Walla County was selected as a pilot county for a Trauma-Informed Recovery-Oriented Systems of Care (TI-ROSC) initiative through the National Council on Wellbeing. TI-ROSC combines two evidence-based frameworks with overlapping shared values and principles that can lead to improved health and wellness for people with SUDs.[23] Providers we interviewed endorsed the CRI as a key resource for their work toward strengthening trauma-informed practices. While the CRI is a key resource, and many people and organizations have availed themselves of CRI trainings, there was agreement that there is still work to do.

Service Information and Navigation

A range of programs and services are currently available in Walla Walla County to support people to learn about, engage in, and organize services and supports. Ideally, those with the most complex service needs receive the most intensive service coordination and navigation support.

How the Community Learns about Services

There are currently multiple behavioral health service directories in Walla Walla County:

- Washington 211
- Helpline
- Mental Health Network of Walla Walla – website maintained by BMHC
- One Walla Walla List (OWWL) app
- MCO Provider Directories – Amerigroup, Community Health Plan of Washington, Coordinated Care Plan of Washington, Molina Healthcare of Washington

[23] National Council for Mental Wellbeing. (n.d.). *Trauma-informed, recovery-oriented systems of care: Transforming care one county at a time.*

> "One of the things I don't feel educated about, what is out there?"
>
> *Service user*

Despite these resources, difficulty accessing clear, up-to-date information about behavioral health services was a common theme in stakeholder interviews. When asked how people find out about services, stakeholders reported a range of sources and methods including word-of-mouth, Internet searches, social media, and primary care providers. In fact, having multiple sources may contribute to confusion about what is available and thus lead people to give up on seeking help. The dearth of clear information has the potential to contribute to a sense that the behavioral health system is unsupportive of community need.

> "Sometimes the community doesn't understand the restrictions within the services or what the services can provide, so frustrations grow, so there's a belief that there's a gap in services, lack of understanding, or not enough staffing, or someone not held accountable."
>
> *Provider*

Case Management and Navigation Support

Stakeholders called for an expanded community case management model with the capacity for warm handoffs and strong coordination within and across service systems.

The primary provider of traditional case management services in the County is Comprehensive Healthcare, which serves about 1,000 people annually in case management across the County. Typically, case management services are available to people who have been through an assessment process with the agency and are determined to have more intensive service coordination needs. The BH-ASO recently awarded a grant to Blue Mountain Heart to Heart to provide recovery navigation for people in SUD recovery. The program, launched in February 2022, includes peer support services and a flexible fund to cover expenses related to recovery such as food, housing, and clothing needs. Beginning in February 2021, BMHC began offering behavioral health navigator services through its student-run clinic. Behavioral health navigators support clients 13 years of age and older while they wait for long-term care with community providers. Behavioral health navigators connect clients with a range of mental health, primary care, counseling, and social services, and work with clients to find providers that accommodate their preferences and insurances. In 2021, 268 unique people were served by BMHC behavioral health navigators.

Recognizing the challenges for individuals with complex behavioral health conditions in accessing services, many health systems, including Providence Health, have established community health workers (CHWs) or "promotores de salud." These workers are effective, especially in engaging hard-to-reach and underserved populations in accessing services and adherence to treatment.[24] A program of Providence St. Mary Medical Center, each Providence Population Health team is comprised of one Master of Social Work (MSW), three CHWs, a promotora, a pharmacist manager, and one community registered nurse (RN). At the time of writing there are no behavioral health providers on staff;

[24] Allen, C.G., Sugarman, M.A. & Wennerstrom, A. (2017). Community health workers: A resource to support antipsychotic medication adherence. *Journal of Behavioral Health Services & Research, 44*, 341–346.

however, there are plans to embed behavioral health consultants in primary care later in 2022, likely replicating a model from Providence Spokane.

Population Health received about 1,000 referrals per year. Although data were not available on demographic characteristic of persons served, according to the Population Health program, they are among the community's most medically and socially complex. The CHWs and promotora served 2,200 individuals in 2021, with the primary populations served including underinsured or uninsured, Hispanic, Medicaid enrollees, and high ED/emergency medical services (EMS) utilizers.

Community-Based and Outpatient Services

Although specialty behavioral health services were the primary focus of this assessment, it is important to note that in Walla Walla County, as in most locales, a considerable portion of mental health services for less severe conditions such as mild depression and anxiety disorders are treated in primary care and by clinicians in private practice. Of 20,878 persons served at Providence Medical Group Primary Care, 46% have an active behavioral health diagnosis[25]. The Yakima Valley Farm Workers Clinic Family Medical Center, located in Walla Walla, offers mental health and SUD treatment services along with other healthcare services. One in five of the people served are agricultural workers or their dependents. In 2020, the clinic provided 3,423 mental health visits and 780 SUD visits. Additionally, a range of social service organizations provide behavioral health-related support services as part of their programming, notably substance use recovery. The largest providers of specialty community-based and outpatient behavioral health services in the County are Comprehensive Healthcare, Serenity Point, and BMHC.

Comprehensive Healthcare

Founded in 1972, Comprehensive Healthcare is a nonprofit, community-focused, behavioral health organization that provides mental health, SUD, and co-occurring services to adults, youth, and families. It offers a range of outpatient and community-based services, including therapy, case management, child/family services, medication management, and high-intensity services and supports, including the following:

- **Housing and Recovery through Peer Services (HARPS)** provides housing services for people 18 years of age and older who have used inpatient services or are experiencing chronic homelessness
- **Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR)** assists people who are experiencing or at risk of homelessness and have complex medical or behavioral health needs with accessing SSI/SSDI benefits
- **Wraparound with Intensive Services (WISe)** for youth and family with complex behavioral health needs

[25] Figure provided by Providence Health. Active behavioral health diagnosis defined as within the past 2 years.

- Supportive living, including permanent supportive housing services

In the spring of 2022, Comprehensive Healthcare closed its PACT, an evidence-based program providing intensive treatment services for people diagnosed with serious mental illness at risk of hospitalization and crisis services.

Figure 14 shows the number of people served at Comprehensive Healthcare's outpatient and community-based programs. Adult mental health outpatient services serve the largest number of individuals. The number served in outpatient child/family programs increased by 21 percent between 2020 and 2021.

Figure 14

Numbers Served at Comprehensive Healthcare's Outpatient Services

	Fiscal Year (FY) 2020	FY 2021
Total Unique Persons Served	**2,389**	**2,492**
Outpatient Adult Mental Health	1,121	1,097
Outpatient Child/Family Programs	478	579
SUD Programs	168	178
Medication Management	589	597
Number Served by Peer Services	58	80
Program-Specific Numbers Served		
HARPS	239	206
PACT	0	44
Law Enforcement Assisted Diversion (LEAD)	0	62
SOAR	254	209
Permanent Supportive Housing	37	34
WISe	76	90

Source: Data provided by Comprehensive Healthcare in its FY21 Annual Report and by request for this project

Figure 15 below shows the demographic characteristics of individuals served at Comprehensive Healthcare in 2021. About two-thirds (66 percent) served are adults ages 26-65. Data on ethnicity was missing for one quarter (25 percent; N=245) of persons served, therefore the 27 percent of persons served who are Hispanic is likely an underestimate. Similarly, race information was missing nearly one quarter (24 percent) of persons served.

Figure 15

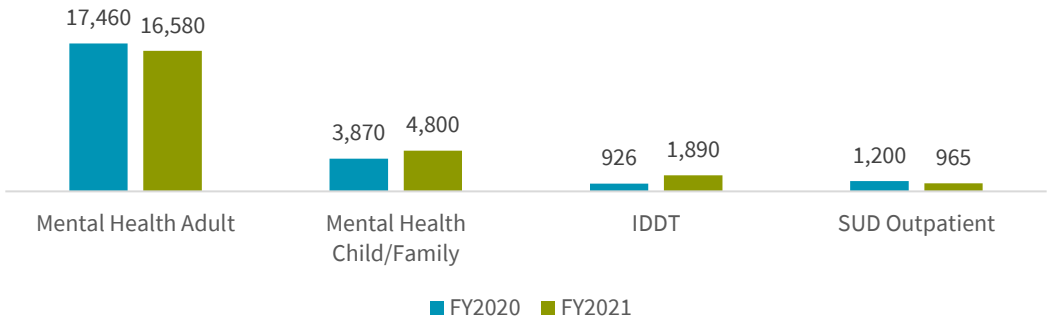
Demographic Characteristics of People Served at Comprehensive Healthcare, 2021

	N	%
Age Group		
17 and younger	155	16%
18 to 21	46	5%
22 to 25	80	8%
26 to 65	646	66%
Over 65	51	5%
Sex		
Female	543	56%
Male	415	42%
Other Sex	20	2%
Ethnicity		
Hispanic	262	27%
Not Hispanic	460	47%
Unknown Ethnicity	256	26%
Race		
White	653	67%
Other Race	94	10%
Unknown Race	231	24%

Source: Data provided by Comprehensive Healthcare

Figure 16

Numbers of Completed Outpatient Appointments at Comprehensive Healthcare, by Program



Serenity Point

Serenity Point is an outpatient counseling organization specializing in treatment for SUD. Serenity Point offers individual and group-based counseling, 12-step programs, intensive outpatient treatment, and driving under the influence (DUI) assessments. Serenity Point has at times offered

mental health counseling services, but at the time writing (spring of 2022), it was not offering mental health assessments or services due to workforce shortage.

The total number of SUD assessments per year provided by Serenity Point are as follows:

- 2019: 734
- 2020: 794
- 2021: 621 (note; data were not available for the month of December 2021)

Serenity Point offers same-day walk-ins on a first come, first serve basis, and reports no wait time for SUD assessments. However, some stakeholders noted long wait times for walk-in appointment slots. Wait times for admission to services for SUD or mental health clients that have had an intake/evaluation with another provider agency range from two to five days according to the agency.

Blue Mountain Health Cooperative

BMHC was founded in 2020 to address the need for timely access to mental health services for individuals 13 years of age and older. BMHC provides a walk-in clinic four days a week, an outpatient clinic, behavioral health navigators, and provider trainings and support. BMHC is staffed by undergraduate and master's level student interns from Walla Walla University's social work program, overseen by licensed supervisors. It is a unique collaborative that fills a community need for walk-in mental health services, as well as training opportunities and clinical experience for students entering the workforce.

In 2021, BMHC served 589 unique individuals with clinical counseling and medication management.[26]

Figure 17

BMHC - Utilization and Persons Served, 2021

	Counseling Intakes	Counseling Follow-ups	Psychiatric Intakes	Psychiatric Follow-ups	Total Clinical Sessions Completed	Total Unique Clients Served
Outpatient Clinic	285	561	166	286	1,298	451
Walk-In Clinic	132	168	N/A	N/A	300	396*

Source: Data provided by Providence St. Mary, Division of Population Health Integration
*Notes: N/A = not applicable; * = includes counseling and Behavioral Health Navigation services*

Stakeholders were quick to endorse the BMHC student clinic as valuable for connecting people to same-day support services. In particular, they saw value in the BMHC student clinic because of same-day availability of counseling services and connection to a behavioral health navigator to assist in long-term support. Several homeless service providers indicated the student clinic is their "go-to"

[26] The total unique individuals served includes a small number served at the Wellness Clinic at College Place Public Schools (CPPS).

resource to obtain behavioral health supports for their population because of the ease with which people access appointments there.

Peer Services

> "I really like having the peer support. It's the best part about services here."
>
> *Service user*

Peer support is the provision of supportive services by specially trained staff with lived experience of the behavioral health system. Comprehensive Healthcare has approximately eight positions for Peer Specialists, with services available through its WISe, Rising Sun Clubhouse, HARPS, and SOAR programs. Trilogy Recovery Community also offers peer support. Blue Mountain Heart to Heart's newly established recovery navigation program includes positions for peer counselors, while Serenity Point recently created a position for a peer support counselor, and the newly established Mobile Outreach Services Team (MOST) will include a peer support counselor. While it does not currently provide paid peer services, the National Alliance on Mental Illness (NAMI) Walla Walla offers some volunteer peer-to-peer support groups.

State policymakers have expressed an interest in expanding peer services throughout the state, offering trainings and a state certification through the state Healthcare Authority and expanding the role of peer support counselors on mobile crisis teams.[27] There are approximately 300 certified peer counselors in the Greater Columbia area, with 40 in the Walla Walla area alone.[28] Currently, peer services are covered as a Medicaid managed care benefit, but peer crisis supports are not yet a billable service. The BH-ASO will be providing grants to mobile crisis providers to cover the costs of peer crisis services in the coming year.

Peer support was widely endorsed as a valuable service that should be expanded throughout Walla Walla County. Service users noted that it is easier to relate to someone who has similar lived experience and spoke favorably of the peer services they received. Peer recovery stakeholders saw a need for more education about peer services and recovery-oriented systems. This concern is consistent with the national conversation on the appropriate role of peer supports in behavioral health systems.[29]

NAMI was endorsed as a valuable community asset by stakeholders, with many expressing a desire to expand NAMI to include more diversity of age, ethnicity, and lived experience, as well as mental health advocacy and peer support spaces.

Substance Use Recovery Services and Supports

There are several organizations in Walla Walla County dedicated to supporting recovery from SUD. Trilogy Recovery Community provides peer support, counseling, referrals, groups and educational

[27] Washington State Healthcare Authority. (n.d.). *Peer support.*
[28] Data provided by Washington State Healthcare Authority
[29] Jones, N., Niu, G., Thomas, M., Riano, N. S., Hinshaw, S. P., & Mangurian, C. (2019). Peer specialists in community mental health: Ongoing challenges of inclusion. *Psychiatric Services, 70*(12), 1172-1175.

classes to youth, adults and families, and is a member of the Association of Recovery Community Organizations. Hope Street, opened in 2021, is an accredited, level II recovery home through the Washington Alliance for Quality Recovery. They offer one-on-one recovery coaching and support services, assistance connecting to community resources, connection with peers in recovery, and life skills training.

School-Based Services

Currently, school behavioral health programming is supported through a range of sources, including state grants and insurance. Walla Walla Public Schools (WWPS) employ a Social Emotional Team that includes a mental health specialist, two behavior specialists, and two behavior coaches. College Place Public Schools (CPPS) employs a school social worker at each school within the district.

In addition to school behavioral health professionals, several organizations provide behavioral health services onsite at schools in the County. Within CPPS, Trilogy Recovery Community employs a Recovery Support Ally and BMHC provides services at the CPPS Wellness Clinic. Commitment to Community (C2C) and Strengthening Families are also used within some schools. As noted in an earlier section, the 1/10th of 1% funding covers costs for school-based mental health services in Prescott, Dixie, and (beginning in 2022) Touchet school districts.

The Health Center has been providing health and behavioral health services in Walla Walla County schools since 2009. Figure 18 depicts the number of clinical appointments at The Health Center by month, for which behavioral health appointments outnumber appointments for primary medical care. In addition to behavioral health consultations, The Health Center provides services for food, water, and hygiene to address students' basic needs.

Figure 18

To Date, The Health Center Provided More Behavioral Health Appointments Than Primary Medical Care Appointments in 2021-22 School Year

Month	Behavioral Health Appointments	Primary Medical Appointments	Total Appointments
September	36	26	62
October	70	49	119
November	105	47	152
December	67	59	126
January	105	129	234
February	119	130	249
March	115	100	215
April	121	81	202
Total	**738**	**621**	**1,359**

Source: Data provided by The Health Center in May 2022

In this study, we did not conduct an inventory of services available in private schools and for homeschooled students. Future studies should consider these circumstances, as well.

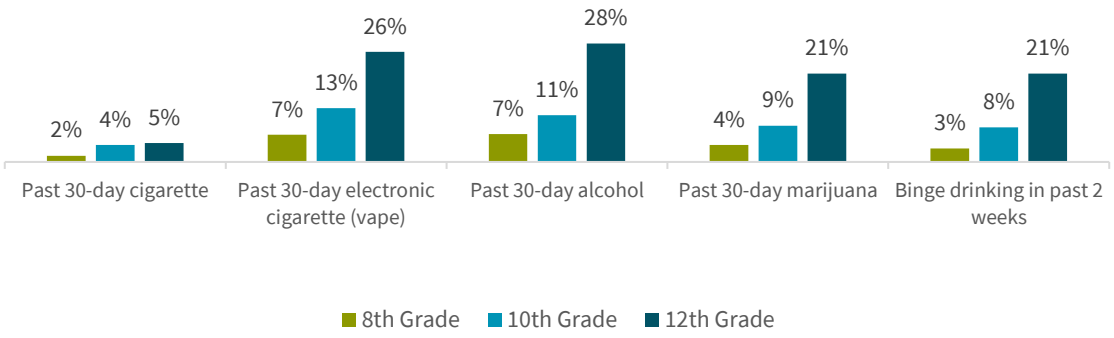
Due to the national emergency in children's mental health, exacerbated by the pandemic, the role of school-based mental health services has become a heightened priority.[30,31] Figure 19 shows the prevalence of substance use among students in grades 8, 10, and 12 in Walla Walla County using data from the 2021 Healthy Youth Survey. The Healthy Youth Survey is conducted every two years to evaluate the health of youth in Washington State.

Although statewide rates are not shown in the chart, prevalence is similar in Walla Walla County compared to the rest of state with two statistically significant exceptions:

- Prevalence of past 30-day electronic cigarettes (e.g., vaping) is significantly higher among Walla Walla County students in grades 10 and 12 compared to the state average (grade 10: 13 percent usage vs. 8 percent statewide; grade 12: 26 percent usage vs. 15 percent statewide)
- Prevalence of binge drinking is significantly higher among Walla Walla County students in grade 12 compared to the state average (21 percent vs. 12 percent)

Figure 19

Prevalence of Substance Use Among Students in Grades 8, 10, and 12 in Walla Walla County



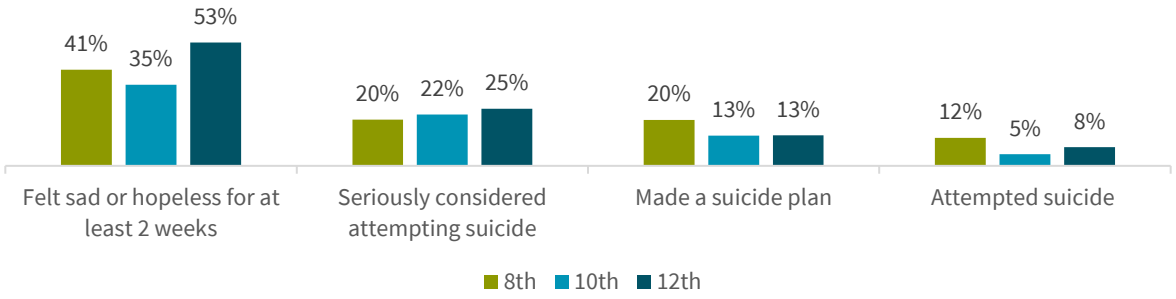
Source: Healthy Youth Survey, 2021. Sample size of number of students with valid survey responses: 8th grade N=370, 10th grade N=346, 12th grade N=299; however, number of valid responses varies by question item.
Note: Currently only two school districts in the County participate in the Healthy Youth Survey, WWPS and Waitsburg School District.

Figure 20 shows the prevalence of depression and suicidal feelings and actions among students in Walla Walla County. These proportion of students feeling hopeless and considering suicide, which do not differ significantly from the statewide values, highlight the critical need for prevention efforts and service access for middle school and high school youth.

[30] Hopeful Futures Campaign. (2022). *America's school mental health report card.*
[31] The White House. (2022). *Fact sheet: Biden-Harris administration highlights strategy to address the national mental health crisis.*

Figure 20

Prevalence of Self-Reported Depression and Suicidal Feelings and Actions among Students in Grades 8, 10, and 12 in Walla Walla County in the Past Year



Source: Healthy Youth Survey, 2021. Sample size of number of students with valid survey responses: 8th grade N=370, 10th grade N=346, 12th grade N=299; however, number of valid responses varies by question item.
Note: Currently only two school districts in the County participate in the Healthy Youth Survey, WWPS and Waitsburg School District.

To understand behavioral health needs of students and the nature of services in schools, we interviewed school administrators, school behavioral health professionals, and families. The following is representative of the information we obtained:

- Students whose primary avenue for support is schools have experienced a "double-whammy" of increases in child abuse and domestic violence, coupled with students being more disconnected from school because of the pandemic.
- COVID-19 has widened the academic and social divides for students with behavioral health concerns.
- Educators and other school professionals are experiencing high rates burnout and trauma.
- School behavioral health services are hindered by the same workforce shortages experienced by the community at large. In particular, there is a lack of bilingual and bicultural school behavioral health professionals.
- High rates of turnover among counselors resulted in students bouncing from counselor to counselor and experiencing disrupted care. For example, data from The Health Center show a turnover of seven staff in 2020-2021, and four staff in 2021-2022. Staffing shortages also reduce capacity for school-based services during summers and vacations.
- There is wide variation in school-based behavioral health resources across Walla Walla County, with uneven capacity to meet behavioral health needs of students across districts and across schools within districts. There is a lack of clarity about how resources are allocated to meet the high behavioral health needs of students in schools. While school-based services are endorsed as a good use of 1/10th of 1% funding, there is confusion about how funding is allocated.

- Many schools lack infrastructure – including space, hardware, personnel, and capacity for third-party billing – to take advantage of funding opportunities to expand behavioral health services.

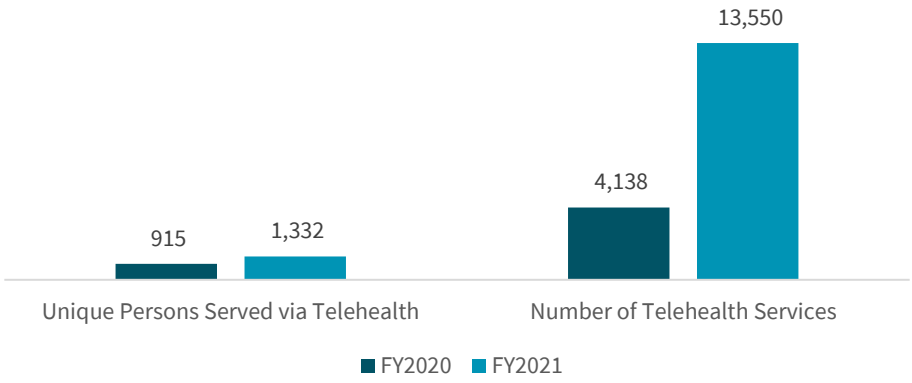
Telebehavioral Health Services

Consistent with national trends, the use of telebehavioral health services has increased greatly in the County in recent years. This upward trend was observed prior to the pandemic and skyrocketed at the onset of the pandemic.[32] Telebehavioral health services delivered by Comprehensive Healthcare, for example, more than tripled from 2020 to 2021 (Figure 21).

> "Kids are not into telehealth. We have bilingual families, families who don't own a home computer. You can get telehealth online, these families don't utilize it, they can't utilize it. Kids wanna connect with somebody, build a relationship, and then they'll share."
>
> *Provider*

Figure 21

Telebehavioral Health Services Dramatically Increased Between 2020 and 2021



Source: Data provided by Comprehensive Healthcare

> "I really like it. It's helpful, I like it when I can use it. When I can see my prescribers, I don't have to drive across town."
>
> *Service user*

Providers and other system leaders endorsed telebehavioral health as a good option for addressing access barriers, and service users noted the convenience afforded by having a telebehavioral health option.

Others pointed out that telebehavioral health is not a viable option for some communities where broadband internet is unavailable or expensive – and people in those communities may be more likely to experience behavioral health needs. And stakeholders expressed doubts about telebehavioral health's effectiveness, particularly for children and people who are not comfortable with the technology.

[32] Molfenter, T., Heitkamp, T., Murphy, A. A., Tapscott, S., Behlman, S., & Cody, O. J. (2021). Use of telehealth in mental health (MH) services during and after COVID-19. *Community Mental Health Journal, 57*(7), 1244-1251.

Crisis Services

In Washington State, crisis services are funded and delivered separately from other behavioral services (i.e., those provided by MCOs or the private sector).[33] These are among a set of services administered by the BH-ASOs that are available to anyone, regardless of their insurance status or income level. As discussed later in this section, behavioral health crisis services are also delivered through Providence Health in its ED and its Community Paramedicine program.

Comprehensive Healthcare is the BH-ASO crisis services contractor for a nine-county region, of which Walla Walla County is part. The following services may be provided by Comprehensive Healthcare to anyone in the region who is experiencing a mental health or SUD crisis:

- A 24/7/365 regional crisis hotline for mental health and SUD crises
- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals with certified peer counselors available Monday through Friday 9am to 5pm
- Application of mental health and SUD involuntary commitment statutes, available 24/7/365, to conduct involuntary treatment act (ITA) assessments and file detention petition
- Short-term SUD crisis services for people intoxicated or incapacitated in public

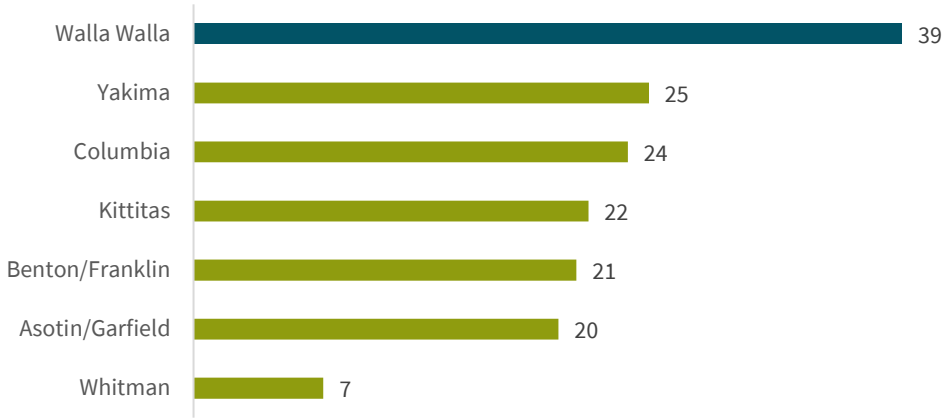
This system is likely to change soon due to recent state legislation – E2SHB 1477 – which will redesign the state's crisis behavioral health services system and tie service delivery to 988, a universal three-digit telephone number for people to call when they or a loved one experiences a behavioral health crisis. [34]

According to the most recent data from GCBH, there are more crisis contacts per capita and more high utilizers of crisis services in Walla Walla County than in other counties in the region. Figure 22 below shows the average number of crisis contacts per 10,000 population in Walla Walla County compared to the other counties served by GCBH. In the six months between October 2021 and March 2022, the average number of crisis contacts in Walla Walla County was 39 contacts per 10,000 population; the next highest, in Yakima County, was 25 per 10,000 population.

[33] Washington State Healthcare Authority. (2019). *Behavioral health administrative service organization (BH-ASO) fact sheet.*
[34] Washington State Legislature. (2021). *Engrossed Second Substitute House Bill 1477.*

Figure 22

The Average Number of Crisis Response Team (CRT) Contacts Per 10,000 Population are Higher in Walla Walla County than Other Counties in the Region



Source: Crisis Data Dashboard monthly data for October 2021-March 2022 was provided by Greater Columbia Behavioral Health. The average number of contacts per 10,000 population was calculated by converting the per capita rate to a rate per 10,000 and taking the average over the 6-month period (October – March 2021).

In addition to having more frequent crisis contacts, there are more people in Walla Walla County who use crisis services at a high frequency. GCBH defines a "high utilizer" of crisis services as an individual who accesses crisis services more than three (3) times during a given month. The table below shows on average one in five individuals (20 percent) who access crisis services in Walla Walla County are high utilizers. The rate of high utilizers across all counties served by GCBH is around 13 percent.

Figure 23

There are More People Accessing Crisis Services 3 or More Times a Month in Walla Walla County than Other Counties in the Region

Month/Year	Number of Unduplicated Individuals Served by Designated Crisis Responder (DCR) Services in Walla Walla County	Number of High Utilizers of DCR Services in Walla Walla County	% High Utilizers Walla Walla County	% High Utilizers GCBH Overall
Oct 2021	113	21	19%	13%
Nov 2021	106	22	21%	14%
Dec 2021	92	17	18%	12%
Jan 2022	88	19	22%	15%
Feb 2022	97	21	22%	12%
Mar 2022	102	20	20%	12%

Source: GCBH; the rate of high utilizers for GCBH Overall was extracted from monthly dashboard reports; the Walla Walla-specific numbers were provided in response to request for this study.

Crisis Response Team

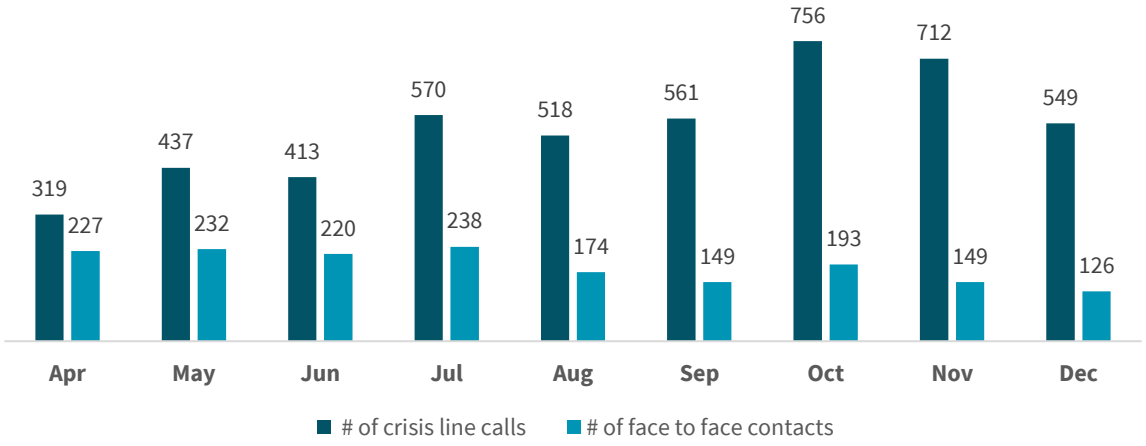
Contractually, Comprehensive Healthcare's CRT is required to respond to a "emergent" crisis within two hours and an "urgent" crisis within 24 hours to determine whether a person is a danger to themselves, a danger to others, or "gravely disabled," and if so, initiate an ITA process. According to the data, the CRT meets its contractual obligations for these responsibilities. The state requires the following response times by crisis status:

- **Emergent:** requires two-hour response time
- **Urgent:** requires 24-hour response time

Figure 24 summarizes the number of crisis line calls and face-to-face crisis contacts by month in Walla Walla County for April-December 2021. There is a noticeable increase in calls from April (the first month for which county-level data are available) and the fall (October and November) of that year. During the same time, the number of face-to-face contacts decreased: in April, roughly 70 percent of crisis calls resulted in a face-to-face contact as compared to October-December when only around 25 percent of calls resulted in a face-to-face contact.[35] This supports community members perceptions' that most crisis calls do not result in the CRT attending in person, and may have contributed to frustration as the proportion of calls resulting in a contact decreased between spring and fall of 2021.

Figure 24

CRT - Number of Crisis Calls and Face-To-Face Contacts in Walla Walla County, 2021



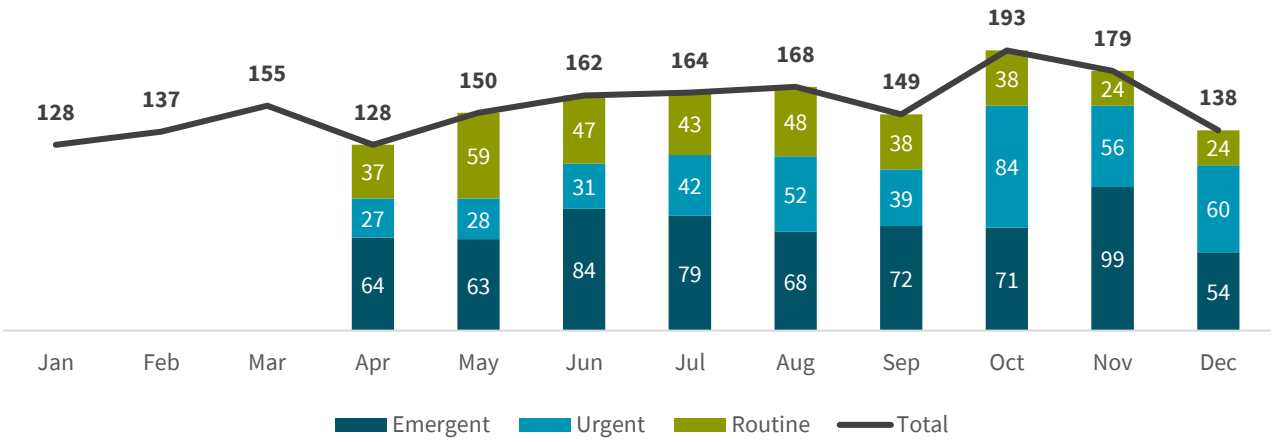
Source: Data provided by Comprehensive Healthcare
Note: Face-to-face contacts include contacts via teleconference.

[35] Face-to-face contacts include teleconference.

Crisis contacts are designated as “emergent” (requiring a 2-hour response time), “urgent” (requiring a 24-hour response time), or “routine” for things like follow-up. The following chart shows that in Walla Walla County typically around half of crisis contacts are designated as emergent, with the rate ranging from 37 percent (October) to 55 percent (November).

Figure 25

CRT Contacts in Walla Walla County by Crisis Status, 2021

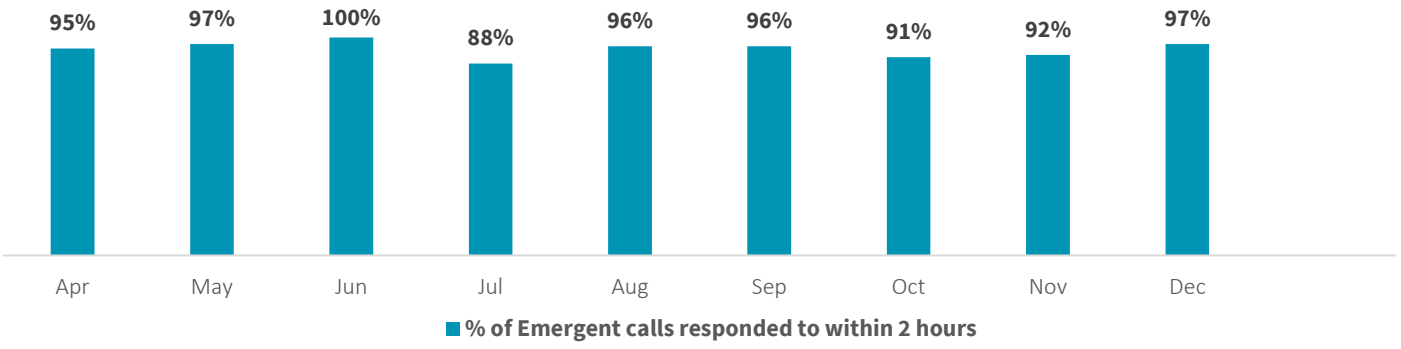


Source: Data provided by Comprehensive Healthcare

Comprehensive Healthcare is largely in compliance with the state-required response time of two hours for emergent calls as shown in Figure 26. However, in three of the nine months for which data were available (July, October, and November), about one out of ten emergent calls did not receive a response within two hours. For calls designated as “urgent” for which a 24-hour response time is required, the DCR Team met the target 100 percent of the time (data not shown).

Figure 26

The CRT Responded to Most Calls Within State-Mandated Response Time of Two Hours in 2021

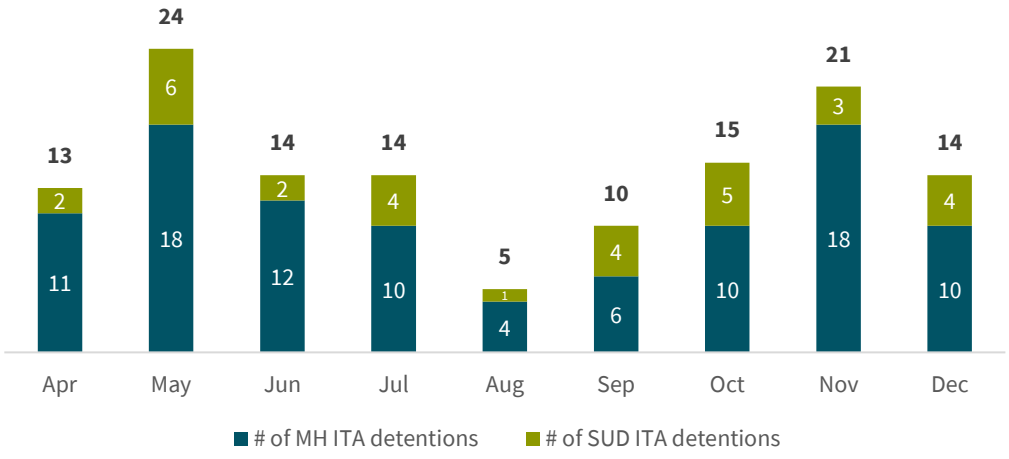


Source: Data provided by Comprehensive Healthcare

Only a small number of face-to-face contacts result in ITA detentions. Figure 27 below shows the number of ITA detentions in Walla Walla County by type (mental health or SUD), with the total number of ITA detentions for each month shown above each bar. The majority of ITA detentions in the County are for mental health.

Figure 27

Most ITA Detentions in Walla Walla County Were for Mental Health Concerns



Source: Data provided by Comprehensive Healthcare

Figure 28

Number of Acute Crisis Services, Persons Served, and Crisis Stabilization Placements at Comprehensive Healthcare

	FY 2020	FY 2021
Number of Crisis Services (Acute Care)	3,768	3,353
Unique Persons Served by Crisis Services	846	852
Number of Crisis Stabilization Placements	170	138

There were no data available on the demographic characteristics of people in crisis in Walla Walla County. It was noted that individuals calling the crisis line often do not want to share information on demographic characteristics. More detailed demographic information may help target resources to underserved groups and inform efforts to close gaps in services contributing to higher rates crisis contacts for certain groups.

Crisis services were the most referenced subject in our stakeholder interviews. More than half of the stakeholders we spoke with – including service users, family members, providers, and first responders – raised concerns about options for crisis response in Walla Walla County and described negative experiences with the CRT. Negative perceptions of CRT appear to be a combination of quality issues (they "no longer call crisis" because of negative experiences with crisis responders) and misunderstanding of CRT's mandate.

> "Part of it is communicating what they can do and what they cannot do because people don't understand when they call crisis what happens."
>
> "What's the criteria? They always make it sound like it's the law tying them up."
>
> *Two providers*

Stakeholder comments regarding CRT include the following:

- Objection to the CRT's application of the threshold used to determine if a person is danger to themselves or others or is "gravely disabled." Someone who is in crisis and reaching out for help may be told they are "not sick enough."
- Valuing the high threshold as protecting against inappropriate involuntary intervention, instead emphasizing treatment in the least restrictive setting.
- Concerns around the role and effectiveness of crisis responders when the DCR determines the ITA process is not appropriate, including a lack of follow-up after crisis contacts.
- Confusion about the role of CRT and the scope of their mandate.

> "More often than not, I don't get the help that I need. I can't count on them. More often than not, I get more frustrated. I let them know that I'm feeling suicidal, self-harm thoughts, and they tell me to call the office tomorrow morning. How is that supposed to help me right now? It's frustrating, it's absolutely frustrating."
>
> *Service user*

According to Comprehensive Healthcare, if the ITA process is not appropriate, the DCR can make referrals to other services or provide additional support. CRTs are obligated to provide referrals and perform follow-up within two weeks of a crisis event. This "second response" to crisis is widely understood to be integral to a well-functioning crisis service system.[36] We were unable to obtain data related to the frequency and nature of referrals or follow-up contacts in these instances, so there are no quantitative data points to determine whether and how these functions are being performed. But the qualitative data we collected for this study suggest a need for more training, supervision, and quality monitoring of crisis services beyond the state-required metrics, for example to ensure that post-crisis follow-up occurs.

> "Our crisis team right now say, 'no we don't do that,' and they walk away instead of saying 'yes,' but here's what we can do, slowly walking them gently to something else, there's real area for improvement."
>
> *Provider*

[36] Substance Abuse and Mental Health Services Administration. (2020). *National guidelines for behavioral health crisis care – A best practice toolkit*.

We believe many issues with CRT are related to the fact that the County lacks low barrier, after hours, supportive services that serve the function that many expect for CRT of proving support and follow-up for people experiencing urgent behavioral health needs.

If the CRT is not the appropriate service to perform this function, such services should be provided through other avenues. The appropriate role of the CRT should be messaged to the community, particularly people who use services and those who support them and first responders. One stakeholder described their concern in this way: "The challenge is when Comprehensive states they provide crisis services in the County but does not provide a full scope of these services, then no one steps in to provide robust crisis services."

> "We have people who are often in these moments, in their own minds as crisis but don't qualify as crisis by 'crisis standards.' [We need] people who can respond to those calls who have the kind of training to do so."
>
> *Housing provider*

Emergency Department

Providence St. Mary Medical Center is the only hospital located in Walla Walla County, serving nine rural counties in southeast Washington State since 1905. They have the County's only ED, as well as offer a range of primary and specialty care services, but do not currently provide inpatient behavioral health services. There were nearly 800 annual ED encounters for mental health at Providence St. Mary in 2020 and 2021, with 222 ED encounters for SUD in 2020, and 274 in 2021 (a 23 percent increase). Annually, around 4 percent of all ED encounters are for behavioral health (mental health or SUD).

Figure 29

Mental Health and SUD Account for 4% of ED Encounters at Providence St. Mary Medical Center

	2020	2021
Total # of ED encounters (all cause)	25,901	29,186
Number of ED encounters for mental health	796	788
% of ED encounters for mental health	3.1%	2.7%
Number of ED encounters for SUD	222	274
% of ED encounters for SUD	0.9%	0.9%
% of ED encounters for mental health or SUD	3.9%	3.6%

Source: Data provided by Providence St. Mary, Division of Population Health Integration

Data on the demographic characteristics of individuals presenting to the ED for behavioral health were not easily extractable, therefore not available for this report.

Providence St. Mary Medical Center ED doctors and nurses we interviewed were extremely concerned about the high rates of ED boarding for people with behavioral health needs. It is difficult to find inpatient placements, resulting in long periods of ED stays – sometimes up to eight days – as patients must stay in one room without treatment beyond medication. ED doctors and nurses shared their

frustration with the situation as people come in crisis to receive help but end up being detained, agitated, and often chemically restrained.

Community Paramedicine

Community Paramedicine is an emerging field in healthcare where emergency medical technicians (EMTs) and paramedics operate in expanded roles to connect underutilized resources to underserved populations.[37] The Walla Walla Community Paramedic Program, started in May 2021, is administered through the Walla Walla Fire Department and funded by Providence Health. The program receives referrals through the Providence Population Health program to support medical needs, including behavioral health needs, as well as social care needs for approximately 28 people. Services come to people in the community wherever they are needed. The program is highly regarded by the community as an asset for the County.

> "[The community paramedic] has changed the culture out there because he's out there all the time building relationships."
>
> *Provider*
>
> "Having a community paramedic has certainly been a gamechanger for us … When there is a need, he's there and that has been such a big deal."
>
> *Housing provider*

The most successful elements of the program appear to be its flexibility, responsiveness, and capacity to build relationships with people who use the service, as well as the community providers who interact with those with complex needs in the County. Stakeholders saw value in having personnel trained as a first responders – not utilizing uniformed law enforcement officers for mental health intervention.

Notably, the current Community Paramedic has his own lived experience of psychiatric crisis and receiving behavioral health services. This experience informs his work and appears to facilitate trusting relationships with people who use services and other community members.

The following are data points provided by program:

- 531 persons served
- 76 avoidable ED diversions in first 6 months (estimated at $182,400 savings)
- Original grant amount $110,000 from Providence St. Mary
- One Community Paramedic covering 40 hours per week

With regard to sustainability, program leadership intend to look into billing insurance (including Medicaid and Medicare) and expanding the program to include a second paramedic. They will explore incorporating more sophisticated data practices to monitor and improve quality and demonstrate impact over time.

[37] Health Resources and Services Administration. (2012). *Community paramedicine: Evaluation tool.*

Residential Treatment

Waypoint, housed at Comprehensive Healthcare's Walla Walla campus, is the County's only residential treatment facility. Waypoint is a 16-bed unit providing 24/7 treatment to adults (18 years of age and older) who meet medical necessity criteria for admission based on significant mental health or co-occurring disorder(s). The program does not provide medical detoxification. Four of the 16 beds are reserved for crisis stabilization and the remaining 12 beds are reserved for residential treatment. Admission to both programs is voluntary. Below is a brief description of the of the referral and admission criteria to each program.

- **Waypoint Crisis Stabilization**: Treatment is voluntary and intended as a resource for individuals who are experiencing a mental health crisis that might otherwise meet hospital admission criteria. Individuals are first assessed by the DCR to determine the need for the level of care; if level of need is met, a referral is made to the Acute Care Team. Average length of stay is 1-14 days.

- **Waypoint Residential Treatment**: Serves individuals who have mental health or co-occurring disorder(s) and require a residential level of care based on level of functioning. Individuals must have significant functional impairment due to mental illness. It must be determined during assessment that there are no other services available to treat the disorder or prevent the worsening of the condition. Referrals are made to the Residential Program Manager. Average length of stay is 1-180 days.

Figure 30

Number Served at Comprehensive Healthcare's Waypoint Residential Unit

	FY 2020	FY 2021
Total Persons Served at Waypoint	193	168
Number of Residential Placements	51	78
Number of Crisis Stabilization Placements	170	138

Source: Data provided by Comprehensive Healthcare

Two service users we interviewed described negative experiences with the Waypoint crisis stabilization unit centered around inconsistent programming and workforce turnover. Several others, however, found Waypoint's residential and crisis services to be a valuable resource and support for their recovery.

> "Waypoint was very excellent in housing me when I got out the first time, making sure I was plugged in, they do really good job with that, making sure I had doctor's appointment, dentist appointment, safe place to stay before I exited. Their staff does wonders."
>
> "[Waypoint] was definitely great for me, it's what led me to get to housing … Just having stability at Waypoint, know where I was, have a routine again."
>
> "Waypoint, as far as having a crisis facility, I think it was really helpful to have that."

Inpatient Treatment

In a 2017 survey conducted by the Suicide Prevention Work Group (SPWG), respondents were asked, "Which interventions do you feel are most needed and least accessible for people in need of mental healthcare in Walla Walla County?" Inpatient mental health treatment for people of all ages was the most common response, with 62 percent of nearly 2,000 respondents selecting the response. Inpatient services for older adults (with a geriatric/psychiatric unit mentioned specifically) and for children and youth are particularly needed, according to stakeholders.

Currently, there are no inpatient facilities in Walla Walla County. In response to community need, Comprehensive Healthcare is in the process of developing a new 16-bed facility in Walla Walla County that will have eight beds for acute psychiatric treatment and eight beds for detox. The facility will serve adults only and is expected to open in April 2023.

When inpatient hospitalization is needed, residents are referred to inpatient options outside of the County, creating major transportation barriers, which were described by numerous stakeholders we interviewed. Figure 31 shows, in alphabetical order, the psychiatric hospitals and psychiatric units from which Walla Walla County residents were discharged in 2019 and 2020, along with their location and distance from Walla Walla. Of the 66 discharges in 2019 and 62 in 2020, the majority were from Lourdes Counseling Center in Richland and Providence St. Luke's in Spokane.

Figure 31

Walla Walla Residents Travel Long Distances for Inpatient Psychiatric Care

Hospital/Unit (Listed Alphabetically)	Location	Distance from Walla Walla (miles)
Cascade Behavioral Hospital	Tukwila	278
CHI Franciscan Rehabilitation Hospital	Tacoma	290
Fairfax Behavioral Health Everett	Everett	295
Fairfax Behavioral Health Kirkland	Kirkland	275
Fairfax Behavioral Health Monroe	Monroe	291
Inland Northwest Behavioral Health	Spokane	153
Lourdes Counseling Center	Richland	58
Providence Sacred Heart Med. Center	Spokane	153
Providence St. Luke's Rehabilitation	Spokane	153
Rainier Springs Psychiatric Hospital	Vancouver	249
Skagit Valley Hospital-Psych	Mt. Vernon	328
Smokey Point Behavioral Hospital	Marysville	306
Swedish Edmonds - Psych	Edmonds	287
UW Medicine Harborview Med. Center	Seattle	272
Yakima Valley Memorial Hospital	Yakima	132

Source: Hospital Discharge Data (CHARS), Hospital Inpatient Discharge Database Report, 2019 and 2020. Dataset for Hospital Census and Charges by Patient Zip Code. Accessed at: https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS/CHARSReports

"We can't just institutionalize everyone because they have a mental health problem."

Service user

A few stakeholders highlighted the need to bring back inpatient psychiatric hospitals and involuntary treatment services that were previously available in the local community. Others questioned whether inpatient treatment is a primary solution for meeting behavioral health needs, emphasizing the importance of prioritizing voluntary community-based options, which are more desirable and effective.

Transitions of Care

"Continuity of care is broken. Maybe there's not enough employees for services that are needed."

Housing provider

Service users and housing stakeholders identified a lack of coordination with services following discharge from inpatient facilities or short-term crisis stabilization. Waypoint offers coordination by making sure service users connect with housing and transportation upon discharge and have appointments scheduled with healthcare providers for medications and related needs. However, some stakeholders emphasized that Waypoint does not have a safe place to send people after their stay other than shelters, and it can take weeks before service users can see a prescriber for medications after discharge.

In March 2022, the legislature passed House Bill 1860, "An Act Relating to Preventing Homelessness Among Persons Discharging From Inpatient Behavioral Health Settings," to improve coordination and outcomes with the following performance measures to be included in contracts with providers

- Improvements in client health status and wellness
- Increases in client participation in meaningful activities
- Reductions in client involvement with criminal justice systems
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons
- Increases in stable housing in the community
- Improvements in client satisfaction with quality of life
- Reductions in population-level health disparities

Shelter and Housing Services

Housing is one of the most critical SDOH and behavioral health. According to the Point-in-Time count of people who are homeless in Walla Walla County, 39 percent had a chronic SUD, and 20 percent had an identified mental health condition.[38] According to Medicaid data presented later in Figure 34, 2 percent of Medicaid beneficiaries in Walla Walla County were homeless in at least one month during FY 2021, a rate lower than the statewide rate of 3 percent.

There are numerous community assets and initiatives working to address the crisis of affordable housing, which is not unique to Walla Walla County. These include the Community Council, which is facilitating a multi-sector and multi-jurisdiction Affordable Housing Implementation Task Force that has conducted an in-depth study of affordable housing in the region and produced numerous reports and resources, as well as the Walla Walla Regional Housing Action Plan, among others. Figure 32 depicts the organizations that supported people experiencing or at risk of experiencing homelessness in 2020.

Figure 32

In 2020, Walla Walla County Providers Supported 694 People to Access Housing and Shelter Services and Avoid Entering Homelessness

Organization	Individuals Served
Blue Mountain Action Council	326
Comprehensive Healthcare	26
Joe's Place	41
The STAR Project	80
City of Walla Walla	221
Total	**694**

Source: 2020 Affordable Housing and Homeless Housing Fund Report Walla Walla County

[38] Walla Walla County Department of Community Health. (2018). *Walla Walla County point in time 2018: Final results*.

> "They really need more [housing], not just shelters, if I was president, everybody would get a house."
>
> *Service user*

Housing service providers noted a need for permanent supportive housing (PSH), an evidence-based model that places few restrictions on residents to maintain sobriety or receive treatment as a precondition for housing. Currently, PSH is available but limited in Walla Walla County. The Walla Walla Housing Authority is currently developing 29 PSH units on land within the County with the expectation for units to be available in the fall of 2022. Along with the expansion of PSH, it will be important for the County to establish processes to assess fidelity to the PSH model and collect and review data to understand if PSH is reaching individuals and families most in need.

Housing – including affordability and access as well as a need for supportive service to help people attain and maintain housing – was the number one concern for some people we interviewed. In general, stakeholders gave high marks to the current network of housing agencies and providers and the ways in which they collaborate to connect people to housing. They also noted insufficient options for people with felony convictions, and lack of options for families to shelter together in the community. In terms of connection to behavioral healthcare, shelter provider stakeholders noted that having a mental health professional embedded at a shelter location would greatly facilitate access to care for people who are unhoused.

In response to the COVID-19 pandemic, the County's Homeless and Housing System Engagement Program Coordinator convened weekly virtual meetings with providers of emergency services in Walla Walla County to coordinate how to best support and meet individuals' needs during the time of pandemic restrictions. The meetings served such an important role in coordinating services and supports they have continued even after pandemic restrictions were lifted. There is also a monthly meeting specifically for shelter providers. Shelter providers noted the coordinator is serving an important function bringing providers together for coordination meetings and to connect them to funding opportunities.

Services for People with Justice Involvement

People involved in the justice system in Walla Walla County have higher behavioral health-related needs than the general population, and this is consistent with national data. About two-thirds (58 percent) of Walla Walla County Medicaid recipients booked into jail have mental health treatment needs and over half (53 percent) have SUD treatment needs.[39]

Currently, 1/10th of 1% funds a range of behavioral health services for justice-involved youth and adults through County Corrections and the JJC. Figure 33 shows the number served and volume of treatment services (in hours) by location and service type provided in the JJC funded by the

[39] Washington State Department of Social and Health Services. (2016). *Behavioral health needs of jail inmates in Washington State*.

1/10th of 1% in 2021. The majority of services were individual treatment services delivered in the JJC or in the office or telehealth setting.

Figure 33

In 2020, 1/10th of 1% Funded Over 300 Hours of Services to 187 Youth in the Juvenile Justice System

Number Served	
Adult	65
Youth	187
New Clients	45
Service Location	(Hours)
School	34
JCC	168
Home	1
Other (park)	3
Office/Telehealth	124
Service Type	(Hours)
Crisis Services/Crisis Triage	8
Individual Treatment Services	308
Intake Evaluation	18

Source: Data shared by the Walla Walla County DCH among the materials of the 1/10th of 1% funding for the 2021 Annual Report. The timeframe for these data is January 2020 – March 2021.

The STAR Project was founded in 2004 and serves people with felony convictions in Walla Walla and Colombia counties. The STAR's mission is to reduce recidivism by assisting people who are released from incarceration with the essential tools they need to be successful in the community. The STAR Project provides pre-release transition services, case management, transitional housing, employment and education support services, and mentoring. The housing assistance provided by The STAR Project has a clean and sober requirement. From 2013 through 2020, The STAR Project served 856 people for which the average recidivism rate (defined as "any felony offense committed within 36-months of being at-risk in the community which results in a Washington State conviction") was 15 percent, better than the statewide rate of 32 percent.[40] Below are highlights from The STAR Project's 2020 Annual Report:

- 54 new persons served through case management
- 5 persons served through evidence-based Moral Reconation Therapy (MRT)
- 80 persons connected to housing services
- 9 persons enrolled in higher education and two graduates from Walla Walla Community College (WWCC)
- 131 persons served through SUD peer services

[40] The STAR Project. (2020). *STAR recidivism data*.

The LEAD program started in 2020 as a collaboration between Comprehensive Healthcare, Blue Mountain Heart to Heart, and Walla Walla Police Department (WWPD). It is a voluntary program that gives people with low-level offenses and behavioral health needs the opportunity to participate in treatment as an alternative to incarceration to stop the cycle of justice system involvement.

Stakeholder concerns related to recent justice system reforms and their impact on behavioral health service access for justice-involved populations are discussed further in Section 5 (Implications of Justice System Reform Legislation).

Services for Veterans

Walla Walla County is home to numerous programs that support veterans in multiple ways. These include a range of programs offered through the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla Vet Center, Walla Walla County Veterans Services, WorkSource Walla Walla, Veterans of Foreign Wars Local Walla Walla Post 992, Veteran Conservation Corps, and the Service Peace Warriors program. Still, stakeholders who work with veterans noted that many still do not access supportive services offered through VA or elsewhere.

Consistent with national trends, veterans in Walla Walla County have heightened need for behavioral health supports. While local data are unavailable, the fact that veterans regularly seek walk-in urgent behavioral health supports through the VA Medical Center implies the level of unmet need for outreach, support, and treatment in the County is similar to unmet needs observed throughout the United States. The deaths by suicide of two local veterans within two weeks of one another in the fall of 2021 is a painful reminder of these unmet needs.

Many veterans face the same access barriers as the civilian population. Depending on their level of service, income, and assessed need, veterans may not qualify for publicly funded behavioral health services (Medicaid or VA coverage). Veterans and those who work with veteran populations also highlighted the need for education, outreach, and supports, including crisis supports, that are trauma-informed and responsive to the unique needs of veterans.

5. System Considerations

Critically, a behavioral health system is more than its services. In this section, we examine system characteristics drawing from stakeholder interviews and local data.

Managed Care Organization Performance

The table below shows behavioral health-related measures from the Washington State Health Care Authority dashboard for Medicaid enrollees in Walla Walla County compared to statewide averages, providing an overview of MCO performance in Walla Walla County. Values indicated with an asterisk (*) and shaded blue are those for which the difference between the County value and the state value are statistically significant.[41]

There are several notable differences between MCO performance in Walla Walla County and state averages. The Walla Walla County MCOs performed significantly better than the state average in terms of:

- Follow-up with a mental health practitioner within 7 days after psychiatric hospitalization (ages 6 and older); (67 percent vs. 52 percent statewide)
- Smaller percent prescribed high-dose chronic opioid therapy
- Smaller percent experiencing homelessness at least one month of the year (2 percent vs. 3 percent statewide)

MCOs performed significantly worse in Walla Walla County compared to state averages in terms of:

- SUD treatment penetration (34 percent vs. 38 percent statewide). Treatment penetration is defined as the percentage of Medicaid enrollees ages 12 and over with an SUD treatment need identified within the past two years, who received at least one SUD treatment service during the year.

Measures for which the Walla Walla County rate is similar to the statewide rate are not an indication that the system is performing well, necessarily. For example, the mental health treatment penetration rate (defined as the percentage of Medicaid enrollees ages six and over with an identified mental health service need within the past two years who received at least one qualifying service within the year) is 53 percent in Walla Walla County, suggesting nearly half of people with a mental health service need (which is determined based on diagnosis codes in claims data) received no treatment services during the year.

[41] We indicated with asterisk (*) when the statewide value falls outside of the margin of error (95% confidence interval) for the County value, suggesting a meaningful difference. However, this differs from the technical definition of statistical significance because we only had a confidence interval for the County value, and not the state value.

A possible explanation for this shortfall is an inadequate supply of providers, as suggested by a number of stakeholders. MCOs are contractually obligated to maintain network adequacy standards, but these standards may be insufficient for ensuring access due to various issues such as access barriers, workforce shortages, and mismatches between needs and types of available services.

Figure 34

Behavioral Health-Related Measures for Medicaid Enrollees in Walla Walla County Compared to State Averages, State Fiscal Year (SFY) 2021

Measure	State Rate	County Rate	County 95% CI	County Denominator
Antidepressant medication management: acute (%) ↑	59	56	50,62	280
Antidepressant medication management: continuation (%) ↑	43	42	36,48	280
Follow-up after ED visit for alcohol/drugs: 7 days (%) ↑	23	21	14,30	105
Follow-up after ED visit for alcohol/drugs: 30 days (%) ↑	33	27	19,36	105
Follow-up after ED visit for mental illness: 7 days (%) ↑	57	52	40,64	69
Follow-up after ED visit for mental illness: 30 days (%) ↑	70	78	63,88	49
Follow-up after hospitalization for mental illness: 7 days (%) ↑	52	67*	53,80	49
Follow-up after hospitalization for mental illness: 30 days (%) ↑	70	78	63,88	49
Mental health treatment penetration (%) ↑	54	53	51,54	4,482
Patients prescribed chronic concurrent opioids and sedatives (%) ↓	14	13	10,16	478
Patients prescribed high-dose chronic opioid therapy >=50mg (%) ↓	33	23*	19,27	478
Patients prescribed high-dose chronic opioid therapy >=90mg (%) ↓	14	8*	5,10	478
Percent arrested at least once during year (ages 18-64) ↓	5	5	5,6	5,826
Percent homeless during at least one month of year ↓	3	2*	2,2	12,509
SUD treatment penetration (%)↑	38	34*	32,37	1,352
SUD treatment penetration (opioid) (%)↑	58	57	53,62	538

Source: Washington State Health Care Authority dashboard; Version 23/Published on May 2, 2022. Measurement period is SFY 2021: 07/2020 - 06/2021. Accessed 5/3/2022 at https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Measures?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

*Notes: ↑=a higher rate is better; ↓=a lower rate is better; *=state rate falls outside of the 95% confidence interval (CI) for Walla Walla County, suggesting a meaningful difference; this differs from statistical significance because we only had the margin of error for the County value and not the state value. More detail on the specific measures shown in this table is available on the dashboard at the link noted above.*

We examined whether there are differences in rates for the measures above by demographic characteristics in Walla Walla County, for which data are available on the state's dashboard. There are several notable (statistically significant[42]) differences:

- Mental health treatment penetration is higher among youth ages 6-17 (59 percent) and non-Hispanic Whites (55 percent) and lower among Spanish-speakers (47 percent) and people of color (49 percent) compared to the overall County rate (53 percent)
- Follow-up after ED visit for alcohol/drugs is higher among females (38 percent) compared to the overall County rate (27 percent)

[42] For values by demographic characteristics, we compared the margin of error (95% confidence interval) for the demographic category to the margin of error for the County-wide value; values for which the error margins do not overlap are considered statistically significant.

- SUD treatment penetration is lower among people of color (29 percent) compared to the overall County rate (34 percent)
- Percent homeless is higher among males (3 percent) and non-Hispanic Whites (3 percent) and lower among people of color (1 percent) compared to the overall County rate (2 percent)

With the exception of homelessness, these statistics suggest some degree of racial and ethnic disparities in behavioral health treatment.

Workforce Concerns

Shortages in the behavioral health workforce is a national problem, and in Walla Walla County, was one of the most common interview themes. Stakeholders identified shortages in the behavioral health workforce across a wide range of positions including prescribers, school counselors, and licensed clinical social workers. Nearly all provider organizations cited being short-staffed as a barrier to providing high quality and responsive behavioral health services, and to expanding services and programs to meet community needs. Workforce shortages make it more difficult for providers to provide evidence-based practices according to fidelity. Multiple stakeholders surmised that staff turnover contributes to a lack of trust between the community and providers because services cannot be delivered as promised. Issues related to baseline workforce shortages are compounded by high turnover rates, which have been exacerbated by the pandemic. Nationally, turnover rates within the behavioral health workforce are estimated to be 30 percent to 50 percent.[43] In a September 2021 survey, more than 80 percent of a national sample of provider organizations reported difficulty in retaining staff. Walla Walla County providers cited burnout as one factor that is resulting in people leaving the behavioral health field for other positions.

> "A counselor that doesn't leave. If they did leave, to actually tell the person face-to-face instead of in a letter, that's the worse one. Every time a counselor left, I've never heard it from them face-to-face … It's a lot easier that way."
>
> *Service user*

At Comprehensive Healthcare, the staff turnover rate was 28 percent in 2021, on the low end of national estimates. At Serenity Point, the staff turnover rate was cited as two SUD counselors every two and half years and two mental health counselors every one and half years out of staff of 9 clinical full-time equivalents (FTEs). Serenity Point is currently operating with 6 clinical FTEs due to workforce shortage, with two open positions for mental health practitioners that have been vacant for roughly one year. High rates of turnover make establishing a therapeutic relationship difficult, which several service users described as harmful for their recovery. They described how challenging it is to have to tell your story over and over again, and to work through preexisting challenges with anxiety and attachment when a provider leaves. Another common theme in these discussions was a lack of sufficient communication when providers leave. One service user

[43] Herschell, A. D., Kolko, D. J., Hart, J. A., Brabson, L. A., & Gavin, J. G. (2020). Mixed method study of workforce turnover and evidence-based treatment implementation in community behavioral healthcare settings. *Child Abuse & Neglect, 102*, 104419.

reported that they had four therapists in six years, and that only one told them in person that they were leaving.

We were informed that a shortage of bilingual, bicultural providers was a particular problem. Some organizations and school districts reported an adequate number of bilingual providers, but a majority acknowledged a shortage. We were unable to obtain quantitative data on the demographic information, including languages spoken, of providers in Walla Walla County; providers cited difficulty in keeping track of this information given high levels of staff turnover. The ramifications of this shortage were described in terms of service access, quality, and outcomes for underserved groups. These findings are consistent with the Community Health Needs Assessment,[44] which found that the population most impacted by access to care challenges is those whose primary language is not English.

> "I need to have a counselor. I was looking for bilingual, bicultural because that's important to me. Someone who speaks Spanish because I feel comfortable. I couldn't find."
>
> *Spanish group interview*

A number of systemic factors underpin the workforce shortage, none of which are unique to Walla Walla County. According to individuals with knowledge of community behavioral health financing, the current Medicaid reimbursement model underfunds these services. In particular, stakeholders described the current managed care arrangements as insufficient for reimbursing the kinds of outreach, coordination, and wraparound community supports needed for people and families with complex behavioral health-related concerns. They also described providing uncompensated care for people who are funded by Medicare.

> "You have McDonald's hiring and increasing their wages, and you have a really difficult, emotionally exhausting job that pays similar. During COVID-19 when people are overwhelmed and stressed … it makes it difficult for people to stay and do this job."
>
> *Community stakeholder*

> "Where you feel helpless is when you cannot do something for somebody that you should be able to do; that leads people to burnout and quit. As long as you have hope that you can help people in some way, medical people will stay. Nurses are crying because they can't help somebody. That causes a personnel crisis. I want to go somewhere where I can do some good."
>
> *Provider*

National and local economic factors also exacerbate the workforce shortage. The rising cost of living makes it more difficult for providers to afford to work and live in Walla Walla County, and community behavioral health providers are competing with other lower-stress industries for workers.

We also heard from providers about difficulties with the licensing process for some professions such as social work. Employers do not always cover the costs of initial applications, testing, and annual fees for licensure, which can become unaffordable.

One potential solution to the workforce crisis is strengthening the workforce pipeline through partnerships with the three local colleges: Walla Walla University has accredited Bachelor of Social

[44] Providence St. Mary Medical Center. (2021). *Community health needs assessment.*

Work (BSW) and MSW programs, WWCC has a Human and Social Services Program, and Whitman College also offers human services-related internships through some of its programs. The student placements at BMHC have been largely seen as positive, with many students staying on as clinicians in Walla Walla County. Currently, however, there is a greater demand for student placements in the County than there are students to fill the placements, with limited staff to provide clinical supervision for students who are placed.

Disparities, Discrimination, and Cultural and Linguistic Responsiveness

According to our analysis of multiple data sources cited in this report, communities of color experience disparities in social determinants and access to behavioral health services, although unfortunately, quantitative data on rates of access to specific services were unavailable from most providers.

We heard that anti-immigrant discrimination and racism are having a negative impact on the behavioral health of the Hispanic community. An estimated 21,000 people living in Benton, Franklin, and Walla Walla counties are undocumented.[45] Families that have crossed the border illegally may have experienced significant trauma – the stress of living in a community as an undocumented person is also a form of trauma – and there are concerns that this population is not coming forward for help for fear of deportation. Individuals we interviewed described traumas associated with U.S. Immigration and Customs Enforcement (ICE) raids, anti-immigrant sentiment surrounding elections and political discussions, and experiences of discrimination in the community.

Stakeholders described a need for behavioral health system leaders to intentionally work to build trust with the Hispanic community and create more safe spaces for them to engage in services.

> "Unfortunately, in our community, there's a divide between Spanish-speaking and White English-speaking community. We're trying to connect and create a bridge between both communities. We've seen how that divide is affecting our youth, especially with the services provided."
>
> *School-based stakeholder*

[45] Migration Policy Institute. (2019). *Profile of the unauthorized population: Benton-Franklin-Walla Walla counties, WA.*

Within schools, many Intervention Specialists are bilingual and available to work with Spanish-speaking families. However, monolingual Spanish-speaking families may rely on services from Intervention Specialists when a higher level of support is needed, but there are no bilingual providers available to provide that level of support.

> "Diversity here is less than a metropolitan area. I believe that people of color are not seen as much and therefore not seen as much or reached out to as need be. There's an underserved population in that. I believe that it's almost, 'If it's not right in front of your face, it doesn't exist.'"
>
> *Housing provider*

When asked about language preference, stakeholders had mixed views. Some voiced a strong preference for a provider who speaks their native language. Others emphasized the importance of taking an individualized approach to linguistic competency, routinely asking people what language they would prefer to receive services in.

In the absence of a bilingual provider, organizations rely on translation services, either live or machine interpretation. Stakeholders also relayed instances in which translation services were needed but not provided. A few stakeholders voiced concern about the translation services for the CRT, stating the crisis line doesn't routinely ask whether translation services will be needed. They noted the translators used by the CRT speak in medical terminology that is not comprehensible to people in crisis. According to stakeholders we interviewed, negative experiences with linguistically inappropriate services result in dissatisfaction with the system and a reduced likelihood of seeking support.

> "… in Spanish there are more words to express yourself than in English. Some words can't be translated into English."
>
> *Spanish group interview*

Representatives from the Hispanic community noted a need for culturally responsive information and education for the Hispanic community, including information to promote greater awareness of behavioral health resources and strategies to build trust in the behavioral health system for community members who have had negative experiences in the past. They also noted that there are generational differences in communication and help-seeking within the Hispanic community, with younger people more likely to identify behavioral health needs and ask for help. This suggests outreach strategies may need to be tailored to different groups.

> "I've always wondered what else we can do in our community to have these conversations, so they're not taboo? And how do we have these conversations in Spanish, so our families understand? … How can we make sure we bring them to the table, or bring the table to them?"
>
> *Hispanic stakeholder*

Community Engagement

We asked whether there were sufficient forums for the community to receive information and provide meaningful input into decisions about the behavioral health system, and universally, the answer to this question was "no."

In particular, there are limited avenues for people who use services and their families or loved ones to partner with decision makers to shape behavioral health services and resources in the County. Most decisions about behavioral health supports are made by provider organizations without significant efforts to gather information from people who use the services.

One provider articulated a need for themselves and other providers to receive training on how to authentically engage service users and their loved ones in decisions and oversight, the importance of compensating volunteers for their time, and how to avoid being patronizing or tokenizing.

Those running meetings need to have skills and trainings in involving people with lived experience. And community engagement efforts must be inclusive, with outreach and accommodations – such as evening meeting times, childcare, plain language materials, and translation – for those who have been historically underrepresented in community conversations, including members of the Hispanic community.

Several service users said they did not know of a process to file grievances with individual service provider organizations. We also spoke with one who filed a grievance with a provider and received no response.

> "If we give ourselves an opportunity to listen, they [people who use services] have got a lot to say. They can help us and help themselves. They get talked about in meetings but never included. How about including them? They bring a lot to what you do if you listen, incorporate them into what you do. That opened my eyes more, and we shouldn't forget it."
>
> *Provider*

> "I have no idea who I would talk to. I know it would be a higher-up in I I have no idea who I would talk to. I know it would be a higher-up in the community. I know there's a need, but I have no idea who."
>
> *Service user*

Access to Services

We identified several categories of barriers to accessing appropriate services.

Scheduling

We heard about a variety of issues related to scheduling of services, including the time of day that services are available, timeliness of appointments, and appointment cancellations. Stakeholders stressed the need for services to meet people where they are at and service hours that are expanded to evenings and weekends. When services are only available during the workday, it pushes people to choose between work and treatment. This disproportionately impacts the Hispanic community, many of whom work during the day.

> "Most of our [Hispanic] population work in the fields, during the day, early. Depending on the season, they work late. Some families work, depending where it is, 'til 6."
>
> *Spanish group interview*

> "If you did a profile of when people tend to fall apart and have a crisis, it's not often during the day. That's when business hours are. It would be really nice to have a group of people doing a swing shift. That tends to be when people are more likely in crisis."
>
> *Housing provider*

Stakeholders also noted that crises and other intensive service needs tend to happen at night or on the weekend. There aren't many service options available during these times other than the ED or CRT.

While some providers are exploring offering services on evenings and weekends, others emphasized that it is not realistic to expect private providers to offer services after business hours given the current workforce shortages.

Waiting lists were frequently referenced, with waits for children/youth services, services for autism, and services in Spanish as being particularly long. One provider referred to waitlists as a "desperate scenario," a sentiment echoed by many others. Interviewees reflected on the benefits and drawbacks of waiting lists. Being on a waiting list can provide piece of mind for people who are in distress, but some providers have closed waiting lists because the wait periods were inordinately long and unlikely to be helpful to people seeking services.

> "There are providers that have taken themselves off Psychology Today and Mental Health Walla Walla because they don't want clients to find them. They are backed up to the point where they don't have to worry about work again."
>
> *Provider*

We noted a discrepancy between wait times cited by various providers and other stakeholders when it came to scheduling appointments. It's likely these discrepancies reflect a variety of factors including different wait times depending on appointment type and the needs of the person, assessment requirements, insurance status, staffing shortages, and fluctuations in availability of appointments over time.

MCO contracts for Medicaid-funded outpatient services include specific requirements for timeliness of services, including those from behavioral health providers. Non-urgent, routine office visits are to be available within ten calendar days, and urgent office visits within 24 hours.[46] Comprehensive Healthcare and Serenity Point offer same-day appointments, but service users and others described difficulty scheduling with the current model. These stakeholders noted that the "first come, first served" organization of these services made access "arduous" and privileged those with time, resources, and organization to spend an hour or more in a waiting room during the weekday.

Several service users and family members voiced frustration at appointments being cancelled at the last minute by providers. For example, a parent of a child with significant mental health concerns described rearranging their family's work and school schedules to accommodate an appointment scheduled three weeks out, only to have it cancelled by the provider the day before.

[46] Washington State Healthcare Authority. (n.d.). *Washington Apple Health integrated managed care contract.*

Figure 35 depicts the percentage of cancelled and no-show appointments by outpatient service type for Comprehensive Healthcare. Overall, roughly half of assessments/evaluations and SUD group therapy appointments were either cancelled or no-shows, and over one-third of individual therapy appointments were either cancelled or no-shows. For each service type except community support (face-to-face), staff were more likely than clients to cancel the appointments; in the case of individual therapy 53+ minutes, 60 percent of the cancellations/no-shows were initiated by staff and for SUD group therapy, strikingly, over 90 percent of the cancellations/no-shows were due to staff. These data support stakeholders' experiences and frustration with providers cancelling appointments, often with little notice or reason given. For its part, Comprehensive Healthcare reports it has been working over the past year to reduce staff-initiated cancellations by not booking appointments more than 30 days in advance so as not to conflict with staff vacations or trainings that arise, which it cited as the driving reason behind staff-initiated cancellations. Clinicians are now expected to submit requests for time off at least 90 days in advance, when possible, to reduce occurrence of staff cancellations.

> "I think probably one of the most frustrating aspects was last minute cancellations. Two-fold, when it takes a lot for someone to reach out and access services, gearing up to be able to commit to it, and when it feels so dismissive to cancel it at the last minute, it feels like an invalidation of what that person is doing. Also lack of convenience, meet people where they're at. Not being able to give appointments until three or four weeks out is not how we'll get people the services that they need."
>
> *Service user*

Figure 35

Comprehensive Healthcare Appointments Cancelled or No-Show Status, 2021

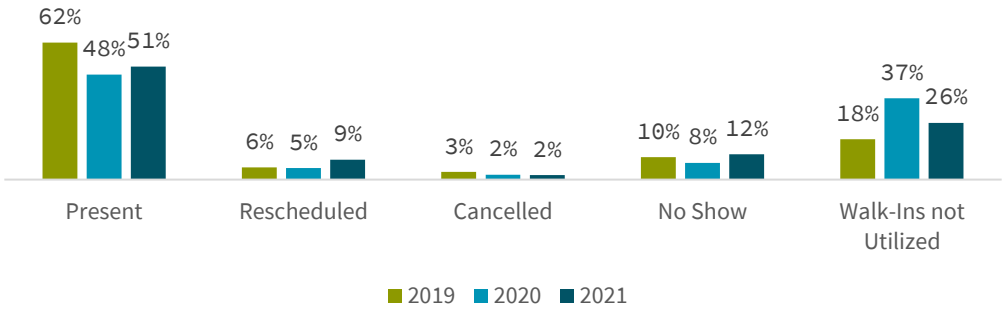
Service Type	# of Client Appointments	# Cancelled or No-Show	# Cancelled by Staff	% of All Appointments Cancelled or No-Show	% of All Cancelled or No-Show Appointments Cancelled by Staff
Individual Therapy <53 Minutes	11,628	4,211	2,234	36%	53%
Community Support	5,586	903	456	16%	51%
Community Support - Face to Face	3,722	566	45	15%	8%
Individual Therapy 53+ Minutes	2,902	1,237	744	43%	60%
Group Therapy - SUD	2,865	1,465	1,350	51%	92%
Assessment - Evaluation	1,423	673	360	47%	53%

Source: Data provided by Comprehensive Healthcare. The percentage of cancelled or no-show appointments cancelled by staff was imputed based on the percent of appointments cancelled by clients (not shown) that was included in the data provided.

Figure 36 depicts cancellation information for Serenity Point, which had lower rates of cancellations and no shows than did Comprehensive Healthcare.

Figure 36

Serenity Point Assessments by Appointment Status, 2019-2021



Source: Data provided by Serenity Point. Note: the percentages represent the average monthly average per year. The total number of assessments per year are as follows: 2019 N=734; 2020 N=794; 2021 N=621 (note; data were not available for the month of December 2021).

One common concern was a requirement that services be "restarted" with a new assessment if too much time elapses between visits, or if a person is discharged from services and attempts to reengage. Stakeholders expressed frustration that appointments cancelled and rescheduled by the provider contributed to time lapses between appointments and requirements that assessments be redone.

> "… what tends to happen, if they miss an appointment or not able to confirm an appointment, they're back to the bottom of the list."
>
> *Service user*

Transportation

In a geographically dispersed community like Walla Walla County, lack of transportation impacts people who must travel farther for services. Stakeholders noted the need for more resources available in rural communities, rather than expecting people to travel to Walla Walla for all services. We were told that buses are available for people to access services and bus stops are located near services. While providers can connect people with bus passes, more financial support (e.g., vouchers) for accessing transportation is needed.

Others noted that it is difficult for people to access services when transportation is not available during service hours. For example, some support groups are scheduled in the evening. Early morning, evening, and weekend bus schedules are needed to facilitate access to services. For students, school-based services are key to mitigate transportation barriers. Having services available onsite at the school was key for accessing support without transportation.

> "Transportation, even though we have public transportation, it's not like big city where it runs in early morning hours, weekends. Some folks have hours that may not be conducive to bus schedules."
>
> *Provider*

We note that MCOs are required to adhere to travel time and distance standards, but we do not know whether people identifying transportation barriers were Medicaid enrollees.

As part of the effort to increase access to services in rural communities, a new mobile resource, MOST has been developed that will visit rural areas. MOST is a partnership between Walla Walla Alliance for the Homeless, Blue Mountain Action Council, and Providence Population Health.

Cross-Border Healthcare

Providers noted that they provide care to Oregon residents without being able to bill Oregon Medicaid for the services. They describe billing Medicaid as "almost impossible" due to administrative barriers.

We were unable to obtain data that fully depicts the extent of this dynamic, but a significant number of Oregon residents seek behavioral health services in Walla Walla County; for example, data shared by the Yakima Valley Farm Workers Clinic's Family Medical Center located in Walla Walla shows 28 percent of persons served are Oregon residents (Figure 37).

Figure 37

More Than One in Four People Served at Yakima Valley Farm Workers Clinic Family Medical Center Located in Walla Walla Were Oregon Residents

	N	%
Total Served	**8,241**	**100%**
Oregon resident	2,302	28%
Washington resident	5,731	70%
Residence unknown	208	3%

Source: Data provided by the Yakima Valley Farm Workers Clinic's Family Medical Center

Stakeholders expressed concern that it results in more limited access for people who live in Oregon and heightened cost for community providers who provide uncompensated care. This is an issue that requires further investigation, however. Our understanding is that MCO contracts include provisions for providing services for individuals from adjoining Oregon and Idaho counties. In 2021, Comprehensive Healthcare provided $244,855 in uncompensated care to 3,329 people, although it was not clear how many of those were Oregon residents.

Access to Barriers for People with Complex Needs

For people in difficult life situations – such as homelessness, poverty, unemployment, co-occurring mental health and substance use concerns, and complex health problems – it can be difficult to make, schedule, and keep appointments, complete follow-up, and keep providers up to date. Service users and homeless service providers described the expectation that people attend appointments and complete follow-up by themselves as ultimately punitive. When someone misses a step, they are "thrown out" of treatment. And placing a high degree of responsibility on service users to make and keep appointments privileges those with less complex needs because they are more likely to have the skills and resources to comply with provider scheduling processes.

> "[thinking about the phrase] 'Bureaucracies are soul-crushing:' I think that's very true with trying to get people the services they need in a timely matter, that's the right service for them, because there's so much bureaucracy in place, so much red tape. So many people who will say 'no' instead of 'let me see what I can do,' and you have to be invested in that individual to help them create change for themselves."
>
> *Provider*

Stakeholders also emphasized that for youth and adults with substance use concerns, time is of the essence. When a person comes forward as ready, it is important that the system responds quickly to capitalize on that readiness and engage them in services. Stakeholder interviewees describe instances where services are offered or promised but never materialize, with a response of, "We never said we'd do that." From their perspective, the stakeholders experienced this complexity paired with limited communication as "gaslighting."

The stresses associated with accessing appointments (arduous enrollment processes, cancellations, unclear policies) result in people giving up seeking services, which could ultimately result in a greater need for crisis services because of unmet needs and higher levels of instability for people with the most complex needs

Co-Occurring Mental Health and Substance Use Services

> "It doesn't matter where it starts, if substance use brings on mental health issues, or if mental health brings on substance issues, they are so directly intertwined in a way that's impossible to separate."
>
> *Housing provider*

A special category of persons with complex needs are those with both mental health and SUD. Mental illness and substance use are often linked with high rates of co-occurrence, and experts recommend they be addressed together with evidence-based screening and treatment processes. In Walla Walla County, however, we were told that providers treat them separately, and that some programs will not provide mental health treatment when substance use is involved. Stakeholders emphasized that a good program would address both mental health and substance use together.

> "I gave up. I was fine with where I was at in that moment. It started getting hard to deal with."
>
> *Service user*

.

"Sometimes people don't reach out for help until they're 100% ready and that's rock bottom time. You can't get in for six weeks, and you decide you don't need this anymore. That's the unfortunate thing."

Provider

"How can we as a community say, 'yes,' as soon as person steps forward with courage to change the situation. How do we tell you in a week to come back? Very short window when person wants to commit to getting help vs. when they'll change their mind. How can the community say, 'yes,' when this happens?"

Service user

"I would say anybody who is in a moment of saying, 'I need assistance with mental health or SUD,' trying to get out from under that, them making that decision, there has to be an ability to jump: 'Let's do this now.'"

Housing provider

The state requires a full mental health and SUD assessment prior to accessing services for co-occurring mental health and substance use needs, which presents an additional layer of complexity for people with these complex needs. Several stakeholders identified problems with intake and assessment processes, citing cost, time, and limited options as contributing factors that limit access to assessments for many, but particularly for those seeking treatment for co-occurring disorders. Stakeholders described lengthy wait times for assessments followed by wait times to obtain the results of those assessments, which ultimately results in delays in accessing services including rehab, therapy, and medication.

Implications of Justice System Reform Legislation

Several pieces of recent state legislation have influenced the behavioral health landscape in Washington State:

- House Bill 1310 Concerning permissible uses of force by law enforcement and correctional officers.
- House Bill 1735 Modifying the standard for use of force by peace officers.
- Senate Bill 5476 State vs. Blake Decision Reducing the offense of simple drug possession from felony to a misdemeanor
- Becca Bill – Revised Code of Washington (RCW) 28A.225 and 13.32A Truancy, At-Risk Youth (ARY), and Child in Need of Services (CHINS)

A summary of these pieces of legislation can be found in Appendix H.

In the English listening session and interviews, stakeholders voiced concern about the consequences of these recent justice system reforms, which they saw as hampering community policing and engagement. Law enforcement stakeholders noted that the legislation was entirely partisan, and that law enforcement stakeholders were not included in the policymaking at the state level.

All law enforcement stakeholders we interviewed voiced frustration and concern over the changes in their role associated with House Bill 1310. Many saw the law as preventing them from performing their responsibilities to keep a community safe, particularly with regard to performing wellness checks for people who may be experiencing suicidal intensity. They described a "moral dilemma" in which community members call them because of a behavioral health crisis, and they cannot respond. They also noted that the legislation places a higher demand on the fire department in responding to crisis.

> "There's got to be a better engagement between law enforcement, mental health, and judicial. If you pull one of the legs out, you're sitting on the ground, and right now we're sitting on the ground."
>
> *Justice system stakeholder*

Other stakeholders shared concern about the framing of the legislation. They noted that the legislation is portrayed as something being taken away from the community that makes the community less safe, which contributes to stigma around behavioral health as dangerous. They called for a more balanced discussion of the legislation along with sustainable solutions involving enhanced collaboration with community providers so law enforcement can remain supportive within the requirements of the new legislation.

Prior to the passage of House Bill 1735, interpretation of House Bill 1310 was left to local law enforcement agencies, and agencies have had to adjust their guidance over time. We observed that strong relationships between law enforcement, fire, and providers are key in navigating the requirements associated with the legislation and continuing to meet the needs of the community as much as possible.

Law enforcement agencies' collaboration with the CRT has shifted over time, influenced by the pandemic and by legislation. Before the pandemic, Comprehensive Healthcare had a ride-along arrangement and met regularly to coordinate with WWPD, but these collaborations "fizzled" and have not been resumed. In 2022, the BH-ASO provided a grant to WWPD for $100k per year for two years to establish a mental health professional who works with the WWPD to respond to behavioral health-related calls.

There was widespread agreement amongst stakeholders that law enforcement involvement in behavioral health crisis situations should be kept to a minimum and that police are not ideal responders for someone in crisis. While all law enforcement officers in Washington State receive Crisis Intervention Team (CIT) training, they cannot take the place of a community provider in offering support for those in crisis. However, stakeholders also pointed out that there are situations in which police presence is important, and that in the absence of community crisis responders, police may need to step in to fill a gap.

Stakeholders in the justice system shared concerns that Senate Bill 5476 (The Blake Decision) resulted in reduced "leverage" to compel people into treatment. Similarly, the Becca Bill, which decriminalizes truancy, has resulted in fewer access points for needs identification and treatment for youth. Although reduced justice system involvement is a good outcome, they worried about missed opportunities to

engage people in treatment, resulting in higher levels of unmet need that will result in poorer long-term outcomes for people and families. They argued that it is short-sighted to reduce justice system involvement in behavioral health if community resources aren't in place to engage communities and meet underlying behavioral health needs.

> "Lower detention populations is a good thing if the community is healthy, [but] not a good thing if there are youth languishing because there aren't things being done."
>
> *Justice system stakeholder*

The Blake Decision has resulted in implementation challenges for programs designed to divert people from the justice system to treatment. Under the reforms, drug possession is considered a misdemeanor only the third time an individual is found to be in possession, and law enforcement can only make referrals to services the first two times a person is found to be in possession. However, law enforcement stakeholders expressed concern about the implementation of referrals, noting that there is no structure for tracking referrals across jurisdictions. Further, law enforcement do not (and should not) follow up with people to see if referrals result in connections to services, calling into question the efficacy of such an effort.

Data Sharing for Service Coordination and Performance Improvement

Data systems, data sharing and interoperability are increasing recognized as essential for high performing behavioral health systems and especially for capacity to address SDOH.[47] According to providers, however, there is limited data sharing in Walla Walla County, including among crisis response, ED providers, and community providers who conduct street outreach. Data sharing is also limited for community-based services. Different providers use different modes of communication; for example, many community partners endorsed texting as a preferred method of day-to-day communication, but Comprehensive Healthcare providers do not communicate via text message due to privacy concerns. We were told that notes from assessments by CRT, entered in Epic, Comprehensive Healthcare's electronic health record, are too cursory to be informative for follow up by behavioral health providers. Privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Title 42 of the Code of Federal Regulations (42CFR) for substance use information, are one barrier to greater data sharing, although stakeholders noted that with adequate coordination, such barriers are not insurmountable.

In addition to data sharing to facilitate service coordination, stakeholders also expressed a need to improve the use of data to inform behavioral health system decisions, particularly with regard to allocating resources, including 1/10th of 1% funding.

> "If you can't show me results, it's hard to put money towards something."
>
> *Elected official*

[47] Centers for Medicare and Medicaid Services. (2022). *Medicare and Medicaid promoting interoperability program basics.*

"It's like these siloes, some things are duplicated, a lot of gaps are missed. How do we build bridges to effectively utilize the human capacity and financial resources? … It would help everybody. I don't get it, I don't understand. It seems so intuitive to me."

"There's a lot of ego involved. We lose sight of why we do what we do. It's so cutthroat, it's ridiculous, it's a cutthroat business. Historically, everyone was fighting for that same dollar. We're not in that world anymore, there's plenty to go around for everyone. The only one that loses out are the patients."

"I do think that our system tends to have been developed in a capitalistic society in that we're in a competition for dollars in the nonprofit world. That prevents true collaboration to occur. We have to guard the dollars to deliver our services."

Three providers

Providers identified a need for better data literacy so they can collect, analyze, and share data to promote their goals and understand if the needs of the community are being met.

Sustainability

Although the 1/10th of 1% funds are a huge community benefit, there is ambivalence about the current use of those funds. One concern is that many of the grants are used to fund direct services, which raises questions about sustainability of these services over the long term. Programs are most beneficial when they're established and "mature" in implementation; grant funding for one or two years does not support this kind of maturation. Some suggested the money would be better invested strategically to address structural concerns, such as workforce shortages and capacity for bringing in new revenue.

Stakeholders expressed confusion about the methods of allocating the 1/10th of 1% funding – a process in which the Behavioral Health Council members reviewed, scored, and made recommendations on how the funding should be awarded, and then the Board of County Commissioners made the ultimate determination of how the funds were spent. We were told that some community providers were not aware of applications, requiring that the deadline be extended.

Collaboration

Behavioral health systems are complex, requiring active efforts to foster collaboration among providers to avoid fragmentation and duplication. And collaboration between behavioral health and social services is necessary for addressing SDOH and person-centered care.

Providers spoke at length about challenges related to collaboration, communication, and role clarity amongst providers in Walla Walla County. They voiced contradictory views about what role different organizations can and do play within the system along with feelings that some organizations are not fulfilling their perceived responsibility in the community. These conversations were characterized by frustration rooted in a shared passion for community wellbeing.

Workforce turnover is a major barrier to collaboration: one staff person leading a coordination effort or holding a collaborative relationship leaves the agency, and no one takes over in the person's place. And workforce shortages endemic across the County contribute to limited time for providers to dedicate to coordination, collaboration, and relationship-building efforts. Some noted a sense of competitiveness amongst providers, with multiple organizations vying for the same funding and seeking to distinguish themselves from other organizations. Organizations are being protective of their turf, thus inhibiting development of productive partnerships. Underlying trust issues rooted in personal relationships and past negative interactions inhibit collaboration – challenges that are common in small communities like Walla Walla County. As noted under collaboration, providers differ in their means of communications, which is a barrier to collaboration. Some were dismayed that providers in private practice are rarely part of discussions about the behavioral health system and were unsure how to "bring them to the table."

> "Communication is key for the people that are helping me. If one fails, the whole thing fails. They need to be talking to each other."
>
> *Service user*

There are and have been multiple efforts to convene provider stakeholders to clarify roles, facilitate dialogue, and identify opportunities for collaboration. However, these efforts have not been sustained, are sometimes ad hoc, and are not regularly attended by representatives from all major organizations in the County. There are lots of meetings, but stakeholders questioned whether they are productive.

Stakeholders called for a forum for providers to meet to build relationships, explore opportunities to partner, and engage in conversations about improving the system that are proactive and not reactive (e.g., "putting out fires," "playing whack-a-mole"). The housing and shelter collaboration was held up as an example of a productive collaborative partnership that could serve as a model for behavioral health. Housing stakeholders found the regular meetings to be useful and were glad to have a designated coordinator at the DCH to facilitate coordination, information sharing, and collaboration on grant funding opportunities.

"Duplication"

A common – and controversial – theme in interviews was whether the current system includes services that are "duplicative." In the estimation of some, an unclear understanding of community need has resulted in providers creating new services that are already present in the community, which could result in an inefficient use of public funds on administrative and overhead functions. Others pushed back on framing the newer services as a "duplication," arguing that services such as flexible outreach low-barrier, same-day access to behavioral health are deeply needed. Another counterpoint to the duplication framing is the

> "I do believe there's natural overlap because there's such need in our community. It's not a duplication necessarily. Two people doing the same thing doesn't mean there's a duplication."
>
> *Provider*

importance of having multiple options for seeking behavioral health services and having adequate amounts of services to meet community need.

Leadership

There was no consensus among those we interviewed about who comprises the leadership in the behavioral health system, and what people or organizations should be held accountable for overseeing behavioral health in Walla Walla County. Many noted that, although its current role is unclear, the DCH could step in to perform a coordinating and technical assistance role. The DCH is widely seen as being objective and as having personnel who are valued and well-regarded by the community. And, importantly, because the DCH does not provide services, it is seen as a neutral party and thus well-suited to facilitate collaboration amongst provider organizations.

6. Recommendations

We offer two sets of recommendations. The **DCH Recommendations** are for the Walla Walla County DCH and are intended to create a stronger infrastructure for local behavioral health systems change efforts and elevate prevention and wellness promotion as part of the behavioral health continuum. A larger set of **Community Recommendations** are for the consideration of Walla Walla County stakeholders, including physical and behavioral healthcare providers, private and nonprofit social service organizations, advocates, and other community leaders.

DCH Recommendations

We offer seven recommendations the DCH can take now to strengthen the behavioral health system in Walla Walla County.

Recommendation 1: Establish a behavioral health leadership position at the DCH.

Why: We observed a need for a dedicated leader who can support a more coordinated, data-driven, and responsive behavioral health system. This leader should be familiar with Walla Walla County's behavioral health landscape and neutral (not representing the interests of any one provider or organization, but rather representing the people of Walla Walla County).

How: The behavioral health leader would be responsible for:

- Developing, coordinating, and monitoring a behavioral health strategic plan. The strategic plan could use this study as a starting point, with ongoing community input and a yearly process for reassessing and revising.
- Overseeing the 1/10th of 1% process (see recommendation 2 for more detail on 1/10th of 1% funding review and allocation process).
- Establishing a community forum to ensure robust and ongoing dialogue between system leaders and people who use the system, with representation from people who use services

and their families and targeted efforts to engage historically underrepresented voices and perspectives.

- Offering training and resources in best practice in stakeholder engagement to promote stronger lived experience engagement across the County.[48]
- Coordinating a behavioral health advisory group that would oversee and advise the strategic planning efforts as well as the 1/10th of 1% process (see recommendation 3 for more recommendations on the composition and function of the advisory group).
- Facilitating coordination between the stakeholder groups in Walla Walla County to clarify roles, coordinate service offerings, gain information about relevant policies, programs, and funding opportunities, and provide input into the overarching behavioral health strategy.
- Evaluating state and federal legislation to determine impacts on behavioral health programs and services in the County.
- Working closely with the BH-ASO and the GCACH to ensure involvement in all regional behavioral health-related initiatives and to advocate for system improvements that would impact the behavioral health system in Walla Walla County.
- Monitoring funding opportunities (e.g., state and federal grants, foundation grants) and getting word out to relevant entities so they can apply.
- Providing (or connecting to resources for) technical assistance to smaller entities to obtain and meet requirements of 1/10th of 1% and other funding sources. This technical assistance would be prioritized for smaller community-based organizations that meet needs identified in the strategic plan (e.g., peer support organizations, organizations providing culturally specific services).
- Representing the DCH to elected officials and key stakeholders for matters related to behavioral health.
- Sharing information and best practice with other county health departments in the state on matters related to behavioral health.

Recommendation 2: Establish a more robust, strategic, and transparent 1/10th of 1% funding review and allocation process.

Why: The 1/10th of 1% tax represents an unusual and progressive approach to funding local behavioral health services. A major advantage is the flexibility and responsiveness to local needs that it allows, with priorities determined by representatives of the community. In addition, it has important symbolic value as a concrete demonstration of the community's commitment to addressing behavioral health need. Therefore, the DCH should maximize opportunities to take advantage of these benefits.

How: We recommend the DCH take a more active approach in the application process and establish more specific requirements for grantees. A behavioral health strategic plan, referenced in

[48] National Center on Advancing Person-Centered Practices and Systems. (2020). *Engaging people who receive services: A best practice guide.*

recommendation 1, could provide a structure for ongoing system needs identification and prioritization, along with a robust stakeholder engagement process.

Beyond announcing availability of funds and waiting for organizations to respond, the DCH should actively engage organizations that are positioned to serve the priority areas identified in its strategic plan, encouraging them to apply. Especially for community-based organizations with limited resources that serve historically marginalized groups and organizations that focus on wellness promotion and prevention, the DCH may wish to provide guidance for preparing and submitting a proposal. To take full advantage of the flexibility of funds, the DCH could identify services or programs that would have the greatest impact and address the most critical needs, especially projects that address disparities and inequity and those that focus on wellness promotion and prevention.

Applicants should describe how the proposed project meets the identified community needs. Applicants should be required to describe their sustainability approach in the application, and upon reward, develop a sustainability plan. Applicants should be scored based on potential for long-term sustainability (e.g., are they using the funds to invest in sustainable practices over the long-term, or if not, how will they seek sustainable funding). Applicants should be required to propose performance measures, expected outcomes. The scoring for the performance portion of the application should be based on the capacity and willingness to work with DCH to develop and report performance metrics. Once an application is approved, the DCH could work with grantees to refine the model, processes, objectives, performance targets, measures and reporting requirements, and build these into the contracts with grantees. DCH may also want to identify one or two metrics that all grantees are required to report to allow for cross-program comparisons and benchmarking. Finally, DCH may consider incorporating a value-based payment scheme in which a small portion of the funds are set aside and awarded upon achievement of key outcomes.

The DCH should make maximum efforts to ensure a transparent application and award process and publicize the results of these projects as an acknowledgement of the contribution of taxpayers. This would include publication of the scoring criteria and process, and public presentations as part of the application process, and efforts to eliminate conflict of interest among application scorers. Year-end reports and/or presentations to the community can detail lessons and celebrate successes.

Recommendation 3: Establish a community behavioral health advisory group that includes broad representation of people who use the behavioral health system and other historically underrepresented groups.

Why: A community behavioral health advisory group serves an important function in providing guidance for behavioral health systems. If DCH expands its presence and leadership in the local behavioral health system, it will be important that its work is informed by the interests and perspectives of the entire community.

How: The DCH could establish a Behavioral Health sub-committee of the Community Health Advisory Board as its behavioral health advisory board. Best practice suggests such boards should have

majority (at least 51 percent) representation of people with lived experience of the behavioral health system, including people with direct experience as service recipients and family members or loved ones of people who are service recipients. Representation should also include people with expertise in prevention to represent the full continuum of behavioral health services. The County should make vigorous efforts to recruit council members that represent the diversity of the community, especially groups that are traditionally marginalized and underserved including Hispanic communities, LGBTQIA+ communities, people with disabilities, and people living in rural parts of the County.

Recommendation 4: Ensure a central, comprehensive, up-to-date, and accessible source of service information for the public.

Why: Although there are several behavioral health service directories for the County, most are unfunded and aren't resourced to meet community need over the long term, and there is no single resource that people in Walla Walla County turn to for information about services. Maintaining and publicizing a comprehensive directory requires dedicated staff time on an ongoing basis, and the DCH has an opportunity to provide leadership in this area. Ideally, one directory could be designated, resourced sustainably, and promoted widely as being the primary source of up-to-date information for people seeking services in the County.

At the national level, SAMHSA has just launched its 988 Suicide and Crisis Lifeline initiative[49] that includes funding and technical support to establish a single entry point to accessing crisis services, including connection to behavioral health supports. This initiative presents an opportunity to rethink and align efforts to educate and inform the public about behavioral health services.

How: The DCH and community partners should begin with an in-depth exploration of whether and how the 988 initiative will support efforts to strengthen information sources. If DCH determines a local directory is needed, it must secure resources (staff time and funding) to keep it active. A single entity needs to take responsibility for and be funded to host, maintain, and publicize the directory over the long-term. Maintenance would involve reaching out to listed providers to determine they are still actively providing services and accepting insurances. Information must be sufficient to understand eligibility, limitations, and nature of the services. The directory must be easily accessible and navigable, available online, and translated into languages most commonly spoken in the community (at a minimum, Spanish).

Recommendation 5: Facilitate a community conversation followed by readily available and widely disseminated informational materials about the role of the CRT in the crisis response continuum.

Why: We observed a lack of clarity about the role and responsibility of the CRT to address urgent behavioral health needs in the County. There is no shared definition of "crisis" amongst stakeholders we interviewed, and disparate views on what an ideal crisis service continuum looks like. This

[49] Substance Abuse and Mental Health Services Administration. (2022). *988 Suicide and crisis lifeline.*

conversation would be timely given the changes in the crisis response process with the new federal 988 Suicide and Crisis Lifeline initiative and the local Crisis Intercept Mapping for Veterans initiative.

How: As a government entity that oversees the health of the Walla Walla Community, the DCH would be an appropriate convener of this conversation. It is essential that leaders from Comprehensive Healthcare, the BH-ASO, Providence Health, and first responders are key partners, and that it produces next steps to create more clarity about the role of CRT and to fill gaps in the crisis response continuum.

Recommendation 6: Conduct an assessment to understand how the County, providers, and schools work together to support student behavioral health.

Why: The current HSRI Behavioral Health System study has documented significant and increased need for behavioral health services for students in Walla Walla County. And one theme coming from stakeholder interviews is confusion and lack of clarity around the distribution of resources to support behavioral health within schools. The DCH is concerned about shifting and growing behavioral health needs within schools and would like to have a plan to target resources based on need and how to allocate future resources to support wellbeing of students and families. The study findings will also guide school leadership in their strategic planning and provide additional leverage for future grant funding opportunities.

How: HSRI has engaged with a subject matter expert at the University of Maryland School of Medicine National Center for School Mental Health to develop a proposed study that will inform collaboration and improvement of school behavioral health services and supports at the county level.

Recommendation 7: Develop and implement a behavioral health prevention strategy.

Why: When asked about the behavioral health system, most stakeholders discussed treatment services. However, best practice dictates – and local stakeholders with expertise in prevention insisted – prevention and wellness promotion are foundational for a well-functioning behavioral health system. While Walla Walla County is home to several successful prevention initiatives, there is an insufficient focus on prevention. And like many communities, there is a disparity in funding for prevention and wellness promotion compared to treatment services. We observed a disconnect between prevention programming - which is done through the DCH and community initiatives - and other behavioral health services; nearly all behavioral health-focused organizations focused solely on treatments and other supports. DCH has an opportunity to play a role in elevating prevention as an integral part of the behavioral health continuum.

How: With guidance from community stakeholders, DCH should support staffing to develop and implement a county-wide prevention strategy. Using this strategy, DCH can work with stakeholders to identify and pursue funding to support expanded prevention programming. The strategy should include:

- Expansion or adoption of evidence-based practices such as Strengthening Families and nurse-home visiting as well as grassroots wellness promotion initiatives (e.g., partnering with faith communities to raise awareness about social and emotional wellness).
- More opportunities for public, private, and nonprofit organizations to take advantage of the nationally recognized CRI resources.
- Linkages with the study of school-based behavioral health services.
- Continuation and expansion of SUD prevention programming for middle and high school students, including programming that includes emphasizes vaping and binge drinking for children in older grades.
- Expansion of suicide prevention programming throughout the system. This includes coordinating with Providence Health on its Zero Suicide initiative to address suicide prevention in primary care, partnering with the VA to explore opportunities to enhance their suicide prevention programming, and sustaining and expanding to all schools the Sources of Strength curriculum.

Community Recommendations

Our community recommendations, drawn directly from our analyses of qualitative and quantitative data rooted in the study aims, are offered to all stakeholder groups within Walla Walla County. These recommendations vary in size, scope, and complexity, and most would require collaboration between multiple stakeholders. Others – particularly those related to service expansion – require collaboration and resources with regional and state healthcare entities. We recognize some of these recommendations may not be feasible to implement immediately and may be beyond the capacity of local stakeholders alone. Nonetheless, we offer these recommendations to inform future collaborations, strategic planning, and advocacy efforts.

Recommendation 8: Establish voluntary, low-barrier, accessible service options for people experiencing urgent distress. As discussed extensively in this report, there is a clear service gap for those needing support for urgent behavioral health-related issues, including self-defined crisis. Such services must be available on evenings and weekends and have minimal criteria for access (i.e., not limited to those assessed as being a danger to themselves or others). Service expansions should be informed by best practice in behavioral health crisis services outlined by SAMHSA[50] and nationally recognized initiatives such as Crisis Now.[51] Briefly, crisis services should be flexible and available on a continuum of support intensity. County stakeholders should strongly consider incorporating more peer support into the existing continuum; SAMHSA recently released helpful guidance to do so.[52] Peer service options include warm lines[53] and voluntary drop-in programs such as living room or peer

[50] Substance Abuse and Mental Health Services Administration. (2020). *National guidelines for behavioral health crisis care: Best practice toolkit.*
[51] National Association of State Mental Health Program Directors. (n.d.). *Crisis now*.
[52] Substance Abuse and Mental Health Services Administration. (2022). *Advisory: Peer support services in crisis care*.
[53] Warmline. (2022). *Warmline portal*.

respite.[54,55] In addition to putting more upstream and voluntary crisis options in place, there may be opportunities to expand capacity to provide short-term crisis support and stabilization through Providence Health to reduce the amount of time spend in the ED for people in behavioral health distress.

Key stakeholder groups: Behavioral health service providers, peer advocacy organizations including NAMI, BH-ASO, GCACH, Providence Health

Recommendation 9: Examine formal and informal policies that impact access to outpatient services. We observed a discrepancy between stakeholder reports and MCO time and distance standards for outpatient services. According to available data, providers have appointments available, and those seeking services can access them in a timely manner. However, stakeholders in interviews and community listening sessions consistently described very long wait times and a range of challenges accessing timely and appropriate services. We were unable to ascertain whether stakeholders who reported substantial wait times for behavioral health services were Medicaid enrollees; knowing this would be important for developing strategies to address the access barriers they identified. Data from Comprehensive Healthcare show staff-initiated cancellations are common; in 2021 of over 4,000 cancelled or no-show appointments for individual therapy 53% were staff-initiated, and of 1,465 cancelled or no-show appointments for SUD group therapy over 90% were cancelled by staff. We recommend that behavioral health service providers explore additional strategies to reduce the rates of provider-cancelled appointments as well as no-shows and cancellations and explore ways to streamline the assessment process, particularly for those seeking services for co-occurring mental health and SUD treatment services. We also recommend that providers work together with leaders in the Hispanic community to identify, understand, and reduce access barriers; those identified in this report include limited linguistic accessibility and cultural responsiveness, racism and discrimination, and concerns about deportation.

Key stakeholder groups: BH-ASO, behavioral health service providers, DCH

Recommendation 10: Expand the availability of CHWs and promotores. CHWs, and the Hispanic equivalent, "promotores de salud" are trained public health workers who serve as a bridge between communities, healthcare systems, and public health departments.[56] Although research on the impact of CHWs is still in the developmental stage, many CHW programs have been implemented and shown to be successful. One study, for example, showed that a CHW program achieved the triple aim of increasing team productivity, improving outcomes and reducing costs.[57] Providence Population Health's three CHWs and promotora served 2,200 individuals in 2021, but wait times are long due to staff shortages. CHWs would also address the issues of severe workforce shortages, need for more engagement with the Hispanic population and the need for more navigation of the behavioral health

[54] Shattell, M. M., Harris, B., Beavers, J., Tomlinson, S. K., Prasek, L., Geevarghese, S., Emery, C. L., Heyland, M. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The Living Room." *Issues Mental Health Nursing, 35*(1), 4-12.

[55] Live & Learn, Inc. (2018). *Peer respites action and evaluation*.

[56] Centers for Disease Control and Prevention. (2019). *Promotores de salud/community health workers*.

[57] Findley S, Matos S, Hicks A, Chang J, Reich D. (2014). Community health worker integration into the healthcare team accomplishes the triple aim in a patient-centered medical home: A Bronx tale. *Journal of Ambulatory Care Management, 37*(1), 82-91.

system.
Key stakeholder groups: Providence Health, GCACH, MCOs, HCA

Recommendation 11: Expand the Community Paramedicine program. The Community Paramedicine program serves people with highly complex needs and appears to be effective in connection people to needed supports in the community. Walla Walla County has more people who frequently use crisis services than neighboring counties, suggesting a need for expanded supports that proactively target people with complex needs before a crisis develops. Expansion of the Community Paramedicine program should be coupled with stronger coordination with the CRT and alignment with future crisis response services and initiatives (including 988). We also recommend stakeholders continue to explore more sustainable funding for the program, including establishing processes for billing insurances.
Key stakeholder groups: Walla Walla Fire Department, Providence Health, Comprehensive Healthcare CRT program

Recommendation 12: Enhance service coordination and navigation services for those with the most complex needs. An effective and comprehensive service coordination model would enable collaboration between service providers across multiple health and social care sectors in Walla Walla County, with a goal of addressing social determinants and promoting population health. Such an initiative would require extensive coordination between provider organizations and Providence Health systems, with clear data sharing agreements in place. GCACH is currently exploring the potential of establishing a Community Information Exchange,[58] which would serve this function.
Key stakeholder groups: Providence Health, Washington State Department of Health, GCACH

Recommendation 13: Adhere to best practice in data collection and reporting to promote more equitable access and improve quality of services. Locally available data for this study included a number of limitations. For one, data on demographic characteristics of individuals served by the CRT were not available. Demographic data on persons served in the ED for behavioral health were also not readily available for this study. There is variability across provider organizations in data collection practices such that it was difficult to examine service utilization and characteristics of persons served across organizations. Providers in Walla Walla County could enhance data practices by gathering accurate demographic data for populations served and using these data to inform service expansions and system improvements. Data collection fields should adhere to best practice in measuring race, ethnicity, sexual orientation, gender identity, language preference, and other demographic characteristics. In particular, we recommend providers work together to gather, disaggregate, and examine demographic data to better understand the population experiencing crisis, including those who are high utilizers of crisis services. To better understand the disparities identified in this study, it is essential that providers track and disaggregate service utilization, quality (including experience

[58] The National Center for Complex Health & Social Needs. (n.d.). *Community Information Exchange toolkit: Collaboration and cross-sector data sharing to create healthier communities.*

measures), and outcome data to monitor and address inequities in access, quality, and outcomes.
Key stakeholder groups: Behavioral health providers, Providence Health, BH-ASO

Recommendation 14: Support participation in the Healthy Youth Survey. The Healthy Youth Survey is conducted every two years and gathers information about the health of youth in Washington State. Understanding the needs of young people is essential to providing responsive behavioral health services, from primary prevention to intensive treatment. The Healthy Youth Survey is a key data source to raise awareness of youth thoughts, feelings and behaviors and provide insight on current health trends and concerns. The data can help schools make evidence-based decisions that lead to positive academic outcomes and identify conditions that impact learning. And it can be used by schools and communities to apply for grants and inform programming and planning.[59] Currently, about one half of the County's eligible students participated in the 2021 survey because only two school districts, WWPS and Waitsburg School District, participate in the survey.
Key stakeholder groups: CPPS, Prescott School District, Columbia School District, Touchet School District

Recommendation 15: Enhance and strengthen the behavioral health workforce. Workforce limitations are at the root of many of the challenges identified in this study, and these limitations are endemic throughout the United States. Promising workforce strategies include: gathering and tracking provider race, ethnicity, and culture to identify shortages and inform recruitment and retention efforts; creating incentives for local providers to cover the costs of licensure for the emerging behavioral health workforce with an emphasis on bicultural/bilingual providers and other provider types of which there are shortages; and convening local institutions of higher education and providers to develop and implement a strategy for strengthening the workforce pipeline.
Key stakeholder groups: Behavioral health providers, local colleges, Walla Walla Community College, Walla Walla University, Whitman College

Recommendation 16: Expand peer support. Highly valued by stakeholders in Walla Walla County, peer support is an evidence-based practice that supports recovery. While there are notable peer services available in Walla Walla County, expanding these services and strengthening the peer workforce would contribute to a better behavioral health system overall. In addition to peer service enhancements to the crisis continuum referenced above, Certified Peer Counselors could aid in service navigation, outreach and education, and Peer Bridger interventions that support transitions from inpatient hospitalization to the community.[60] Expansions should involve partnerships with local, regional, and state peer leaders and should ensure alignment with best practice in peer support implementation.[61,62,63]
Key stakeholder groups: Local and state peer-run organizations, behavioral health providers

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[59] Washington Office of the Superintendent. (n.d.). *Healthy youth survey.*
[60] New York Association of Psychiatric Rehabilitation Services, Inc. (n.d.). *Peer bridger project*.
[61] Mutschler, C., Bellamy, C., Davidson, L., Lichtenstein, S., & Kidd, S. (2022). Implementation of peer support in mental health services: A systematic review of the literature. *Psychological Services, 19*(2), 360-374.
[62] Pillars of Peer Support. (n.d.). *Navigating pillars of peer support.*
[63] Foglesong, D., Knowles, K., Cronise, R., Wolf, J., & Edwards, J. P. (2022). National practice guidelines for peer support specialists and supervisors. *Psychiatric Services, 73*(2), 215-218.

Recommendation 17: Strengthen and grow behavioral health advocacy organizations that center lived experience. A stronger advocacy community will enhance the behavioral health system by providing a pathway for people who use the system and their loved ones to participate in system reforms, holding systems accountable, and generating ideas and innovations to meet community need. We recommend expanding the membership and program offerings of NAMI, and exploring options for creation of additional peer-run organizations that provide advocacy, peer support, and community education that are lead and staffed by people with lived experience of the behavioral health system.[64] Organizations that represent the interests of the Hispanic community should be supported and encouraged to engage in advocacy in the behavioral health space given the access barriers and disparities we have outlined in this report.

Key stakeholder groups: NAMI, grassroots peer advocacy groups, DCH

[64] Ostrow, L., & Hayes, S. L. (2015). Leadership and characteristics of nonprofit mental health peer-run organizations nationwide. *Psychiatric Services*, *66*(4), 421-425.

7. Appendices

A. Methodology, Data Sources, and Limitations

The ultimate goal of the project was to position the county to maximize its resources and set a course for system planning and ongoing improvement to support community health and wellbeing through a full spectrum of accessible, equitable, and effective services. The assessment had four interrelated aims:

Aim 1: Understand behavioral health needs and assets in Walla Walla County

- What is the prevalence of behavioral health needs in Walla Walla County?
- What community assets have a positive impact on behavioral health?
- What contextual factors (e.g. social determinants of health) have an impact on behavioral health in Walla Walla County?

Aim 2: Examine available behavioral health system resources

- What behavioral health services are currently available in Walla Walla County?
- What is the current provider capacity across the behavioral health continuum of care?
- What is the quality of behavioral health services?
- Are the benefits of behavioral health system resources equitably distributed to all, including communities of color, non-English speakers, LGBTQ+ communities, older adults, people with disabilities, veterans, immigrants, people with lower socioeconomic status, and people living in rural areas?
- To what extent are services integrated through communication and coordination between different providers and other systems, including health, education, justice, aging, disability, and housing?

Aim 3: Identify gaps between existing and needed behavioral health services

- What are the unmet behavioral health service needs in Walla Walla County?
- Are there barriers to access and/or quality of behavioral health services because of systemic factors such as geographical location, cultural competence and humility, workforce capacity and competency, affordability, eligibility requirements, or other formal or informal policies or practices?
- Are the gaps in the behavioral health system disproportionately experienced by communities of color, non-English speakers, LGBTQ+ communities, older adults, people with disabilities, veterans, immigrants, people with lower socioeconomic status, people living in rural areas, or other underserved groups?
- What are the impacts and costs of unmet behavioral health service needs in Walla Walla County?

Aim 4: Provide recommendations for closing gaps and maximizing community resources

- What would be required to close behavioral health system gaps in Walla Walla County?
- What would be required to ensure that the benefits of the system accrue to all communities, particularly those who have been historically underserved by the system?
- What are the priorities identified by stakeholders for an optimal system?
- What are the differences between the current system in Walla Walla County and model systems?
- How should resources be allocated based on current system gaps, equity considerations, community priorities, and best practice for county mental health systems?

For this study, we sourced data in multiple formats from a range of entities within the county and from publicly available state and national datasets and used both qualitative and quantitative data analysis methods.

Qualitative Methodology

Between September 2021 to May 2022, HSRI conducted 98 interviews with 158 people. Of those, 32 represented the perspective of service users and/or family members. A total of 120 people participated by telephone or videoconference, and 38 were interviewed in-person during a site visit in March 2022. A list of organizations represented among stakeholder interviewees is included in Appendix B.

Stakeholder interviewees were recruited through multiple means. Initially, the DCH identified a preliminary list of key stakeholders, including advocates, providers, and administrators. Additional stakeholder interviewees were identified through a process of "snowball sampling" in which interviewees were asked to identify others who have unique perspectives and/or particular expertise related to the behavioral health system. Other stakeholders with interest in participating in the study contacted HSRI staff and/or the County team to be included in the interview process. HSRI worked with the DCH and stakeholder organizations to invite service users and their family members, significant others, close friends, and caregivers to participate in the study using a recruitment flyer in English and Spanish. Service users and their loved ones were given the option to participate in interviews through telephone, video call, or in-person during the site visit and were compensated $20 for their time.

A demographics survey was conducted to better understand interviewee characteristics. Interviewees who participated through telephone or video call were sent a follow-up email with a link to an online demographics survey. Stakeholder interviewees who participated in person responded to demographics questions at the end of the interview.

Interviews were semi-structured using an interview guide that was developed based on study aims, with review and feedback from DCH. HSRI interviewers with expertise in qualitative research conducted the interviews in a semi-structured style, using the guide as a starting point but allowing

for flexibility and pursuing other areas as they emerged. All interviews were conducted with two or more HSRI staff, with one leading the conversation and the other taking detailed notes. Interviews were recorded with interviewee permission. Using notes and the recording, an HSRI team member created a notes summary of each interview. At least two HSRI staff identified and extracted themes from each notes summary for analysis.

Quantitative Methodology

We identified and extracted data from public use data sources to describe the demographic characteristics, healthcare access, and social determinants of health of individuals in Walla Walla County. These sources include the U.S. Census Bureau's American Community Survey, County Health Rankings, and the Health Resources & Services Administration (HRSA). The following are additional details on methods and data sources for data analyzed for this report:

- **Prevalence of behavioral health conditions**. Prevalence data were obtained from the National Survey of Drug Use and Health (NSDUH) for the Greater Columbia region and compared to statewide averages, taking into consideration the margin of error to determine if differences from the statewide rates were statistically significant. We applied the prevalence rates to the latest County population estimates from the U.S. Census Bureau to estimate the size of the population in the County with mental health conditions and substance use. We also included prevalence data from the 2022 Healthy Youth Survey for which data were available for 8th, 10th, and 12th graders from two school districts in Walla Walla County.
- **Behavioral health service penetration**. Data from the Washington State Health Care Authority dashboard were available to report the penetration of mental health and SUD services among Medicaid enrollees in Walla Walla County, as well as other Medicaid performance measures related to behavioral health. We examined the confidence intervals of the county estimates to identify meaningful differences from the statewide averages.
- **Comprehensive Healthcare** provided data on the number of unique persons served by program type (outpatient and residential), as well as demographic characteristics of persons served, appointment cancellations, and staff turnover. Comprehensive Healthcare also provided data on crisis contacts in Walla Walla for April-October 2021.
- **Greater Columbia Behavioral Health ASO** provided data on crisis contacts for all the counties it serves, as well as data on high utilizers of crisis services in Walla Walla County.
- **Other provider organizations** provided data on number of persons served and/or number of appointments, when possible by service type, as well as any available data on staffing levels and staff turnover rates. Organizations that provided data include Providence Health, The Health Center, Serenity Point, and Yakima Valley Farm Workers Clinic Family Medical Center.
- **Hospital Discharge Data**. We extracted data from Washington's Comprehensive Hospital Abstract Reporting System (CHARS) on the number of individuals in Walla Walla County who were discharged from a psychiatric unit or psychiatric hospital in 2020 and 2021.
- **One Tenth of One Percent**. The Walla Walla Department of Community Health provided data on funding and budget allocation of the one tenth of one percent funds.
- **Other data sources.** We reviewed and included relevant data from numerous other available reports and resources, including WallaWallaTrends.org, COVID-19 Behavioral Health Impact reports, and other resources noted in the Asset Map in Appendix F.

Limitations

Several important limitations impacted the data available for this study. First, within the scope of this study we were unable to obtain data on behavioral health services delivered by practitioners in private practice including the number and characteristics of persons served. We were also unable to quantify the volume of behavioral health services delivered in the primary care setting. Second, data on the demographic characteristics of individuals calling the crisis hotline or served by the Crisis Response Team are unavailable, and data on the characteristics of individuals presenting to the emergency department for behavioral health crises were not readily accessible for this study. Additionally, there is variability across provider organizations in data collection practices such that it was difficult to obtain comparable data across organizations. There is also lack of data linkages to determine if individuals served in the emergency department or through crisis services were also receiving community-based services. With regards to workforce, data from the National Provider Identifier (NPI) registry were not up to date so we lacked a full inventory of behavioral health practitioners in Walla Walla County.

B. List of Organizations Included in Stakeholder Interviews

- Behavioral Health Council
- Blue Mountain Action Council
- Blue Mountain Foundation
- Blue Mountain Health Cooperative
- Blue Mountain Heart to Heart
- Blue Zones Project
- Catholic Charities Walla Walla
- Children's Home Society of Washington
- Christian Aid Center - Walla Walla Rescue Mission
- College Place Police Department
- College Place Public Schools
- Community Resilience Initiative
- Comprehensive Healthcare
- Dixie School District
- Educational Service District 123
- Greater Columbia Accountable Communities of Health (GCACH)
- Greater Columbia Behavioral Health Administrative Services Organization (GCBH-ASO)
- Hope Street
- Juvenile Justice Center
- National Alliance on Mental Illness of Walla Walla
- Park Manor Rehabilitation Center
- Pierce County Human Services
- Providence Health
- Serenity Point Counseling

- Southeast Washington Aging and Long-Term Care
- The STAR Project
- The Health Center
- Touchet School District
- Trilogy Recovery Community
- VA Medical Center
- Veterans' Relief Advisory Board
- Walla Walla Alliance for the Homeless
- Walla Walla Clinic
- Walla Walla Community Council
- Walla Walla County Commissioners
- Walla Walla County Department of Community Health
- Walla Walla County Prosecutor's Office
- Walla Walla County Sheriff's Office
- Walla Walla Fire Department
- Walla Walla Housing Authority
- Walla Walla Police Department
- Walla Walla Public Schools
- Walla Walla University
- Washington State Department of Corrections
- Yakima Valley Farm Workers Clinic – Family Medical Center
- YWCA Walla Walla

C. Key Informant Demographic Characteristics

Of the key informants who participated in stakeholder interviews, 114 of 158 responded to survey questions about demographic characteristics. This is a response rate of 72%.

Characteristic	Responses (n=114)	
	N	%
Gender		
Female	77	68%
Male	34	30%
Transgender	0	0%
Non-binary	1	1%
Genderqueer	0	0%
Skipped or prefer not to say	1	1%
Prefer to self-describe	1	1%
Age		
18-24 years old	3	3%
25-34 years old	15	13%
35-44 years old	31	27%
45-54 years old	35	31%

55-64 years old	18	16%
65-74 years old	10	9%
75 years or older	2	2%
Prefer not to say	0	0%
Hispanic or Latino		
No, not Hispanic or Latino	92	81%
Yes, Hispanic or Latino	22	19%
Prefer not to say	0	0%
Race (check all that apply)		
American Indian or Alaska Native	4	4%
Asian	2	2%
Black or African American	1	1%
Native Hawaiian or other Pacific Islander	0	0%
White	101	92%
Prefer not to say	0	0%
Other (please specify)	4	4%
Zip Code		
99323	0	0%
99324	15	13%
99329	0	0%
99348	0	0%
99360	2	2%
99361	2	2%
99362	82	72%
99363	0	0%
I live outside Walla Walla County	13	11%

Note: 4 people did not respond to the question about race. Percentage for race does not add up to 100% because participants could check all races that applied, and several identified more than one race.

D. Systems Goal Exploration

HSRI implemented a systems goal exploration exercise designed to help the team learn more about the County leaders' vision for the system. The discussion was structured with a tool adapted from the Charting the LifeCourse Trajectory, a person-centered planning method. On September 2, 2021, HSRI conducted this initial goal exploration through videoconference with the County team. County leaders were asked to describe what they considered an "ideal" behavioral health system and conversely about the system they don't want; they were also asked to identify the strengths and weaknesses of the current system. Finally, the HSRI team asked the County team to identify actions and conditions that will result in the ideal system and those that will result in the undesired system. The results of this exercise are presented on the following page.

Systems Change Goal Exploration - Walla Walla County – September 2021

3. Strengths of our current system

- Culture of volunteerism
- Community values innovation and agencies that support health and wellbeing
- People see that there are gaps in the behavioral health system
- County Commissioners and Walla Walla city elected officials are strong advocates for behavioral health transformation
- 1/10 of 1% funding to meet needs
- Comprehensive is an experienced, established provider
- Programs like Law Enforcement Assisted Diversion (LEAD) program and Blue Mountain Health Cooperative (clinic-based walk-in services)
- Police, Sherriff, and Prosecutor are supportive of behavioral health programs
- Three local colleges add to the talent pool (good workforce pipeline)
- Small community – know who people are who have the most complex needs

5. How do we get to the ideal system?

- Expand telehealth
- Share data across agencies
- Providers and other trusted people have information and tools to connect people to services
- A "hub of knowledge" where people can get accurate and timely information
- Information shared with the community regularly about how services are paid for and how the system works (at a grade-school level, infographics)
- Data is collected, analyzed, and reported to inform long-term goals
- School personnel, medical providers ask about behavioral health issues more readily
- Address stigma by talking about behavioral health
- Accountability and leadership– there's a point person with a face and a name for behavioral health
- This assessment and plan! It will serve as a GPS for system transformation

4. Weaknesses of our current system

- Communities and providers lack knowledge about what's available
- Current provider network struggles to engage people quickly
- Multiple, disconnected funding sources
- Services are organized in many different ways
- Difficult to determine how best to distribute resources (1/10th, Dept. of Health funding)
- LEAD referral base declining
- Consequences of the Blake decision in which drug possession convictions have been overturned: Counties are logjammed with re-sentencing, and problem-solving courts have reduced caseloads because treatment requirements have been rescinded
- See characteristics in #2

6. What results in a system we don't want?

- Lack of funding and competition for scarce resources
- People and organizations are protective of their turf, which inhibits partnership
- Easier to get startup funding than sustainable funding, even for successful programs
- Unclear understanding of entities' roles and functions within the system
- Lack of transparency and accountability
- Limited data sharing among providers and between providers and funders
- Pandemics and natural disasters
- Stigma, which contributes to an unwillingness for people to acknowledge what's going on in their lives and seek help

1. Our ideal system

- Supports people to live happy, healthy lives
- Stakeholders are engaged, listened to, buy into the system, and come to the table to collaborate – "we not me"
- Data-driven decision making to support ongoing system improvements using a GPS
- System is dynamic and responsive to community needs and priorities
- Interconnected with other health and social service systems
- Payer types/funding streams integrated and aligned
- An administrative process that is easy (Funding for Dummies)
- Universal understanding (among the County, providers, the community) of where people go to access services
- The system meets people where they're at in time and place, with easy access pathways to recovery
- Heavy focus on prevention: Prevention first, then treatment, then crisis.
- Data are accessible across providers – a person's story is passed on without them having to tell it over and over
- People with disabilities can access the system without barriers
- Services available throughout the County, not just in Walla Walla city
- People know how to access the system, and the system is easy to navigate
- The system can be understood at a 6th grade level; the community understands the system
- Seamless continuum of services
- Coordination and navigation services (those that involve checking in, communication, follow-through and collaboration) are widely available
- Wraparound services are available and accessible
- Peer-based recovery supports valued and supported
- Healthy competition among providers
- Sustainability for effective services and programs
- Ability to positively impact legislation at the state and federal level to support local needs
- Works to eliminate stigma

2. The system we don't want

- Overly bureaucratic and institutional
- Silos, system disconnected from other systems
- Stakeholders, providers, and systems not collaborating or sharing information
- People get services only when they're in crisis, in the ER, or in jail
- People leave the hospital without a transition plan, without information that they need
- All meetings are emergency meetings
- Stakeholders pointing fingers at one another
- Can't serve people who have extremely complex needs
- Legislative barriers to serving people and keeping them safe
- People are set up to fail and get "kicked out" of the system for not meeting the requirements
- Provider shortages
- Underpaid frontline providers (e.g. case managers, outreach providers)
- Inexperienced providers (e.g. interns, students) working with folks with the most complex needs
- High staff turnover, particularly in community mental health where services are most needed
- Long waitlists
- Disconnected providers don't have time to develop trust relationships with people
- Outcomes that are unfortunate: loss of life, hospital system overuse, avoidable incarceration, bad health outcomes, decline in public trust

E. Community Listening Sessions Summary

In October and November 2021, the Human Services Research Institute (HSRI) held two listening sessions with members of the Walla Walla community. The goal was to hear community perspectives on behavioral health-related needs and the current resources available to meet those needs. The sessions were structured so that members of the HSRI team could hear from many stakeholders at once and gain an understanding of the local context in Walla Walla County to inform the Behavioral Health System Analysis.

One meeting was held in English on October 20; there were 47 attendees, and it lasted 1.5 hours. A second meeting was held in Spanish on November 3; there were 4 attendees, and it lasted 1 hour.

Both meetings followed the same format:

- Introductory remarks and overview of the study
- Discussion (conducted in breakout rooms for the English session and in one group for the Spanish session). Each group was facilitated by an HSRI staff member who documented key discussion points. The groups were asked to respond to two questions:
    - What is your vision for an improved behavioral health system five years from now?
    - What are the most pressing issues and challenges for people with behavioral health-related needs in Walla Walla County?
- Wrap-up and thank you, including how to provide further input to the study

Attendee Characteristics

Self-Identified Roles

Of the attendees of the English-language session, 37 of 47 provided a response to poll questions about their self-identified roles. All 4 of the Spanish-language session attendees responded to these poll questions.

Table 1E. Roles Self-Identified by Participants

Role (check all that apply)	English Session	(n=37)	Spanish Session	(n=4)
	N	%	N	%
Person who uses behavioral health services	9	24%	0	0%
Loved one of someone who uses behavioral health services	16	43%	0	0%
Advocate, self-advocate	17	46%	0	0%
Peer specialist	2	5%	0	0%
Social worker, therapist, counselor, or case manager	8	22%	2	50%
Physician, nurse, or other medical provider	5	14%	0	0%
Community-based service provider	15	41%	1	25%
Hospital employee	4	11%	1	25%
Government (city, county, state, federal) employee	8	22%	1	25%
Other	8	22%	1	25%

Note: Percentages do not add up to 100% because participants could check all roles that applied, and many identified more than one role.

Demographic Characteristics

Of the attendees of the English-language session, 35 of 47 responded to poll questions about demographic characteristics. For the Spanish-language session, 3 of the 4 attendees responded to these poll questions.

Table 2E. Demographic Characteristics

Characteristic	English Session	(n=35)	Spanish Session	(n=3)
	N	%	N	%
Gender				
Female	27	77%	3	100%
Male	6	17%	0	0%
Transgender	0	0%	0	0%
Non-binary	0	0%	0	0%
Genderqueer	1	3%	0	0%
Other	0	0%	0	0%
Prefer not to say	1	3%	0	0%
Age				
18-24 years old	1	3%	0	0%
25-34 years old	4	11%	1	33%
35-44 years old	8	23%	1	33%
45-54 years old	10	29%	1	33%
55-64 years old	9	26%	0	0%
65-74 years old	1	3%	0	0%
75 years or older	2	6%	0	0%
Prefer not to say	0	0%	0	0%
Hispanic or Latino				
No, not Hispanic or Latino	32	91%	0	0%
Yes, Hispanic or Latino	2	6%	3	100%
Prefer not to say	1	3%	0	0%
Race (check all that apply)				
American Indian or Alaska Native	0	0%	0	0%
Asian	1	3%	0	0%
Black or African American	0	0%	0	0%
Native Hawaiian or other Pacific Islander	0	0%	0	0%
White	32	91%	2	67%
Prefer not to say	1	3%	0	0%
Other	1	3%	1	33%
Zip Code				
99323	0	0%	0	0%
99324	5	14%	0	0%
99329	0	0%	0	0%
99348	0	0%	0	0%

99360	0	0%	0	0%
99361	0	0%	0	0%
99362	23	66%	3	100%
99363	1	3%	0	0%
I live outside Walla Walla County	6	17%	0	0%

Themes – English Session

The following themes emerged from the feedback provided during the listening session held in English.

Access

- Need in-person services, improved wait times, transportation, and insurance coverage
- Expanded service hours to evenings and weekends for people who work during the day

Crisis Response

- Crisis response resources are only available to those who are actively in crisis (i.e., a danger to themselves or others)
- Insufficient follow-up after crisis response—including facilitation of ongoing care
- No alternatives to the emergency department, law enforcement, or jail for crisis response
- Need for more mobile crisis response services

Education

- Need more education for county leadership and law enforcement about behavioral health
- Need more education for community about available resources (e.g., where to get help)
- Increase awareness about available providers and services through a directory, quarterly meeting, or centralized site for posting information

Funding

- Insufficient funding for services that address the social determinants of health
- County should focus on efficient use of funding
- Improve sustainability of funding and programs

Gangs and Human Trafficking

- Gangs and human trafficking are prevalent in the community
- Gangs start to target kids in middle school and traffickers target kids in the foster care system
- Need to break generational cycle of gangs and protect youth from gangs and human trafficking

Housing and Homelessness

- Lack of affordable housing, limited supportive housing options, and increasing homelessness
- Need to support people who are homeless in navigating the housing system

Integrated Care

- Need for holistic care that addresses physical health, mental health, and substance use
- Integrate social determinants of health into system

Law Enforcement

- New bills are a barrier for law enforcement to support behavioral health needs and response
- Law enforcement no longer respond to many behavioral health-related calls

NAMI

- Good resource that provides training and support for the community

Prevention

- Need to increase focus on prevention

Providers

- The county is facing a workforce shortage with high vacancies, turnover rate, and difficulty hiring
- Need more behavioral health professionals, particularly psychiatrists
- Need for more bilingual providers

Services Options

- Need alternatives to emergency department for behavioral health, crisis response, and detox
- Need medically assisted detox, improved medical management, and high-level care (e.g., psychiatry)
- Expand peer services

Specific Populations

- Expand tribal services
- Support for people with co-occurring conditions
- Support for children and families

System Coordination

- Decentralize services and increase service options instead of having only one organization providing care
- Designate an “air traffic control” to coordinate innovation and improvement of services (for example, an entity that determines whether to build on existing services or start with a new pilot)
- More cooperation, coordination, communication, and integration between crisis response, law enforcement, fire department, and providers across systems
- Address gaps in the continuum of care and improve transition between providers and different levels of care

Telebehavioral Health

- Telebehavioral health has limitations for certain populations (e.g., rural communities that lack internet access) and certain services (e.g., groups, residential care)

Trauma-Informed Care

- Need for expanded trauma-informed care options
- Providers need to build competencies in providing trauma-informed care through training and skill-building

Youth

- Community-wide prevention to lessen pressure on schools
- Behavioral health outreach for youth needed to address difficulties accessing substance use treatment
- Need to employ curriculum to help youth develop coping skills and resilience
- Need for suicide prevention among teenagers

Themes – Spanish Listening Session

Access for Latino Community

- Few locations with free care
- Many Latinos do not have health insurance
- Need services after 5 pm and on weekends for people who work during the day
- Need transportation since some locations are far

Access for Spanish Speakers

- Difficult to find locations with free care that have Spanish speakers
- Difficult to connect people with services when there are no Spanish speakers available
- Many services do not have Spanish speakers, use telephone translation services, or a third party
- People want to make connections and do not want to go to services that use interpreters

Belonging

- Sense of feeling like "I don't belong" in the community
- Need to feel part of the community

Building Trust

- Lack of trust in the Latino community and historic lack of trust in the government
- Leaders, providers, and organizations that provide behavioral health services need to come into the Latino community to build trust and create safe, inclusive, and informative spaces

Community Engagement

- Less presence in the community due to the COVID-19 pandemic
- Need for Latino community to see that behavioral health services are accessible, so they can accept services when needed

- Leaders, providers, and organizations that provide behavioral health services need to get to know Latino community and who they are, where they are, how they are, and what they need

Divisiveness and Racism

- Divisiveness and racism exist within the community
- Need to address and reduce divisiveness

Education

- Need education to fight stigma, raise awareness about the importance of therapy, and encourage Latino community to seek help
- Need education for specific groups:
    - Hispanic women
    - Students at public schools, starting in elementary school
    - Parents regarding child development and upbringing from infancy to adolescence, to better equip parents to help children
- Public education campaigns can be done through meetings, talks, conferences, etc.

Participation and Engagement of the Community and Leaders

- Lack of participation in community listening session
- Need to hear all voices, including church leaders
- Paper or email invitations are inadequate, need to extend personal invitation and connect with community and leaders in person

Providers

- Need bicultural and bilingual providers
- Need Spanish-speaking therapists and providers

Research

- Need a study that brings change, especially to the Hispanic community

Schools

- Lack of counselors (social workers and psychologists) at schools
- Need counselors with background, credentials, or degrees to provide personalized therapy for children starting at a young age
- Need behavioral health resources within and outside of school

Stigma

- It is a challenge within Latino community to seek help from a therapist, there is a belief that "I am not sick/bad, why do I need to see a therapist"
- Need to eliminate stigma that is passed down from parents to children

Trauma

- Significant trauma in the community, especially in the last few years working with migrants

Waitlists

- Long waitlists for everyone, including children
- Worse waitlists for Spanish services

F. Asset Map

The Walla Walla County asset map is a list of community assets that is categorized based on the Healthy People framework.

Individuals

Walla Walla County's greatest asset is its people. When asked about community strengths, stakeholders were quick to highlight the "spirit of voluntarism" that abounds in the County. They celebrated the many advocates, providers, public agency staff, and elected officials who have a strong commitment to promoting the wellbeing of the whole Walla Walla community.

Community Groups

Walla Walla County's community groups include associations, cultural organizations, coalitions, and initiatives that and contribute to overall quality of life for community members. Associations are committed to increasing social connections and support networks for individuals in the community. Cultural organizations celebrate diversity, provide representation, and address barriers and social issues for historically underrepresented groups within the community. Coalitions and initiatives focus on educating children and youth to make healthy choices, preventing homelessness and substance use, and strengthening rural communities.

Boy Scouts Troop 305
Interact Club of Walla Walla
Reach Out Walla Walla

- Men in the Middle Campaign
- Sources of Strength
- Strengthening Families
- Youth Mental Health and Mental Health First Aid Classes

Rotary Club of Walla Walla Noon
Rotary Club of Walla Walla Sunrise
Walla Walla Community College Hispanic Caucus
Walla Walla Exchange Club Foundation
Walla Walla High School Latino Club
Walla Walla Immigrant Rights Coalition
Walla Walla Latino Alliance Facebook
Walla Walla Rotaract Club
Walla Walla University Asian and Pacific Islander Club
Walla Walla University Black Student Christian Forum (BSCF) Club
Walla Walla University Center for Humanitarian Engagement

Walla Walla University First Nations Club
Walla Walla University French Club
Walla Walla University LatinX Club
Walla Walla Valley Hispanic American Lions Club
Whitman College Bilingual United

Coalitions and Initiatives
College Place Prevention Coalition
Community Conversations, a partnership between Community Council, Blue Mountain Community Foundation, Sherwood Trust, and United Way of the Blue Mountains
Community Prevention Wellness Initiative - W2 for Drug Free Youth Coalition
Southeast Prevention Network

Washington State Coalitions and Initiatives
A Way Home Washington Anchor Community Initiative
College Coalition for Substance Abuse Prevention (CCSAP)
Community Prevention and Wellness Initiative (CPWI)
Fourfront Contributor
Start Talking Now
Washington Healthy Youth (WHY) Coalition

Rural Development Initiatives (Idaho, Oregon, Washington)
Rural Development Initiatives
RDI Civic Engagement Programs
RDI Leadership Programs
RDI Rural Economic Vitality Programs

Private and Nonprofit Organizations

Private and nonprofit organizations include local, regional, and state providers that offer social services. These providers focus on counseling, education, housing, prevention, medical care, and recovery services. They each have an important role that supports behavioral health and wellbeing in the community.

Walla Walla County
Accessible Walla Walla
Anchor Point Counseling
Better Together of Walla Walla
Blue Mountain Action Council
- Commitment to Community
- Strengthening Families

Blue Mountain Health Cooperative
Blue Mountain Heart to Heart
- Walla Walla Law Enforcement Assisted Diversion (LEAD) Program

Blue Zones Project – Walla Walla Valley

Catholic Charities Walla Walla
- The LOFT

Children's Home Society of Washington
Christian Aid Center – Walla Walla Rescue Mission
Community Resilience Initiative
Comprehensive Healthcare Walla Walla
- Housing and Recovery Peer Services (HARPS)
- Rising Sun Clubhouse
- Washington State Wraparound and Intensive Services (WISe) Program
- Walla Walla LEAD Program
- Waypoint Adult Residential Treatment Facility

Friends of Children of Walla Walla
Good Samaritan Ministries Walla Walla
Helpline Walla Walla
Hope Street
Joe's Place
National Alliance on Mental Illness (NAMI) of Walla Walla
Neutral Ground Dispute Resolution Center
Park Manor Rehabilitation Center
Providence St. Mary Medical Center
- Community Paramedic Program
- Community Health Workers and Vital Wines Promotores de Salud Program
- Youth Mental Health and Mental Health First Aid Classes

Serenity Point Counseling
SonBridge Center for Better Living
- Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Overeaters Anonymous (OA), and Sexaholics Anonymous (SA) Support Groups
- Successful Living Programs

SOS Health Services of Walla Walla
The STAR Project
St. Vincent de Paul Society of Walla Walla
The Health Center
The Salvation Army Walla Walla
Trilogy Recovery Community
Valley Residential Services
Vital Wines
Walla Walla Alliance for the Homeless
- Exit Homelessness Program
- Mobile Outreach Services Team (MOST)
- The Sleep Center

Walla Walla Clinic
Walla Walla Community Council
Walla Walla Housing Authority

Walla Walla Senior Center
Walla Walla University
Walla Walla Valley Academy
Walla Walla Valley Disability Network
Walla Walla YMCA
Whitman College
Yakima Valley Farm Workers Clinic – Family Medical Center
Yeehaw Aloha
YWCA Walla Walla

Regional
Blue Mountain Counseling of Columbia County
Central Washington Justice for our Neighbors Mutual Aid
Comprehensive Healthcare Aspen Victim Advocacy Services of Kittitas County
Comprehensive Healthcare Aspen Victim Advocacy Services of Yakima County
Providence St. Mary Medical Center Population Health Department for Southeast Washington

Washington State
A Common Voice (ACV) for Pierce County Parents
Legal Counsel for Youth and Children (LCYC)

Philanthropies
Ballmer Group
Blue Mountain Community Foundation
Comprehensive Mental Health Foundation
Sherwood Trust

Public Institutions and Services

Public institutions and services encompass local, regional, and state advisory boards and councils, fire departments, health departments, police departments, and public schools, all of which have a key role to play in supporting and promoting community behavioral health and wellbeing.

Walla Walla County
Accessible Community Advisory Committee (ACAC)
Blue Mountain Regional Community Health Partnership (BMRCHP)
City of Walla Walla Parks and Recreation
College Place City Council
College Place Diversity Inclusion Advisory Board
College Place Police Department
College Place Public Schools
- Sources of Strength

Columbia School District
Community Health Advisory Board

Council on Housing
Educational Service District 123
Dixie School District
Prescott School District
- Sources of Strength

Touchet School District
Jonathan M. Wainwright Memorial VA Medical Center
Veterans' Relief Advisory Board
Waitsburg School District
Walla Walla/Columbia County Juvenile Justice Center
Walla Walla Community College
Walla Walla County Commissioners
Walla Walla County Department of Community Health
- Tobacco Prevention and Education Program
- Veteran Assistance Program and Benefits Claims
- Youth Marijuana Prevention and Education Program (YMPEP)

Walla Walla County Prosecutor's Office
Walla Walla County Sheriff's Office
Walla Walla Fire Department
- Community Paramedic Program

Walla Walla Police Department
- Walla Walla LEAD Program

Walla Walla Public Schools
- Sources of Strength

Walla Walla Valley Suicide Prevention Work Group (SPWG)

Regional
Greater Columbia Accountable Communities of Health (GCACH)
- COPE, CALM, and CARE Campaign for Community Resilience
- Practice the Pause Training

Greater Columbia Accountable Community of Health Leadership Council
Greater Columbia Behavioral Health Administrative Services Organization (GCBH-ASO)
Southeast Washington Aging and Long-Term Care (SE WA ALTC)

Washington State
Northwest Justice Project
Washington Medical Commission Health Equity Advisory Committee (HEAC)
Washington Nonprofits
Washington State Children and Youth Behavioral Health Work Group (CYBHWG)
Washington State Community Health Workers Association
Washington State Crisis Response Improvement Strategy (CRIS) Committee and Steering Committee
Washington State Department of Corrections (DOC)
Washington State Department of Health

- Healthier Washington Collaboration Portal
- Washington Maternal Mental Health Access (MaMHA)

Washington State Diversity, Equity and Inclusion (DEI) Council
Washington State Family Youth System Partner Round Tables (FYSPRTs)
Washington State Healthcare Authority (HCA)

- HCA Children's Long-term Inpatient Program (CLIP) facilities
- HCA Division of Behavioral Health and Recovery (DBHR) Prevention Fellowship program
- HCA Dual-Eligible Special Needs Plan (D-SNP)
- HCA Evidence-based and research-based practices reports
- HCA Medicaid Transformation Project (MTP)
- HCA Peer Support Program
- HCA State Opioid and Overdose Response (SOOR) plan
- HCA Student Assistance Prevention and Intervention Services Program (SAPISP)
- HCA Substance use disorder prevention and mental health promotion webpage
- HCA The Center of Parent Excellence (COPE) project
- HCA Tribal Prevention and Wellness program
- HCA Washington State Hub and Spoke (H&S) project

Washington State Hospital Association Health Equity Collaborative
Washington State Human Rights Commission
Washington State Office of Recovery Partnerships (ORP)
Washington State Opioid Response Workgroup

Northwest State Region (Alaska, Idaho, Oregon, Washington)
Northwest Center for Public Health Practice
SHARE-NW

Grants
Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grants
Drug Free Communities Support Program
State Opioid Response (SOR) grant

Legislation
Behavioral Health Legislative Implementation
Engrossed Senate Bill 5476: State v. Blake decision
Mental Health Assessment for Young Children
House Bill 1054: Establishing requirements for tactics and equipment used by peace officers
House Bill 1310: Concerning permissible uses of force by law enforcement and correctional officers
Initiative 502: Marijuana legalization and regulation
Revised Code of Washington 28A.225.030: Becca Bill
Ricky's Law: Involuntary Treatment Act

Information Resources

Information resources include data sources, help lines, media, and service directories. They provide community members with a place to connect with peers, providers, and information about services. Community awareness and availability of services is important for contributing to overall behavioral health and wellbeing of the community.

Data Sources

2021 Community Health Needs Assessment (CHNA) - Providence St. Mary
Community Council Affordable Housing Data & Measurement Report
Healthy Youth Survey
Opioid Overdose Dashboard
Risk and Protection Profile for Substance Abuse Prevention in Walla Walla County
WallaWallaTrends.org
Washington State Healthcare Authority Data Dashboard
Weekly Behavioral Health COVID-19 Impact Situation Reports

Help Lines

A Mindful State
Comprehensive Healthcare Free Crisis Phone Service
Crisis Connections
Crisis Text Line
Department of Health Hotlines, Text, and Chat Resources
National Suicide Prevention Lifeline
Partnership Access Lines
Teen Link
Washington Warm Line
Washington Listens
Washington Recovery Help Line

Media

Walla Walla Union-Bulletin

Service Directories

Mental Health Network of Walla Walla
One Walla Walla List
Washington 211
Boy Scouts Troop 305
Interact Club of Walla Walla
Reach Out Walla Walla

- Men in the Middle Campaign
- Sources of Strength
- Strengthening Families
- Youth Mental Health and Mental Health First Aid Classes

Rotary Club of Walla Walla Noon
Rotary Club of Walla Walla Sunrise
Walla Walla Community College Hispanic Caucus
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Walla Walla University Asian and Pacific Islander Club
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Walla Walla University Center for Humanitarian Engagement
Walla Walla University First Nations Club
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Community Prevention and Wellness Initiative (CPWI)
Fourfront Contributor
Start Talking Now
Washington Healthy Youth (WHY) Coalition

Rural Development Initiatives (Idaho, Oregon, Washington)
Rural Development Initiatives
RDI Civic Engagement Programs
RDI Leadership Programs
RDI Rural Economic Vitality Programs

Informal Organizations and Intangibles

Informal organizations and intangibles include community strengths that may be hard to define, such as relationships between organizations and community spirit, that support the overall wellbeing of the Walla Walla community.

Commitment to Behavioral Health

The County's investment in a behavioral health system assessment of this type speaks to the commitment to community wellbeing on the part of the Board of County Commissioners and the Department of Community Health. This commitment is also evident in Walla Walla County's adoption of the 1/10th of 1% tax. The volume of people who came forward to engage in listening sessions and to be interviewed for this study is a testament to the shared commitment to behavioral health amongst a range of stakeholders. Stakeholders we interviewed also noted the following evidence and breadth of commitment:

- Elected officials and others we interviewed affirmed collaborative relationships to support common goals of community wellbeing. Collaboration occurs across political parties because of shared commitments.
- Numerous stakeholders noted that law enforcement, the County Sheriff, and the County Prosecutor, are supportive of behavioral health programming and see the value of collaboration with community providers to promote behavioral health in the population.
- A multitude of social service organizations with a long history of working together on a range of issues, staffed by committed leaders who care deeply about the community. According to one community leader, because of their history and experience, leaders from these organizations are "able to make things happen that might not happen in other communities."

Spirit of Volunteerism

There are a multitude of community organizations and events, often staffed by volunteers or funded through charitable giving. Stakeholders we interviewed celebrated this "spirit of volunteerism" as a defining characteristic of Walla Walla County.

Positive Experiences with Services

Service user and family stakeholders endorsed numerous programs, services, and organizations that have had a meaningful positive impact on peoples' lives and supported recovery in powerful ways. These include all of the organizations listed in the Asset Map.

G. Summary of Washington State Health Care Reform Activities

Nationally, the prevalence of behavioral health conditions among Medicaid enrollees is greater than for the general population, with approximately 28 percent of adults aged 18-64 having a mental illness diagnosis and 8 percent with a diagnosis of a serious mental illness. This is compared to 19 percent and 4 percent respectively for individuals with private insurance.[65] It is likely, therefore, that a preponderance of people with behavioral health conditions in Walla Walla are served by providers in the Managed Care Organizations (MCO) networks. Accordingly, we provide an overview of the Medicaid system, including developments over time as a significant feature of the County's behavioral health system.

Washington has been at the forefront with innovations in its Medicaid program for a number of years, readily taking advantage of opportunities offered by Centers for Medicare & Medicaid Services (CMS),

[65] Medicaid and CHIP Payment and Access Commission. (2020). *Behavioral health in Medicaid: Work plan and initial analyses*

and generally including an emphasis on behavioral health. Because these initiatives have important current and future implications for behavioral health care for Walla Walla County residents, we provide detailed descriptions here. We note, however, that these initiatives are complex and overlapping, and our descriptions are derived from multiple sources that are not entirely consistent in their explanation of the interrelationships; therefore, we seek corroboration or correction from key informants prior to producing our final report.

Medicaid Expansion: Washington was among the earliest states to adopt Medicaid expansion, one of five states to use a Medicaid waiver to implement expanded coverage in 2011, five years expansion was an option under the Affordable Care Act (ACA). Subsequently the state adopted the ACA provisions in 2014, the first year of availability, with the result that Medicaid enrollment has increased 76 percent from 2014 to the present. In Walla Walla County, 20-25 percent of the population is enrolled in Medicaid, about evenly divided between children and adults, all but a few hundred of which are enrolled in one of four managed care plans.

Amerigroup Washington Inc	834
Community Health Plan of Washington	2,299
Coordinated Care Corporation	1,487
Molina Healthcare of Washington Inc	11,729
Total	**16,349**

Since Medicaid expansion, Washington has continued with an array of overlapping innovative strategies, differentiated by various CMS programs. There are now referred to collectively as the Medicaid Transformation Project (MTP).

State Innovation Model (SIM) Grant: In 2014, Washington obtained a 5-year CMS SIM grant, which allows states to implement delivery system reform models to lower costs, achieve better quality of care, and improve the health of the population. Washington's SIM incorporated four alternative payment models focused on different aspects of the Washington State health care delivery system, the first of which was Fully Integrated Managed Care (FIMC). Rolled out between 2016 and 2019 on a regional basis, FIMC consists of contracts with five MCOs: Amerigroup Washington, Coordinated Care of Washington, Community Health Plan of Washington, Molina Healthcare of Washington, United Healthcare Community Plan. Four of these operate in Walla Walla County, the exception being United Healthcare. MCO contracts put a strong emphasis on access to behavioral health care and integration with primary care. Today, 85 percent of Medicaid recipients are now enrolled in one of the five MCOs.

Accountable Care Organizations (ACOs): Funding through the SIMs Round 2 test grant and supportive state legislation in the 2014 session provided for the initial development of ACOs designed to provide the infrastructure for regional, multi-sector collaboration; developing regional health improvement plans; jointly implementing or advancing local health projects; and advising state agencies on how to best address health needs within their geographic areas. Beginning in 2016, resources and functions of the ACHs were expanded through Washington's Delivery System Reform

Incentive Payment (DSRIP) program. In 2017, ACOs were reformulated and expanded as Accountable Communities of Health (ACHs).[66]

Delivery System Reform Incentive Payment (DSRIP): In 2016, CMS and the State of Washington signed a contract for implementation of a 5-year Medicaid DSRIP Program, Washington is the most recent of 12 states to implement a DSRIP program and will be the last as CMS is discontinuing the program. Originally set to expire in five years, Washington's DSRIP CMS was extended by CMS for another year and will now end December 31, 2022, unless CMS authorizes another extension or renewal.

DSRIP programs, approved as part of broader demonstrations under CMS Section 1115 waivers, aim to advance state and federal delivery system reform goals, such as reducing avoidable hospital use, improving care coordination, and improving the integration of physical and behavioral health services. DSRIP funding is tied to implementation of projects and achievement of specific milestones, with a reduction in funding if the state fails to reach certain goals. Washington's maximum possible reimbursement contingent on meeting program goals is $1.125 billion over the 5-year period.

Some DSRIP programs, including Washington's, incorporate both statewide and provider-specific performance goals. One of the latter is that MCOs must adopt alternative (i.e., performance based) payment methods for some proportion of network providers. Washington's target is one of the highest, at 90 percent of Medicaid payments to be made through alternative payment models, though this was reduced to 85 percent through agreement with CMS, due to delays related to the pandemic.

CMS has required independent evaluations of state DSRIP programs. According to the Medicaid and CHIP Payment and Access Commission, results have been mixed, with most programs meeting DSRIP targets but little evidence of sustained cost savings. There is some evidence that DSRIP is improving health outcomes and reducing hospital utilization, but it is difficult to isolate the effect of DSRIP projects from other concurrent policy changes and initiatives, with control groups it is not clear whether these gains might have been achieved without DSRIP funding.

Washington's DSRIP Statewide Accountability (SWA) Measures: CMS DSRIP payments are contingent on the state reaching performance targets in ten areas. Notably, three of the ten measures focus specifically on behavioral health, and several others (diabetes care, emergency visits and readmission rates) are particularly relevant for behavioral health conditions.

- All-Cause Emergency Department Visits per 1000 Member Months
- Antidepressant Medication Management (acute/continuation phase)
- Comprehensive Diabetes Care: Blood Pressure Control
- Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9 percent)
- Controlling High Blood Pressure (<140/90)
- Medication Management for People with Asthma: Medication Compliance 75 percent
- Mental Health Treatment Penetration (Broad)
- Plan All-Cause Readmission Rate (30 days)
- Substance Use Disorder (SUD) Treatment Penetration

[66] Center for Community Health and Evaluation. (2019). *Regional collaboration for health system transformation: An evaluation of Washington's Accountable Communities of Health.*

- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Medicaid Transformation Project (MTP): In 2017, as one component of the DSRIP program HCA launched a large-scaled initiative known as the MTP. Enhancement of the Medicaid-funded behavioral health system is a key feature the MTP, as indicated by the project goals:

- Focusing on whole-person care, where a person can access care for their mind, body, and SUD in one system through a network of providers (this is also called integrated managed care)
- Moving from a fee-for-service approach to paying for health and value through value-based purchasing
- Building healthier communities with local and regional partners
- Implementing projects focused on improving health equity
- Supporting older adults and family caregivers
- Helping our most vulnerable population get and keep stable housing and employment
- Improving access to SUD treatment and treatment facilities
- Improving access for mental health inpatient care and treatment options

By January 2020, all regions of the state had transitioned to an integrated system for physical health, mental health, and SUD services in the Washington Apple Health (Medicaid) program, known as Integrated Managed Care (IMC).

Cross-Sector Performance Measures: HCA and the Department of Social and Health Services (DSHS), per Senate Bill 5732, developed a set of 51 performance measures to track behavioral health services for Apple Health (Medicaid).[67]

These measures are included in Medicaid contracts with Behavioral Health Organizations, MCOs, county chemical dependency coordinators, and Area Agencies on Aging.

Measures developed from this legislation address the following outcomes:[68]

- Improvement in client health status
- Increases in client participation in employment, education, and meaningful activities
- Reduced client involvement in criminal justice systems and increased access to treatment for forensic patients
- Reduced avoidable use of hospital, emergency rooms, and crisis services
- Increased housing stability in the community
- Improved client satisfaction with quality of life
- Decreased population level disparities in access to treatment and treatment outcomes

MCO Regional Service Areas: The ten Regional Services Areas consist of counties grouped to represent approximately equivalent population sizes; accordingly, the number of counties in a Regional Service Area range from one to as many as nine. Walla Walla County is in the Regional Service Area known as Greater Columbia, which consists of nine contiguous counties in the Southeast corner

[67] Washington State Department of Social and Health Services. (n.d.). *Cross-system outcome measures for adults enrolled in Medicaid.*
[68] Washington State Health Care Authority. (n.d.). *Mental health reports.*

of the state. Four of the five MCOs operate in all ten regions, the exception being United Healthcare, which operates only in some regions, not including Greater Columbia.

Regional Behavioral Health Administrative Services Organizations (BH-ASOs): Under the Integrated Managed Care, most services for Apple Health clients are provided through managed care organizations. However, some services in the community, such as services for individuals experiencing a mental health crisis, must be available to all individuals, regardless of their insurance status or income level. For these services HCA contracts with regional Behavioral Health Administrative Services Organizations (BH-ASOs). The following are services provided by BH-ASOs:

- Medically necessary Behavioral Health Crisis Services and services related to the administration of the Involuntary Treatment Act (ITA) and Involuntary Commitment Act Services
- A behavioral health ombudsman to assist with grievances and appeals
- Management of block grants based on locally approved block grant plans
- Management of Criminal Justice Treatment Account funds and Juvenile Drug Court funds
- Oversight of committees formerly led by the regional behavioral health organization, such as the Behavioral Health Advisory Board, Wraparound with Intensive Services (WISe), Children's Long-term Inpatient Program, and Family Youth System Partner Round Table

The following are the services provided by BH-ASOs that are available to anyone experiencing a behavioral health crisis, regardless of their insurance status or income level:

- A 24/7/365 regional crisis hotline for mental health and SUD crises
- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors
- Short-term SUD crisis services for people intoxicated or incapacitated in public
- Application of mental health and SUD involuntary commitment statutes, available 24/7/365, to conduct ITA assessments and file detention petition

Within available resources (including block grant funding), the BH-ASO may provide non-crisis behavioral health services, such as outpatient SUD and/or mental health services, or residential SUD and/or mental health services (to low-income individuals not eligible for Apple Health and who meet other eligibility criteria):

- Mental health evaluation and treatment services for individuals involuntarily detained or who agree to a voluntary commitment
- Residential SUD treatment services for individuals involuntarily detained as described in state law
- Outpatient behavioral treatment services, in accordance with a Less Restrictive Alternative court order

The following are among are among the contractual requirements for the organization (Contractor) with which the ASO contracts to provide crisis services (i.e., Comprehensive Healthcare in the case of Walla Walla County:

- The BH-ASO shall collaborate with the Contractor to develop and implement strategies to coordinate care with community behavioral health providers for individuals with a history of frequent crisis system utilization, or those enrolled in high intensity programs such as WISe and PACT. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and Mental Health Advance Directives in treatment planning consistent with requirements in Section 14 of this Contract.
- The BH-ASO shall collaborate with the Contractor to support data exchange between the Contractor, the BH-ASO, and with community behavioral health providers, consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data, sharing of care plans, crisis plans, critical incidents, and mental health Advance Directives, and other relevant information necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42CFR Part 2.

Greater Columbia Behavioral Health, LLC (GCBH): GCBH, the ASO for the region that includes Walla Walla County, is an entity formed by an inter-local agreement among nine counties: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima Counties. GCBH contracts with a network of six provider organizations, with either one of two for each county. The executive committee consists of a primary and alternate commissioner from each county The Greater Columbia BH-ASO Region with Comprehensive Healthcare to provide these services and functions.[69]

ACHs under DSRIP: DSRIP funding provided for an expansion of Accountable Care Organizations financed under the SIM. ACHs play an integral role in Washington's Medicaid transformation efforts, although ACHs are working in many ways to improve the health of their communities as a whole.[70]

ACHs have a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories:[71]

- Primary care providers
- Behavioral health providers
- Health plans, hospitals or health systems
- Local public health jurisdictions
- Tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region
- Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region

ACHs promote health equity, address and coordinate around social determinants of health, and respond to regional needs and issues, including COVID-19. ACHs, in partnership with health care providers, local health jurisdictions, community-based organizations, and others, are working to:

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[69] Washington State Health Care Authority. (2019). *Behavioral health administrative service organization (BH-ASO) fact sheet.*

[70] Washington State Health Care Authority. (n.d.). *Accountable Communities of Health (ACHs).*

[71] Myers and Stauffer. (2021). *Medicaid transformation Accountable Communities of Health semi-annual reporting guidance.*

- Align resources and activities that improve whole-person health and wellness by bringing people and organizations together across sectors for discussion, training, and strategic planning
- Support efforts that improve the Medicaid health care delivery system, such as workforce development and value-based purchasing
- Support the integration of physical and behavioral health care, known as managed care.
- Connect people to care and help coordinate care between providers and organizations.
- Address the opioid use public health crisis
- Invest in community infrastructure, like electronic health records

ACHs may earn DSRIP incentive funds for themselves and partnering providers. Approved uses of funds are: [72]

- Administration
- Project management
- Provider engagement, participation, and implementation
- Provider performance and quality incentives
- Health systems and community capacity building

Timeline for Communities of Health Planning Grants, SIM, DSRIP, MTP, ACOs, and ACHs

<table>
<tr><td>2014</td><td>2015</td><td>2016</td><td>2017</td><td>2018</td><td>2019</td><td>2020</td><td>2021</td></tr>
<tr><td>COH Planning</td><td colspan="5">SIM funding</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td colspan="5">DSRIP/MTP</td></tr>
<tr><td></td><td colspan="2">ACO Designation</td><td colspan="2">ACH certification for MTP</td><td></td><td></td><td></td></tr>
</table>

Adapted from https://www.hca.wa.gov/assets/program/cche-evaluation-report-for-ACHs.pdf

Greater Columbia ACH (GCACH): GCACH is the ACH that serves nine-county region that includes Walla Walla County as well as Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Whitman, and Yakima counties. Recent activities include the following:

COVID-19 response: GCACH collaborated with Medical Teams International (MTI), the Tri-Cities Hispanic Chamber of Commerce, and seven community-based organizations, including housing agencies, food banks, churches, and free clinics to vaccinate targeted populations within Benton and Franklin counties.

Workforce development: GCACH was awarded $146,667 per year for two years for a behavioral health pilot program. Contracts were signed with seven community behavioral health agencies to support workforce needs related to reimbursement and incentives for supervision of interns and trainees in December. The Emergency Medical Services Innovated (EMSI) program aims to bridge the gap between unmet health care needs, high-cost care, and access to care. GCACH is funding a scholarship program to support Heritage University's newly developed Behavioral Health Aide (BHA) Certificate program: Indigenous Education Pathway for Tribal Nations.

[72] Washington State Health Care Authority. (2019). *DSRIP payments through financial executor portal.*

Community information exchange: GCACH is pursuing the development of a decentralized, open-source community information exchange (CIE). SiteSavvy is creating a resource directory for the GCACH service area, which will be finalized at the end of January 2022. GCACH is putting together a request for proposals (RFP) for the research, development, and implementation of a client data exchange for use by community-based organizations, human service agencies, and other non-clinical providers. GCACH is in early discussions with the Yakama Nation to pilot a potential Community Data Exchange (CDE) to connect their programs and services.

Multi-Payer Primary Care Transformation Model (PCTM): GCACH has been following the development of HCA's Multi-payer Primary Care Transformation Model (PCTM). PCTM closely aligns with the Patient-Centered Medical Home model of care, giving GCACH an opportunity to transition all provider sites into the HCA's PCTM, and providing the technical support needed to be successful under a value-based payment contract. GCACH is in close contact with HCA to find opportunities to help launch the PCTM model in 2023 as part of GCACH's scale and sustain strategy.

Local Health Improvement Networks (LHINs): LHINs are groups supported by ACHs to address social determinants of health. GCACH works with seven county-based LHINs, to support initiatives delivering on these needs across the region. Each LHIN is a formalized group of individuals who coordinate and collaborate on activities to address the health issues and disparities in their respective communities. Once the most critical SDOH are determined for that area, GCACH provides funding support to philanthropy organizations to align services that will address those areas of need. The LHIN for Walla Walla and Columbia counties is the Blue Mountain Region Community Health Partnership (BMRCHP).

BMRCHP: The LHIN for Walla Walla and Columbia counties, is cross-sector coalition consisting of providers, partners, and organizations throughout the Blue Mountain Region. These partners coordinate to assess the needs of the Blue Mountain Region and develop a unified response to ensure residents in the Blue Mountain Region have access to high quality, affordable health care and resources to sustain a healthy lifestyle. The SDOH prioritized by the BMRCHP are behavioral health, housing, and education. The affiliated philanthropic organization is the Blue Mountain Community Foundation (BMCF).

H. Summaries of Justice System Reform Legislation Impacting Behavioral Health

Legislation	Summary
House Bill 1310 Concerning permissible uses of force by law enforcement and correctional officers. Date passed: April 2021 Date effective: July 2021	This bill describes the circumstances that law enforcement and correctional officers are allowed to use physical force and deadly force. Officers may use physical force only when there is "probable cause to make an arrest; effect an arrest; prevent an escape; or protect against imminent threat of bodily injury." Officers must use "reasonable care when determining whether to use physical force and when using physical force" and "exhaust all available and appropriate de-escalation tactics prior to using any physical force." Officers must "use the lease amount of physical force necessary" and terminate it once the necessity of the force ends. Officers must use "less lethal alternatives before using deadly force" and "make less lethal alternatives issued to the officer reasonably available for their use."
House Bill 1735 Modifying the standard for use of force by peace officers. Date passed: February 2022 Date effective: March 2022	This bill recognizes the implementation challenges posed by House Bill 1310 and clarifies the standard for use of force by peace officers for police agencies and the public. "The legislature intends for peace officers to continue the critical role of supporting those in crisis and assisting vulnerable members of our communities. The legislature does not prevent or prohibit peace officers from protecting citizens from danger."
Senate Bill 5476 State vs. Blake Decision Date passed: April 2021 Date effective: July 2021	This bill was enacted in response to the Washington Supreme Court ruling that the statute making possession of a controlled substances a felony is unconstitutional. It reduced the offense of simple drug possession from felony to a misdemeanor. A misdemeanor can be punished by up to 90 days in jail and a $1000 fine. The bill also states that law enforcement officers must offer diversion programs, have specific training on drug users and directs agencies, and have systems in place to track contacts with drug offenders and steps they have taken to get treatment. Prosecutors must offer additional diversion programs after the first 2 instead of conviction. Lastly, the possession of drug paraphernalia when intended to use to ingest in the body was decriminalized.
Becca Bill – Revised Code of Washington (RCW) 28A.225 and 13.32A Truancy, At-Risk Youth (ARY), and Child in Need of Services (CHINS) Date effective: July 1995	The "Becca Bill" requires all children between the ages 8 and 18 to attend school regularly and the responsibly of the school when students are absent without a valid excuse. The truancy petition describes the responsibility of the school district to file petitions to the juvenile court for truancy. The at-risk youth (ARY) petition describes the process for a parent to file a petition with juvenile court. The child in need of services (CHINS) petition allows a parent, child, or department to file a petition with juvenile court to approve an out-of-home placement for a child in need of services.

I. Acronym List

ACA: Affordable Care Act
ACEs: Adverse Childhood Experiences
ACH: Accountable Communities of Health
ACO: Accountable Care Organizations
ALICE: Asset Limited, Income Constrained, Employed
ARY: At-Risk Youth
ASO: Administrative Services Organization
BHA: Behavioral Health Aide
BH-ASO: Behavioral Health Administrative Services Organization
BHP: Basic Health Plan
BMCF: Blue Mountain Community Foundation
BMHC: Blue Mountain Health Cooperative
BMRCHP: Blue Mountain Region Community Health Partnership
BSW: Bachelor of Social Work
C2C: Commitment to Community
CBT: Cognitive Behavioral Therapy
CDC: Centers for Disease Control and Prevention
CDE: Community Data Exchange
CFR: Code of Federal Regulations
CHINS: Child in Need of Services
CHIP: Children's Health Insurance Program
CHNA: Community Health Needs Assessment
CHWs: Community Health Workers
CIE: Community Information Exchange
CIT: Crisis Intervention Team
CMS: Centers for Medicare and Medicaid Services
COVID-19: Coronavirus Disease 2019
CPPS: College Place Public Schools
CRI: Community Resilience Initiative
CRT: Crisis Response Team
DCH: Department of Community Health
DCR: Designated Crisis Responders
DSHS: Department of Social and Health Services
DSM: Diagnostic and Statistical Manual of Mental Disorders
DSRIP: Delivery System Reform Incentive Payment
DUI: Driving Under the Influence
ED: Emergency Department
EMS: Emergency Medical Services
EMSI: Emergency Medical Services Innovated
EMT: Emergency Medical Technician
ER: Emergency Room

FIMC: Fully Integrated Managed Care
FTEs: Full-Time Equivalents
FY: Fiscal Year
GCACH: Greater Columbia Accountable Community of Health
GCBH: Greater Columbia Behavioral Health
HARPS: Housing and Recovery through Peer Services
HCA: Health Care Authority
HIPAA: Health Insurance Portability and Accountability Act
HPSA: Health Professional Shortage Area
HRSA: Health Resources & Services Administration
HSRI: Human Services Research Institute
ICE: Immigration and Customs Enforcement
IMR: Illness Management and Recovery
ITA: Involuntary Treatment Act
JJC: Juvenile Justice Center
LEAD: Law Enforcement Assisted Diversion
LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual/Agender/Ally, Others
LHINs: Local Health Improvement Networks
MAT: Medication Assisted Treatment
MCO: Managed Care Organization
MH: Mental Health
MOST: Mobile Outreach Services Team
MRT: Moral Reconation Therapy
MSW: Master of Social Work
MTI: Medical Teams International
MTP: Medicaid Transformation Project
NAMI: National Alliance on Mental Illness
NPI: National Provider Identifier
NSDUH: National Survey of Drug Use and Health
OCD: Obsessive Compulsive Disorder
OWWL: One Walla Walla List
PACT: Program of Assertive Community Treatment
PCTM: Primary Care Transformation Model
PSH: Permanent Supportive Housing
RCW: Revised Code of Washington
RN: Registered Nurse
SDOH: Social Determinants of Health
SIM: State Innovation Model
SMI: Serious Mental Illness
SOAR: SSI/SSDI Outreach, Access, and Recovery
SPWG: Suicide Prevention Work Group
SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income
The STAR Project: The Successful Transition and Reentry Project
SUD: Substance Use Disorder
SWA: State-wide Accountability
TI-ROSC: Trauma-Informed Recovery-Oriented Systems of Care
VA: Veterans Affairs
WHO: World Health Organization
WISe: Wraparound with Intensive Services
WWCC: Walla Walla Community College
WWPD: Walla Walla Police Department
WWPS: Walla Walla Public Schools
WWVA: Walla Walla Valley Academy