

MIDD Briefing Paper

BP 37,51,64,66: South County Crisis Center

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)

New Concept ☒ (Attach New Concept Form)

BP 37 South County Crisis Diversion Expansion

BP 51 South County Crisis Diversion Expansion

BP 64 Kent Crisis Center

BP 66 South King County Crisis Center

Type of category: New Concept

SUMMARY: The South County Crisis Center (SCCC) would provide a crisis diversion multi-service center in the southern region of King County that has multiple co-located on-site services to both serve individuals in behavioral health crisis who are coming into contact with first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This allows for co-location and coordination of many crisis receiving and stabilization services accessible 24 hours a day, seven days per week (24/7), including but not limited to: on-site respite/crisis diversion; mobile crisis teams; on-Site Sobering Services; and many other services.

Collaborators:

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Shannon Baker	Patient Navigation & Care Coordination	Multi-Care Health System
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

- 1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New**

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Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

The South County Crisis Center (SCCC) would provide a crisis diversion multi-service center in the southern region of King County that has multiple co-located on-site services to both serve individuals in behavioral health crisis who are coming into contact with first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This allows for co-location and coordination of many crisis receiving and stabilization services accessible 24 hours a day, seven days per week (24/7):

- On-site respite/crisis diversion;
- Mobile crisis teams;
- On-Site Sobering Services;
- Coordination with, and linkage to, local Withdrawal Management (detoxification) services;
- On-site community/living room trauma-informed space for pre-crisis/crisis prevention time, peer ran groups, and drop-in supports;
- Overnight and short-term stay options;
- Place for care management teams/case managers to meet with individuals;
- Transportation and reentry support/access;
- Housing supports and access;
- Linkage to, and coordination with, Primary Care, including agreements for 24/7 services ;
- Assistance with Apple Health Medicaid enrollment and on-site entitlement assistance;
- Hygiene center providing free restrooms, showers and laundry facilities; and
- Coordination and assistance in accessing community-based services for individuals with behavioral health needs involved in the criminal justice system due to committing quality of life crimes.

This concept relates to the current MIDD strategy 10b in the availability of in-the-community crisis response and the accessibility of a facility-based crisis diversion program, as well as current programs located in Seattle such as the Dutch Shisler Sobering Center and the Urban Rest Stop (URS) Hygiene Center. The program would provide King County first responders with a therapeutic community-based alternative to jail and hospital settings when engaging with adult individuals in behavioral health crisis. In addition, this program would expand accessibility to include referrals from community professionals, as well as self-referral capability,. The intention is to reduce impacts on first responders and hospitals by providing services and supports pre-crisis or earlier in the crisis cycle ,in the moment, in the community.

2. Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area (Select all that apply):

- | | |
|---|---|
| <input checked="" type="checkbox"/> Crisis Diversion | <input checked="" type="checkbox"/> Prevention and Early Intervention |
| <input checked="" type="checkbox"/> Recovery and Re-entry | <input checked="" type="checkbox"/> System Improvements |

Please describe the basis for the determination(s).

These services are intended to provide a pre-booking and/or pre-hospitalization diversion option, and may also be utilized across the Sequential Intercept Model (SIM) continuum. The SIM "provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental

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illness and substance use.”¹ The SIM “envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic state hospital commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support.”²

The goal of these programs is to reduce the cycling of individuals with mental health or substance use disorders (SUDs) through the legal and crisis systems, while also providing supports to individuals who: need services and supports to reduce episodes and impacts of crisis; have not been able to access or maintain services in the community; are struggling with increased symptoms that are, or are likely to result in, significantly impacting their ability to manage daily activities; and/or are releasing from jail and hospitalization and need supports to safely maintain themselves in their communities. These programs allow for individuals to receive services to stabilize crises in the moment and address the situations that cause or exacerbate crises. By focusing on an individual’s immediate needs, and through facilitating engagement in services and supports in the community, the SCCC may be able to reduce the need for first responder involvement and facilitate appropriate community-based connections that support resiliency and recovery for the individual by connecting them to the level of services they need. In addition, by providing alternatives to jails and emergency departments in the moment of crisis/contact with first responders, the focus can be on providing reentry support: linking individuals with behavioral health treatment, primary care, housing services and other basic needs/reentry supports.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

- 1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

Many adults who find themselves in difficult situations due to a behavioral health condition(s) or crisis episode(s) could have resolution without ever entering local jails, emergency departments or hospitals. The criminal and crisis systems are often unable to adequately respond to these situations. A research study found that more and more individuals are seeking psychiatric care through local hospital emergency departments (EDs), noting that 12.5 percent of adult ED visits in 2007 were mental health-related, as compared to 5.4 percent seven years prior³. Additionally, the data showed 41 percent of psychiatric ED visits resulted in a hospital admission, which is over two and a half times the rate of ED

¹ Mark R. Munetz, M.D.; Patricia A. Griffin, Ph.D. *Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness*, PSYCHIATRIC SERVICES, April 2006, Vol. 57 No. 4, pp. 544-549.

² Ibid, Mark R. Munetz, M.D.; Patricia A. Griffin, Ph.D. (April 2006).

³ Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007; Statistical Brief #92: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Health Care Policy and Research (US); published July 2010

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visits for other conditions,⁴ and the five year span between 2001 and 2006 showed that the average duration of psychiatric ED visits were 42 percent longer than those for non-psychiatric issues.⁵ It was also found that growth in these figures may have come about due to the difficulty people experience in accessing community mental health services prior to a crisis, as well as the deinstitutionalization in the 1960's, which caused a significant reduction in inpatient psychiatric capacity nationally that has continued until very recently.⁶

Historically, individuals in behavioral health crisis have been brought to local EDs by local law enforcement and other first responders, causing an overutilization of the highest level of care. This also limits access to immediate services for individual who are in need of emergency services. This not only takes time away from the core duties of law enforcement and other health care professionals, but also has very little impact on the individual with behavioral health need, due to limitations in service availability for individuals who are not in need of immediate crisis intervention. According to Auburn Hospital, individuals are often detained at the ED because there is limited access to psychiatric treatment, and other needed supports, 24 hours a day. Each month Auburn Emergency Room provides services to an average of 125 psychiatric patients, including 80 patients who admit with substance abuse disorders, and seven to 12 patients on Single Bed Certifications, with many patients utilizing a variety of reasons to admit to the hospital just to find shelter and food⁷. Additionally, overutilization of EDs often results in hospitals absorbing the costs of individuals in single bed certifications, patients being served in environments not adequate to meet their psychiatric needs, and staff working to manage behavioral health symptoms beyond what is manageable in that environment without the necessary supports and programming. Auburn Hospital currently has a 35 bed Older Adult Psychiatric Unit that is always full, and in Spring 2016 will open an Adult Psychiatric Unit. The addition of this new unit will likely result in greater utilization of the Auburn ED for individuals with behavioral health disorders, whether they meet inpatient criteria or not, as individuals, family, friends, and first responders attempt to access services to address the needs of this population. As such, the ED will need resources that will support the impact that this will likely have on the community and help get individuals to the right level of care to meet their needs.

The deinstitutionalization of Individuals with mental health and SUDs has also had a significant impact on the criminal justice system. In King County, the Familiar Faces initiative found that 94 percent of individuals booked into King County jail four or more times in a rolling twelve month period, have some sort of behavioral health indicator. Of these, 35-40 percent had contact with the mental health or SUD treatment systems within the 15-month study window; over half received homelessness services (likely an undercount of homelessness), and only half obtained Medicaid during the study year.⁸

A crisis center in South King County would assist in alleviating the pressure on police, first responders, and EDs as an alternative to booking and inpatient psychiatric stays. There is a lack of resource and diversion options for first responders working in many of the jurisdictions and unincorporated areas of South King County, particularly those that are centered/near Kent, Auburn, Renton and Federal Way.

⁴ Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007; Statistical Brief #92: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Health Care Policy and Research (US); published July 2010

⁵ Slade EP, Dixon LB, Semmel S. Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv* 2010; 61(9): 878-84. Cited in Abid, Z., Meltzer, A., Lazar, D., and Pines, J. (2014). *Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions*. (Urgent Matters Policy Brief Volume 1, Issue 2).

⁶ Abid, Z., Meltzer, A., Lazar, D., and Pines, J. (2014). *Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions*. (Urgent Matters Policy Brief Volume 1, Issue 2).

⁷ Information provided by Shannon Baker, MultiCare Health System (Auburn Hospital), December 2015.

⁸ Familiar Faces, Current State-Analysis of Population, March 3, 2015

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Law enforcement in these jurisdictions have limited options for diverting individuals who are in any kind of behavioral health crisis, or in need of sobering services, away from local jails and hospitals/EDs and, as a result, many individuals unnecessarily wind up in jails or EDs. Current options require law enforcement officers to drive into Seattle, which takes them off the streets and away from their duties for long periods of time, or potentially wait hours for a response from the Mobile Crisis Team (MCT).

Many individuals who are seasoned users of the criminal justice and crisis systems, may have been deterred from utilizing appropriate and necessary care due to having experienced difficulty in accessing such services in the past, and/or having experienced the loss of their rights due to detainments or involuntary hospitalizations. A facility that allows for individuals to access the SCCC voluntarily could prevent detainments and hospitalizations. This program would provide a drop-in component that individuals could access without needing to engage with first responders at all, where assistance and case management services can be provided for an individual in a more preventative or early intervention manner. This drop-in component would ideally result in less demand on first responders if individuals are able to access the help they need, when they need it. Having resources and supports that address crisis and pre-crisis needs, and the gaps and barriers that compound and exacerbate crises, allow for the provision of more upfront, preventative, human-centered services that assist people with accessing and utilizing appropriate and needed services, moving them towards recovery and stability.

Finally, King County is seeing an increase in the number of individuals who are without permanent or stable housing. The Point-In-Time count noted a significant increase in homelessness in early 2015. “Last winter’s One Night Count found more than 3,772 men, women, and children without shelter on the streets of Seattle – a 21 percent increase over 2014. People are homeless, on average, about 100 days. So far in 2015, more than 66 homeless people have died on the streets and in unpermitted encampments across the county. The state now reports that 35,000 people in King County become newly homeless at some point during the year.”⁹ Although homelessness is not in and of itself a behavioral health issue, behavioral health conditions and homelessness often go hand-in-hand.

The facility’s ability to provide hygiene and related services, along with case management services seven days per week, will help to facilitate connection and engagement in services while attending to individuals’ most basic needs. This program would operate based on a mutual understanding of dignity and respect for each individual, keeping the facility and program as barrier-free as possible, providing a safe, clean, safe, respectful and welcoming environment. It can be difficult to see the road to recovery if basic human needs are not being met and dignity is lost. Even with motivation, ability, and a willingness to look for employment, an individual who is homeless will struggle to find or maintain housing or employment without access to showers and laundry facilities, as well as other essential needs. The provision of hygiene services is often the first step back into accepting or seeking assistance from a service provider. Many individuals who reside without a permanent residence have had negative experiences with their families and institutions such as schools, military, churches, service providers, employers, Washington State Department of Social and Health Services (DSHS), Child Protective Services (CPS), local, state and federal government agencies. They may not want to be placed in intensive services, yet may be willing to utilize a resource that allows them to access basic services on their own volition, at their own pace.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

⁹ Mayoral Proclamation of Civil Emergency; City of Seattle, November 2015

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Currently, there is no crisis center in South King County that can address the needs of adults experiencing a mental health and/or SUD crisis beyond what local ED's provide. The SCCC would fill that gap and provide needed services 24/7 by a staff of trained behavioral health professionals. By providing an alternative to jails and EDs in the moment of crisis/contact with first responders, this facility can focus on providing the support services needed to help link individuals with behavioral health treatment, primary care and housing services, with a warm hand-off to services in their home communities, which will help ensure individuals remain *in* their home community. Ideally, and depending on the level of ongoing care and support needed, individuals will be linked with a community-based integrated care management team to provide behavioral health, primary care and housing supports and linkages (see below under *Additional On-Site Services Provided in Components Above*). The care management team (described in a separate briefing paper; BP 44 Familiar Faces Culturally Care Management Teams) will work closely with crisis center staff and be able to provide services on-site at the diversion center and other community locations (if the care management team concept is not funded, the SCCC will require additional staffing in order to provide the case management services and ensure connections to behavioral health, primary care and housing supports). Finally, decreasing ED visits for individuals in behavioral health crises that can be managed at the SCCC would make more beds available for people with medical and more acute behavioral health needs. It would also decrease costs to insurance providers like Medicaid, and to hospitals. There could be plenty of meeting space, or other community spaces for on-site culturally specific services and faith-based organizations within the SCCC to offer classes or on-site support and other types of resource-oriented, culturally responsive and trauma-informed services to support stability, de-escalations and embrace recovery and connectivity.

The following programs are included as components of the SCCC, and will collaboratively work to address the needs outlined above regarding jail and ED utilization, and appropriate linkage to community-based services. Individuals may engage in a single program component, as well as any combination of all available components of the program per episode, and may use the SCCC's services repeatedly, as needed.

Mobile Crisis Team:

The facility would house a MCT, focused on responding to needs in the south end of King County. The team would operate 24/7 and respond to first responder calls in the community to assist with people in mental health and SUD crisis. The MCT is intended to be a resource for first responders that would provide crisis response and assist with stabilization services to address the need in the moment. The team would have the ability to intervene with individuals in their own communities, identify immediate resources on the scene and relieve the need for further intervention. The current MCT includes 25 mental health clinicians who are also chemical dependency professionals/trainees who provide 24/7/365 coverage across King County. Expecting that the addition of this program would not need an additional 25 clinicians to meet the need if the services and supports are dedicated to the south end of the County, the expectation would include a team of 13.

Crisis Diversion Facility (CDF):

A CDF program would be available for longer-term crisis stabilization needs. The CDF would include a 16-bed facility that would accept people age 18 and over in behavioral health crisis in order to divert them from jails and hospitals. The facility would accept individuals 24/7, and individuals could stay for up to 72 hours. Individuals arriving at the SCCC would be evaluated within three hours, with some being linked directly to services and released while others are admitted to the CDF. Individuals may be diverted to the facility in lieu of jail for a defined set of low-level criminal offenses in order to focus on the cause of

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the crisis and reduce the negative impacts of a (another) jail stay. Services at the CDF would include crisis and stabilization services, case management, needs assessments, and linkage with community-based services.

Drop-in Center/Hygiene Services/Harm Reduction Space:

This facility/campus would also provide space for individuals to go in a pre-crisis/preventative mode in terms of a “drop-in” type of setting, staffed with peer support, including, individuals in recovery who want to volunteer/participate in helping others experiencing behavioral health challenges/crises. Thus, the center would incorporate both a peer specialist role/jobs and peer mentoring opportunities that support recovery and help individuals build new community; this could be especially valuable for individuals who do not have a natural support system to access. The Drop-in Center would also provide space to address personal hygiene (e.g., showers, laundry, etc.) and on-site access to meals and snacks. Other on-site services would include In-Person Assistor service to help with Medicaid entitlement enrollment via Apple Health and on-site assistance from DSHS with applying for other publicly funded benefits including food stamps, Housing and Essential Needs (HEN), Aged, Blind and Disabled (ABD), and facilitated access to Social Security Administration benefits for those who are eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Transportation assistance (bus passes, taxi scripts and gas cards) will also be provided. Additional information is needed to identify the budget and numbers served for this portion of the program.

Sobering Center:

Sobering services strengthen the availability, quality, and coordination of services for homeless persons with chronic SUDs. They serve as a safe and secure place for persons to sleep off the acute effects of intoxication, and a recovery access point where individuals receive case management services, outpatient behavioral health treatment, and assistance to move towards greater self-determination. Services are designed as low barrier, so individuals can access them without regard to funding or motivation for change.

Additional On-Site Services Provided in Components Above

The following service coordination, in addition to on-site treatment and other interventions for behavioral health crisis, will be available on-site through either direct partnership with existing programs (systems) or SCCC staff being trained in specific system eligibility/connection practices:

- Enrollment in Apple Health for those who are eligible for Medicaid coverage;
- Connection to DSHS financial and social work for publicly funded benefits including food stamps, HEN and ABD;
- Connection to the federal Social Security Administration for SSI and SSDI linkage/re-linkage;
- SCCC staff shall be trained as housing assessors under Coordinated Entry¹⁰ – housing assessors are staff from designated community agencies. Housing assessors may operate out of Assessment Hubs, be designated as the assessor for his/her agency, or may be part of a mobile outreach team. All housing assessors are required to complete a Homeless Management Information System (HMIS) intake and housing assessment with individuals in need of housing and pull available “housing matches” from HMIS. The housing assessor will then pass the referrals to the individual’s case manager or a “housing navigator”. Housing assessors’ responsibilities include, but are not limited to the following:

¹⁰ U.S. Department of Housing and Urban Development Office of Community Planning and Development. “Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status.” (2014).

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- Operating as the initial contact for the *Coordinated Entry and Assessment (CEA)*;¹¹
- Conducting *Housing Assessment*;
- Client notification of *Eligibility and Referral Decisions*;
- Submission of referrals to the *Receiving Program* through HMIS;
- Participation in case conferences as needed; and
- Responding to requests by the *System Manager*, as appropriate.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

The programs that are being proposed for inclusion at the SCCC have shown evidence of success in their current structures in helping to meet the needs of individuals with behavioral health conditions in crisis, and in meeting some of the day to day needs of individuals who are homeless or unstably housed. The programs' successes as they operate today are detailed below.

The current Crisis Solutions Center (CSC) program, which includes both MCT and CDF components, has been operational for a little over three years. In MIDD Year Five, only 285 individuals were eligible for first year outcomes. For these program participants, the average number of days in psychiatric hospitals and admits to the Harborview ED increased between the pre- and first year post-periods. However, by MIDD Year Six, 1,819 people who began services prior to October 2013 were eligible for outcomes. Aggregate analysis of jail bookings and days for the latter cohort showed increases of 30 percent and 56 percent, respectively, over the short term. For the 290 people eligible for a second year post-period, however, aggregate jail bookings fell seven percent, while days in jail rose only 19 percent when comparing the pre-period to the second year after services began. This indicates that the data were beginning to trend in the desired direction, although the sample size is small and continued analysis is warranted.

Similarly, at Harborview ED, first year outcomes with the larger sample (N=1,819) continued to show an increase of 43 percent in aggregate ED visits over the short term. On average, 2.4 visits in the pre-period rose to 3.4 during the first post-period. For the 290 people with two-year post-period data, however, aggregate ED visits fell by 27 percent. Average visits to the ED for the 167 people (out of 290 eligible) who had any visits in either the pre- or second post-period fell from 3.7 to 2.7, which was statistically significant. Those individuals who received more intensive case management services through the third component of the program were most likely to reduce ED visits. Linkages to treatment in the year following an individual's first CSC visit were tracked for all 1,819 people. At least 594 (33%) were linked to primary outpatient mental health benefits, another 89 (5%) were linked with secondary benefits that include specialty programs, such as Assertive Community Treatment or supported employment, and 243 (13%) were linked to SUD treatment.

The Dutch Shisler Sobering Center is an important recovery entry point in King County's recovery-oriented system of care, contracted to a non-profit agency: Pioneer Human Services (PHS). Sobering is a 24/7 safe and secure place for individuals to sleep-off the acute effects of alcohol or other drug

¹¹<http://www.kingcounty.gov/socialservices/Housing/ServicesAndPrograms/Programs/Homeless/HomelessFamilies/CoordinatedEntry.aspx> accessed 12/20/15.

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intoxication. On-site case management, nursing and outpatient SUD services are available.¹² Program success is measured by admissions to sobering, and referrals from sobering to medical detox and other treatment providers. The center, originally intended as a sleep-off center for people who are publicly inebriated, has evolved into much more. For example, in 2012, persons using sobering services also obtained additional services to further their recovery, including:

- 203 persons admitted to medical detoxification services on referral from PHS staff;
- 100 persons admitted to treatment at Pioneer Center North through King County's involuntary SUD treatment process;
- 374 persons were referred to other SUD treatment services; and
- 25 persons moved into permanent supported housing.

Assisting sobering participants with accessing additional services led to a reduction of overall sobering use and a reduction in the frequency of use by many individuals. Overall, 2,031 different individuals were admitted to sobering in 2012¹³, with 21,233 total admissions (Each night is a separate admission).¹⁴

Similar numbers in 2014 indicate a continued focus on providing and connecting individuals to appropriate services in the community:

- 332 persons referred to medical detoxification services, with 179 admissions achieved;
- 203 persons, identified as having high utilization of crisis services, received case management services;
- 97 persons admitted to treatment at Pioneer Center North through King County's involuntary SUD treatment process; and
- 348 persons referred to other SUD treatment services.

In 2014, 2,059 unduplicated persons were admitted to sobering, with 21,134 total admissions. Projected 2015 numbers indicate they are on track to serve a similar number of individuals (1,945) and total admissions (19,541) by the end of year. Referrals for other SUD services are projected at 227 for 2015, which is a drop from 2014; however, there is an increase in the provision of case management services for individuals with high utilization of services (368 projected). The biggest changes in 2015 are the projected decrease in referrals (36) and admissions (53) to detoxification services, due in part due to the closure of the Recovery Centers of King County and a subsequent reduction in available medical detoxification beds in the County.¹⁵ Internal research methods are needed to determine impacts of utilization and cost savings or cost offsets.

The downtown Urban Rest Stop is designed to serve a wide range of people including homeless adults, families with children, youth and the elderly. As of December 31, 2014 the URS served 84,198 unduplicated individuals with 698,826 showers, 305,848 laundry loads and 1,080,232 rest room uses. The URS is the only hygiene facility in Seattle that provides complete hygiene services and social services to homeless families with children.

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Emerging Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

¹² King County Department of Community and Human Services (DCHS) Program Sheet: DETOX/SOBERING/EMERGENCY SERVICES

¹³ Sobering Center/Emergency Services Patrol News

¹⁴ Ibid, DCHS Program Sheet: DETOX/SOBERING/EMERGENCY SERVICES

¹⁵ Information provided from Dan Floyd, MHCADSD, December 2015

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A study by Guo, Biegel, Johnsen and Dyches (2001) evaluated the impact of a community-based mobile crisis intervention program on the rate and timing of hospitalization. The study found that “a matched sample of consumers who used hospital-based crisis services was 51 percent more likely to be hospitalized after other variables had been controlled for, than users of community-based mobile crisis services.”¹⁶ Another study, published in August 2002 in the Australian and New Zealand Journal of Psychiatry, found that “Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics.”¹⁷

In addition, a study done on jail diversion programs for individuals with mental health and co-occurring substance use disorders showed that jail diversion reduces jail days, links individuals to services in the community, and does not increase risk to public safety. “Data from the six sites in the SAMHSA Jail Diversion Initiative suggest the following: 1) jail diversion ‘works’ in terms of reducing time spent in jail, as evidenced by diverted participants spending an average of two months more in the community; 2) jail diversion does not increase public safety risk and, despite more days in the community, diverted participants had comparable re-arrest rates in the 12-month follow-up period; 3) jail diversion programs link divertees to community-based services, although it is not clear from the data whether individuals receive the type, amount, and mix of services, including evidence-based practices, they need to improve outcomes, such as mental health symptoms...”¹⁸

5. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?

The expected outcomes for eligible individuals in South King County are:

- Reduced incarcerations and jail lengths of stay;
- Reduced emergency department utilization;
- Reduced psychiatric hospitalizations;
- Increased referrals and linkages to treatment;
- Increased access to health benefits/entitlements and primary care;
- Reduced deaths due to behavioral health conditions and/or chronic homelessness; and
- Increased diversion access and system response for criminal justice stakeholders, thus reducing the number of people with behavioral health conditions in our South King County jails.

The intent would be for the program to collect information on a wide array of participant related data, including demographics, referral sources, dispositions, and program length of stay/utilization. Data sources include: internal data that the King County Mental Health, Chemical Abuse and Dependency Services Division (MCHADSD) collects on individual-specific demographics, referrals, linkages and treatment admissions; booking and length of stay data already available to MCHADSD from municipal jails, county jails, and state prisons; demographic and service data available through the HMIS; and data available through negotiated agreement with the state Emergency Department Information Exchange (EDIE).

¹⁶ Shenyang Guo, David E. Biegel, Jeffrey A. Johnsen, and Hayne Dyches, *Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization*, Psychiatric Services, Feb 2001; 52: 223 - 228.

¹⁷ Hugo, Malcolm; Smout, Matthew; Bannister, John, *A Comparison In Hospitalization Rates Between A Community-Based Mobile Emergency Service And A Hospital-Based Emergency Service*, Australian and New Zealand Journal of Psychiatry, Vol. 36 Issue 4 Page 504 August 2002

¹⁸ Steadman, H. J. and Naples, M. (2005), *Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders*. Behavioral Sciences and the Law, 23: 163–170. doi: 10.1002/bsl.640

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C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD

Strategy/Program: (Select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> All children/youth 18 or under | <input checked="" type="checkbox"/> Racial-Ethnic minority (any) |
| <input type="checkbox"/> Children 0-5 | <input type="checkbox"/> Black/African-American |
| <input type="checkbox"/> Children 6-12 | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> Teens 13-18 | <input type="checkbox"/> Asian/Pacific Islander |
| <input checked="" type="checkbox"/> Transition age youth 18-25 | <input type="checkbox"/> First Nations/American Indian/Native American |
| <input checked="" type="checkbox"/> Adults | <input checked="" type="checkbox"/> Immigrant/Refugee |
| <input checked="" type="checkbox"/> Older Adults | <input checked="" type="checkbox"/> Veteran/US Military |
| <input type="checkbox"/> Families | <input checked="" type="checkbox"/> Homeless |
| <input type="checkbox"/> Anyone | <input checked="" type="checkbox"/> GLBT |
| <input checked="" type="checkbox"/> Offenders/Ex-offenders/Justice-involved | <input checked="" type="checkbox"/> Women |
| <input checked="" type="checkbox"/> Other – Please Specify: Individuals in behavioral health crisis coming to the attention of first responders. | |

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The target population is adults experiencing a crisis who live in South King County. These include: individuals residing in, or who are coming into contact with first responders in, South King County, who are eligible to be diverted from a (another) jail booking in the Maleng Regional Justice Center (MRJC), South Correctional Entity (SCORE) or Kent City Jail; individuals in South King County who need a place to sleep off the acute effects of substances and access other recovery-based care, such as case management and access to behavioral health treatment services or access to medical services; individuals who need pre-crisis support services to help prevent civil commitment under the Involuntary Treatment Act (ITA) or other preventable hospitalizations; individuals with behavioral health challenges experiencing homelessness who can use drop-in services and connect with housing resources and/or housing case management, health benefit/entitlements enrollment, and connections to other supportive resources needed to remain stable and crisis-free.

2. Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection:

South County

Individuals in South King County would have a place to be taken when coming into contact with first responders other than jail or a preventable Emergency Room visit. This would prevent criminal justice involvement and a criminal record that would potentially create barriers to housing and employment access in the future. There is no current crisis diversion facility or sobering support services program in South King County. In order to utilize the services of the programs that exist in King County, first responders and other referring partners need to transport individuals to Seattle. This has a significant impact on utilization by South County first responders due to the time it removes them from their duties in their community, despite the need for such services for residents of South County.

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Auburn Police Department personnel have stated that having access to a local resource would benefit officers. Law enforcement officers in Auburn have already responded to over 500 calls regarding individuals with mental health needs in 2015, and that number does not include calls where mental health and/or SUDs were identified upon arrival at the scene but were not the focus of the initial call for service¹⁹. Kent Police Department (PD) has expressed similar interest in a program located closer to their jurisdiction. In 2014, Kent PD responded to and referred 650 individuals to local EDs for involuntary commitment evaluations, and as of December 2015, this number is already at 700. These numbers only include involuntary commitment referrals, and do not include individuals who were taken to jail, or responded to and referred to other services, for whom behavioral health issues were noted.²⁰

Most agencies do not collect data on behavioral health needs if the focus or disposition of the call includes another primary outcome (i. e. criminal offense resulting in jail booking or citation). However, the Seattle Police Department (SPD) implemented a data collection crisis template on May 15, 2015 to gather information about all interactions between officers and individuals in crisis regardless of the focus of the call. During the initial three months after the crisis template was launched, officers responded to 2,464 crisis calls, a rate trending towards approximately 10,000 crisis calls annually.²¹ South King County's population (not including unincorporated King County) is approximately 560,000 and approximately equivalent to the City of Seattle at 616,500 residents, according to 2012 data (Source: King County Performance, Strategy and Budget office). It may be inferred that a similar number of calls for law enforcement response regarding individuals with behavioral health disorders is expected.

Additionally, when looking at the CSC program that receives referrals countywide, a total of 3,379 referrals have been from agencies within King County that are south of the Seattle city limits. Of this total, 2,099 referrals are from hospitals, 1,188 are from law enforcement and 92 are from fire departments. If we include referrals from hospitals south of King County (i.e. Pierce County) that are referring King County residents to the CSC, that total raises to 3,550 (25% of all referrals to the CSC), with 2,270 from hospitals. Total referrals to the CSC from August 2012 to September 2015 were 13,955, with 7,809 of them from hospitals, 5,068 from law enforcement, 469 from fire departments. The remaining referrals were from the Crisis Clinic (357), Designated Mental Health Professionals (DMHPs) (244), out-of-county referrals of unknown origin (8) and King County Emergency Medical Services (5), and it is unknown which part of the county these referrals were from. In addition, King County Sheriff's Office (KCSO) referrals were not included in the South County totals; many of the law enforcement referrals may have come from South King County without being identified as such (603 of the total law enforcement referrals were from KCSO, including Metro Transit and Sound Transit). There were a total of 6,909 referrals from within the city limits of Seattle, 50 percent of all referrals made. It seems apparent that location and access impacts utilization, and if a facility was built closer to referring agencies in the south end, where transportation and timelines were less of a barrier to access, referrals from South County would likely increase.

3. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.

¹⁹ Phone interview with Chief Bob Lee, December 2015

²⁰ Information provided from Lt. Scholl, Kent Police Department; December 2015

²¹ Seattle Police Department Crisis Intervention Program Quarterly Update; May 15, 2015 – August 15, 2015

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Partnerships necessary to implement this program include: all first responder agencies in South King County including law enforcement, fire departments/EMS, DMHPs, and hospitals; MRJC; SCORE and other misdemeanor jail facilities; municipal courts and prosecutors (i.e., King County District Court, which is attempting to build a community court in South King County; see BP Expanded Seattle Community Court and Implementation of South King County Community Court); community-based treatment providers; housing and shelter programs; Washington Department of Veteran Affairs; DSHS; primary care providers; transportation agencies; King County Department of Community and Human Services; Public Health – Seattle & King County; and Managed Care Organizations.

Other partnerships include the Law Enforcement Assisted Diversion (LEAD) program, which is currently looking to expand to serve the greater King County region. The LEAD program is a natural collaboration with the SCCC facility and programs, and can be utilized to assist with jail diversion opportunities, especially in providing criminal justice partner support (specifically prosecutorial and local police and KCSO) when officers opt to use this resource in lieu of arrest and potential jail booking. Addressing issues regarding warrant status and low level criminal offending behaviors outside of jails and courtrooms can be cost effective and provide options for diversion in the moment an individual has expressed interest and willingness to participate in services. This will help reduce instances of individuals cycling through re-traumatizing systems or denying them access to services due to eligibility restrictions that can be managed in a less restrictive, more therapeutic manner.

Additionally, All Home (previously the Committee to End Homelessness) has recently released a new strategic plan to address homelessness in King County. This new plan outlines an array of strategies, including advocating for more state and federal funding, increasing the stock of subsidized housing and adding shelter capacity while, at the same time, diverting people from such facilities through an intake system that is more flexible.²² The coordinated entry (CEA) approach works to apply a coordinated entry system-wide and ensure the strengths and benefits of the system are felt by all with equitable access to for all persons experiencing homelessness. The intention is to connect individuals experiencing homelessness to available housing and appropriate service options by streamlining and reducing intensive assessment and screening as much as possible and shorten the amount of time spent navigating resources and eligibility. The SCCC could be part of this approach, serving as, or coordinating with, a regional hub in South King County to connect individuals experiencing homeless to needed resources.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

Health care reform will play a significant role in the work of the SCCC. Specifically, Washington's recent application to the federal Centers for Medicare and Medicaid Services for a Section 1115 Medicaid waiver and the movement towards full integration of physical and behavioral health integration could have a great impact on the work of a potential SCCC. While the Medicaid expansion brought new health coverage that includes a mental health and SUD treatment benefit to many who lacked this resource, limitations still exist around how those benefits are provided and do not address the challenges associated with location and the ability to meet the population where they are. The work to integrate

²² Nino Shapiro, Seattle Times staff reporter; *Helping homeless: Group has new name, new strategy*, Seattle Times, originally published October 4, 2015 at 6:48 pm, updated October 5, 2015 at 10:23 am.

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physical and behavioral health will be a positive step in being able to meet individuals' needs whenever, wherever, and however works best for that person; however, limitations will still exist. The waiver will allow for new flexibilities in how care is provided to achieve better outcomes, and will further the ability of providers to be able to deliver the right care at the right time and to some extent, in the right place.

Development of the SCCC will only further enhance the ability of our community to be able to deliver the right care at the right place, when the individual needs it. The services provided through these programs are an initial step in enhancing the ability of our community to deliver services along the continuum of care, wherever an individual may be in the County, whether they are in need of immediate crisis stabilization services or are in need of connection to longer term services that help them to maintain stability. Without the benefits obtained through healthcare reform, many of these individuals would have been deemed ineligible for Medicaid or other health coverage based on exclusionary factors no longer in place and, without access to benefits, most of the more therapeutically appropriate services needed for stabilization would not have been available to them – treatment, medications, housing – and they would continue to cycle through the hospital and jail settings.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

Siting issues may impact implementation. Recent discussions in South King County regarding siting of facilities that respond to individuals with mental health and/or SUDs, for crisis or on-going services, have met with some local resistance. While both the Auburn and Kent Police Departments noted that their officers would like, and would use, a resource in the south end of the County, they also recognize community concerns regarding siting. Siting issues arose at the CSC during the implementation, and collaborative efforts were established to address community concerns regarding programmatic eligibility and neighborhood impacts. Similar neighborhood engagement, along with stigma reduction efforts, would be recommended prior to the siting of this facility. Local law enforcement, community behavioral health providers, community-based groups, local municipal governments and neighbors would be an integral part of this process.

3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?

The SCCC could have potential unintended consequences to the outpatient system capacity to respond to the influx of referrals that may occur as the result of the referrals made for individuals served through the SCCC programs. Wait times for community-based resources and services could possibly increase. There is a worker shortage and a new program could increase competition for limited staff.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

Individuals with behavioral health disorders will continue to utilize costly resources such as EDs and jails due to the symptoms of their disorder(s). Law enforcement and other first responders would have limited access to resources to assist in the field and would rely on jail and hospital settings to address the needs of this population. There continues to be focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or SUDs, as well as on how law enforcement is responding to these individuals. Without resources that officers can use as alternative options for appropriately addressing those in need, there will continue to be an over-reliance on jails and hospitals to manage this population. South County disparity in service access would continue.

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Information obtained from a fact sheet on the development of Sobering Services in Tacoma, Washington found that when an individual who has chronic homelessness and alcoholism is transported to a local emergency room, the cost incurred can range from \$1,200 to \$2,500 per incident and can utilize the services of a combined 15 professional staff from police, fire and emergency medical services.²³ This can impact service provision at local hospitals for both this population and for any other individual who is attempting to access emergency services through their local ED.

5. What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

There are programs in King County that provide similar services, specifically the CSC, URS, and the Dutch Shisler Sobering Center; however, most of them are based in downtown Seattle and, as such, less accessible in the midst of a crisis episode, or even pre-crisis, especially for individuals in South King County who have transportation needs. Many individuals who choose to live outside of the Seattle city limits are not interested in receiving services outside of their community. Providing services and supports closer to their home community can increase their likelihood of accessing these services.

Transportation is a real barrier, as many individuals do not have access to vehicles of their own, and buses are expensive for individuals without resources and bus trips are often lengthy, depending on where in the South County area the individual lives. Additionally, individuals in crisis may have difficulty managing public transportation options. Some first responders can transport individuals to facilities outside of their community; however, this reduces their availability to respond to ongoing public safety needs, sometimes for hours depending on their location and traffic. The MCT does assist with transportation; however, capacity is limited and their response times continue to grow as their popularity increases.

Outside of the services of the CSC programs and the LEAD program that currently accepts referrals from a limited number of SPD and KCSO officers, law enforcement and other first responders in the County have limited options for diversion when encountering an individual in behavioral health crisis; jails and hospitals are the only available options in the moment of the encounter beyond leaving the individual at the scene of the interaction. Hospitals have a few more options available to them including: Crisis Respite Program, which can serve 20 individuals at any time but has limited referral hours, and the Medical Respite program for individuals with co-morbid physical health needs; both are located in Seattle. There are additional programs available to hospitals; however, both the Peer Bridger program, which began within the past two years, and the Transition Support Program, which was started just over a year ago, are geared toward individuals who are discharging from inpatient psychiatric hospitals.

Enrollment in outpatient behavioral health services is another resource to help stabilize and support individuals in the community, and provide coordination of care to address unmet needs resulting in crises or behavioral problems in the community, and subsequent law enforcement response. This also include crisis response for individuals who are enrolled in the King County Behavioral Health Organization (BHO). The intent of crisis services is to respond to urgent and emergent mental health

²³ The Development of a Sobering Service in Tacoma, Washington: Sound Social and Fiscal Policy in Managing and Assisting Chronic Street Alcoholics.

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needs of persons in the community with the goal of stabilizing the individual and family in the least restrictive setting appropriate to their needs, considering individual strengths, resources, and choice. The current crisis response system for individuals enrolled in the BHO does not require an outreach to the community to assess the individual's needs or determine what services and supports could be provided to assist the individual with remaining in the community. Additionally, many contracted providers subcontract their crisis response services to other agencies, which often includes telephone access only to an individual, with limited outreach availability into the community to directly address a crisis need, and with little direct knowledge about the individual. Finally, enrollment in the BHO is limited to individuals eligible for publicly funded behavioral health services, and there are limited response options for other populations in need.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

When the programs of the CSC were initially identified as a strategy under the MIDD, they were done in line with the SIM, understanding that the earlier individuals can be intervened within their own communities, the more likely they were to stay out of the crisis and criminal justice systems and get the ongoing help they need. The SCCC falls in this model as an initial step in the continuum of care, intended to provide immediate crisis stabilization services and to promote access to community-based services. The SCCC will work with the understanding that recovery can take time, and often requires continued and long-term efforts on the part of first responders and service providers, to support the recovery process. The CSC was intended to specifically link with other County Council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.

The services at the Dutch Shisler Sobering Center are also a critical part of the continuum of care for individuals with the most chronic SUDs. These services are effective in assisting people into recovery systems that help them access case management services, find suitable housing, and access preventative health care. These services limit the visibility of public intoxication, limit the cost of treating people in EDs and jail, and free police and fire for other community work.²⁴

All programs of the SCCC should link with Behavioral Health Integration, especially given the high levels of co-occurring disorders in the population served, which will allow for more integrated and hopefully streamlined access to services. This program already has removed barriers to access by allowing individuals in behavioral health crisis, regardless of whether the crisis is related to mental health, substance use or co-occurring disorders.

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

The intent of the programs at the SCCC would be on meeting the individual where they are, rather than expecting the individual to be ready for services, housing, etc. The recovery aspect would be indicated in the expectation that the SCCC will work with individuals on a repeat basis in order to work on

²⁴ Ibid, DCHS Program Sheet: DETOX/SOBERING/EMERGENCY SERVICES.

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motivation for treatment, while also focusing their efforts on what is important for the individual. Without basic needs being met, and a little human compassion, individuals will likely be moving from crisis to crisis, rather than moving down a path of recovery. By setting the focus on identifying and addressing the most pressing needs – such as obtaining identification, obtaining health benefits, completing housing applications, etc. – the facility will be able to take the extra steps to ensure an individual has access to services and the support they need to help them maintain stabilization.

The programs of the SCCC would utilize the resources and supports of the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC), which supports interest in developing approaches to eliminate the use of seclusion, restraints, and other coercive practices and further advance the knowledge base related to implementation of trauma-informed approaches.²⁵ Additionally, King County MHCADSD is partnering with several other County and City of Seattle departments to apply for a Train-The-Trainer Trauma Informed Care grant which includes two days of training for trainers for community based criminal justice system professionals including law enforcement, court personnel, prosecution, defense, corrections, community based providers and others on the topic of “How Being Trauma Informed Improves Criminal Justice System Responses.” This training is intended to prepare King County and Washington State to move toward implementing a trauma informed continuum of services. The primary goals of the training are to 1) increase understanding of trauma, 2) create an awareness of the impact of trauma on behavior, and 3) develop trauma-informed responses. Achieving these goals will decrease recidivism, increase safety and promote and support the recovery of justice involved persons by linking them to appropriate treatment and support services. Should King County be awarded the grant, the SCCC and interested affiliated partners (law enforcement, case manager/care management teams, etc.) would receive this invaluable training regarding providing services within the context of trauma-informed care and criminal justice.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County’s EQUITY and SOCIAL JUSTICE work?

There are long-standing, widely known issues with the lack of services and diversion opportunities available in South King County. Many people of color and low socioeconomic state reside in this part of the County and many are experiencing homelessness. Often when these individuals come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies), they are taken to jail in lieu of addressing the root cause of the matter: access to treatment, housing, jobs, support, healing and recovery, and a community of people who care and value them as people. At its founding, the diversion center in South King County addresses equity and social justice (ESJ) by allowing individuals to not be criminalized, and families torn apart, due to their social services and access needs, but rather assisted to meet and fulfill those needs.

The SCCC’s focus on promoting stability through the provision of housing services and supports is in line with the King County’s All Home initiative, which aims to make homelessness rare, brief, and a one-time occurrence by addressing crises quickly and tailoring housing and supports to individual needs,²⁶ and addresses the state of emergency regarding homelessness declared by the City of Seattle and King County in November 2015.²⁷ The individually tailored program, designed to connect people to housing

²⁵ <http://www.samhsa.gov/nctic> accessed 12/20/15.

²⁶ <http://allhomekc.org/the-plan/#fndtn-brief-and-one-time>.

²⁷ <http://www.seattletimes.com/seattle-news/politics/mayor-county-exec-declare-state-of-emergency-over-homelessness/>.

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and services, also relates to two determinants of equity identified by the King County ESJ work: access to health and human services and affordable, safe, quality housing.²⁸

The United States Department of Justice asserted in a statement of interest that “[i]t should be uncontroversial that punishing conduct that is a universal and unavoidable consequence of being human violates the Eighth Amendment...Sleeping is a life-sustaining activity—i.e., it must occur at some time in some place... Criminally prosecuting those individuals for something as innocent as sleeping, when they have no safe, legal place to go, violates their constitutional rights... Needlessly pushing homeless individuals into the criminal justice system does nothing to break the cycle of poverty or prevent homelessness in the future. Instead, it imposes further burdens on scarce judicial and correctional resources, and it can have long-lasting and devastating effects on individuals’ lives.”²⁹ Criminalizing homelessness is not the answer. Programs such as the SCCC, that work with local community partners, will help ensure individuals have the resources and services they need to obtain and maintain permanent and stable housing and reduce legal system involvement.

Additionally, a significant problem for homeless individuals is the constant concern of how to address hygiene. The simple act of washing one’s clothes, taking a shower, keeping your hands, face and body clean when living in a place without a roof, running water, electricity, or plumbing is very difficult. If someone’s only access to a bathroom is through a gas station, coffee shop or public library, life becomes very difficult. By providing free access to a safe, clean, welcoming facility, where services are provided without judgement or ideology, in a clear, consistent, respectful, fair and dignified manner, people can begin to relax and gain some peace and begin the process of establishing trust, eventually leading to possible reconnection with services.

The SCCC would focus on both reducing the criminalization of behavioral health disorders, and reducing the reliance on jails and hospitals to address a community need. The program would be staffed to include trained and certified peer counselors to assist with the individual’s engagement and to promote the recognition that recovery is possible, in part through hiring staff that identify as being consumers of mental health services. Peer counselors bring a level of understanding and empathy to help individuals engage with services and to reduce those individuals from feeling alone or different from others. The program will also work to coordinate and collaborate with a wide variety of systems and community supports that have not been available or responsive to individuals’ needs, and work to break down barriers to access that may have prevented successful interactions with community based services.

Provide an Equity and Social Justice Framework for Services Provided under SCCC

Programs must ensure to track disproportionality as well as commit to having active and open conversations about race, take note of the White people in power/decision-making positions, especially White men; track if individuals served in outreach programs (various interventions listed above) are involved in program implementation planning and, if not, make active efforts to remedy; ensure that race and racism, disability and homelessness are understood and honest conversations about what equity means, what being culturally responsive means, and remaining committed to continuous improvement.

²⁸ http://www.kingcounty.gov/~media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en .

²⁹ *Bell v. City of Boise et al.* was filed in the District of Idaho in 2009. United States Department of Justice **STATEMENT OF INTEREST OF THE UNITED STATES** Case 1:09-cv-00540-REB Document 276 Filed 08/06/15, page 3 of 17.

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F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)?

All aspects of establishing a new facility-based program would be required including: a physical space, staff, training, showers, washers/dryers, furniture, kitchen, vehicles, and licensing and certification through state agencies. Additionally, cooperative agreements for outside agencies to provide services on-site (such as DSHS benefits, housing applications, primary care services/pharmacy coordination, and withdrawal management) will be needed.

2. Estimated ANNUAL COST. More than \$5 million Provide unit or other specific costs if known.

The current budget for the URS Hygiene center is \$855,000, including staffing, program, and facility costs. The facility is open seven days per week, with 16 hours of service on week days and 10 hours of service on weekends, and is equipped with five individual shower rooms, two public restrooms, nine double stacked washer/dryers, and three double stacked dryers. The URS program serves between 2,500-4,000 unduplicated individuals per year.

The annual budget for the current MCT is \$1,569,514, which includes 25 mental health clinicians who are also chemical dependency professionals/trainees who provide 24/7 coverage across King County. Expecting that the addition of this program would not need an additional 25 clinicians to meet the need if the services and supports are dedicated to South King County, a revised budget could be assumed at \$800,000, for a team of 13. The budget for the MCT also includes shared facility and overhead costs. In 2014, the MCT received 2,016 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3,070 referrals. The annual budget for the CDF is \$3,515,143, which includes a minimum staff to participant ratio of one to four. Actual CDF costs have been running on average about \$2,900,000 per year, with the highest cost in 2014 of \$3,157,774; thus, an anticipated annual budget is estimated at \$3,200,000. The budget for the current CDF also includes shared facility and overhead costs. In 2014, the CDF received 3,389 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3,280 referrals.

The current budget for the Dutch Shisler Sobering Center, which provides sobering support and case management services, is approximately \$1,500,000 per year. In 2014, the sobering center served 2,059 (duplicated individuals) and is on track in 2015 to serve approximately 1,945.

A potential small scale implementation pilot could include the MCT, CDF and Sobering components. Full scale implementation would include MCT, CDF, Sobering, and Drop-in center/Hygiene Facility components. The anticipated numbers served per year are duplicated across programs as many individuals will likely access multiple programs.

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

There may be some other funding sources available to support some portion of services at the CDF portion of the program. It could be licensed and certified as a Residential Treatment Facility by the State of Washington in order to potentially utilize Medicaid funds to support individuals who are eligible for Medicaid funding when receiving services that are billable under that funding source. However, this would limit capacity to 16 beds due to the Medicaid Institutions for Mental Diseases exclusion.³⁰

³⁰ http://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf accessed 12/20/15.

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4. TIME to implementation: 6 months to a year from award

a. What are the factors in the time to implementation assessment?

Siting issues are potentially a factor; there have been recent episodes of resistance to siting behavioral health programs in South King County in the past few months, including the campus-style Woodmont Project and opiate substitution treatment programs. King County MHCADSD management, neighborhood groups, local community leaders and elected officials, and provider agencies will need to be involved in the development and siting process, as well as educational campaigns regarding behavioral health disorders and stigma. Additionally, implementation will be impacted by the construction or renovation of a facility that can support the programmatic needs. Depending on the extent of renovations or constructions, local permitting may also impact implementation and push the project out beyond a year from award.

b. What are the steps needed for implementation?

The creation of an interagency planning group will be needed to develop programmatic expectations and develop a Request for Proposal (RFP). Scheduling of south-end community meetings to provide education about the SCCC and allow an opportunity for stakeholders to give feedback and identify concerns. After an RFP is awarded, a location will need to be identified; plans for construction will need to be developed; and a general contractor will need to be procured. The agency or agencies awarded the program components will need to hire and train staff prior to the facility opening.

c. Does this need an RFP?

Yes.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

This program links to multiple other briefing papers in regards to the focus on diversion and care coordination programs, including: BP 16 Immediate Community Care for Individuals Experiencing a Mental Health Emergency; ES 17a, BP 4 Crisis Intervention Team-Mental Health Partnership; ES 1b BP 34 39 72 Outreach System of Care; ES 10b Crisis Diversion Facility; BP 114 Familiar Faces; and BP 61 Expanded Seattle Community Court and Implementation of South King County Community Court.

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Concept 37

Working Title of Concept: South County Diversion Service Expansion

Name of Person Submitting Concept: Jesse Benet, Dan Floyd, Brad Finegood, Travis Erickson, Susan Schoeld

Organization(s), if any: King County MHCADSD and Public Health—Seattle & King County

Phone: 206-263-8956

Email: jesse.benet@kingcounty.gov

Mailing Address: 401 5th Avenue, Ste. 400, Seattle, WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.

*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.

Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Provide a Crisis Diversion multi-service center in the southern region of King County that has multiple co-located on-site services to both serve individuals in behavioral health crisis who are coming into contact with south King County first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This aligns with the Campus of Health aspect of the Familiar Faces future state vision (see attached) and allows for a co-location of many crisis receiving and stabilization services:

- On-site respite/crisis diversion
- Mobile crisis teams
- On-Site Sobering Services
- On-Site Withdrawal Management services
- On-site community/living room trauma-informed space for pre-crisis/crisis prevention time, peer ran groups, drop-in
- Overnight and short-term stay options
- Place for care management teams/case managers to meet with individuals
- Transportation and reentry support/access
- Housing supports and access
- Primary Care services on-site and coordination of ongoing access

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

This addresses a lack of resource and diversion in South King County for first responders working in many of the jurisdiction and unincorporated areas of the County that are centered/near Kent, Auburn, Renton and Federal Way. Law enforcement in these jurisdictions have limited options for taking individuals in any kind of behavioral health crisis or need for sobering to any location, but jail, so many individuals unnecessarily wind up in the Kent City Jail or SCORE Misdemeanor Jail instead. Current options require law enforcement officers to either drive into Seattle, which takes them off the streets and away from their duties for long periods of time; or potentially wait hours for a response from the Mobile Crisis Team. Additionally, this concept provides for a drop-in component that individuals to access without needed to been engaged with first responders, and where assistance can be provided for individual in a more preventative or early intervention manner. This drop-in component will also allow for less demand on our first responders if individuals are able to access the help they need, when they need it.

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3. How would your concept address the need?

Please be specific.

By providing an alternative to jails and emergency departments in the moment of crisis/contact with first responders, and then a focus on reentry support, linking individuals with behavioral health treatment, primary care and housing services with a warm hand-off, whenever needed. Ideally, and depending on the level of ongoing care and support an individual needs, they will be linked with a community-based integrated care management team that is working closely with diversion center staff and is able to provide services on-site at the diversion center and other community locations (the care management team model is not included in this concept paper as it is included in another concept paper as a separate strategy). This care management team or other case management services should be offering behavioral health, primary care and housing supports and linkages.

Mobile Crisis Teams:

The facility would house a Mobile Crisis Team (MCT), focused on responding to needs in the south end of King County. The team would operate 24 hours per day, seven days per week, and respond to first responder calls in the community to assist with people in mental health and substance use crisis. The MCT would be intended to be a resource for first responders that would provide crisis response and assist with stabilization services to address the need in the moment. The team would have the ability to intervene with individuals in their own communities, identify immediate resources on the scene and relieve the need for further intervention. The annual budget for the current MCT is \$1,569,514, which includes 25 mental health clinicians who are also chemical dependency professionals/trainees who provide 24/7/365 coverage across King County. Expecting that the addition of this program would not need an additional 25 clinicians to meet the need if the services and supports are dedicated to the south end of the County, a revised budget could be assumed at \$800,000, for a team of 13. The budget for the MCT also includes shared facility and overhead costs. In 2014, the MCT received 2016 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3070 referrals.

Crisis Diversion Facility:

Additionally, a Crisis Diversion Facility (CDF) program would be available for longer-term crisis stabilization needs. The CDF would include a 16 bed facility that would accept people age 18 and over in mental health and substance abuse crisis in order to divert them from the jail and hospitals. The facility would accept individuals 24 hours a day, 7 days a week, and individuals can stay for up to 72 hours. Individuals arriving at the facility would be able to be evaluated within three hours, with some being linked directly to services and released while others are admitted to the CDF. Services at the CDF would include crisis and stabilization services, case management, needs assessments, and linkage with community-based services. The annual budget for the CDF is \$3,515,143, which includes a minimum staff to individual ratio of 1:4. Actual CDF costs have been running on average about \$2,900,000 per year, with the highest cost in 2014 of \$3,157,774; so an anticipated budget could be estimated at \$3,200,000. The budget for the current CDF also includes shared facility and overhead costs. In 2014, the CDF received 3389 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3280 referrals.

Drop-in Center/Harm Reduction Space:

This facility/campus would also provide space for individuals to go in a pre-crisis/preventative mode in terms of a "drop-in" center type of setting, staffed with peer support or even individuals in recovery who want to volunteer/participate in helping others experiencing behavioral health challenges/crises, creating both a peer specialist role/jobs and peer mentoring opportunities that support recovery and

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help individuals build new community, especially if they do not have a supportive/accessible one to “reenter.” The drop-in would also provide space to address personal hygiene (e.g. showers) in a gender neutral manner (single stall) in order to prevent sex segregation and marginalization of transgender and gender nonconforming people. Laundry facilities and access to meals and snacks on-site would also be part of the drop-in setting. Other services on-site would include In-Person Assistor service to help with Apple health Medicaid enrollment and on-site entitlement assistance from Washington State Department of Social and Health Services to help with access to food stamps, Housing and Essential Need (HEN) benefits Aged, Blind and Disabled (ABD) benefits, and facilitated access to Social Security Administration benefits (SSI, SSDI) for those who are eligible for these various entitlements. Transportation assistance (bus passes, taxi scripts and gas cards) will also be provided. Additional information is needed to identify the anticipated budget and numbers served for this portion of the program.

Sobering Center:

Sobering services strengthen the availability, quality, and coordination of services for homeless persons with chronic substance use disorders. They serve as a safe and secure place for persons to sleep off the acute effects of intoxication and as a recovery access point where people receive case management services, outpatient behavioral health treatment, and assistance to move towards greater self-determination. Services are designed as low barrier, so people can access them without regard to funding or motivation for change. There would also be plenty of meeting space within the Sobering area or other community spaces for on-site culturally specific services and faith-based organizations to offer classes or on-site support and other types of resource-oriented, culturally responsive and trauma-informed settings to support stability, de-escalations and embrace recovery and connectivity. The current budget for Dutch Shisler Sobering Center (DSSC) which provides sobering, support and outpatient treatment services, along with case management services, is approximately \$1,500,000. In 2014, the DSSC served 2059 (duplicated individuals), and is on track in 2015 to serve approximately 1945.

In regards to question 9 below:

Small scale implementation includes the Mobile Crisis Team, Crisis Diversion Facility and Sobering components.

Full scale implementation would include MCT, CDF, Sobering and Drop-in center/Hygiene Facility components.

Anticipated number served would be duplicated across programs.

4. Who would benefit? Please describe potential program participants.

Individuals in South King County, especially in the cities of Kent, Auburn, Renton and Federal Way, would have a place to be taken when coming into contact with first responders, other than jail or a preventable Emergency Room visit. This would prevent criminal justice involvement and a record that would create barriers to housing and employment access.

Specifically, the following individuals would be served:

- Familiar Faces residing in or coming into contact with first responders in, South King County, who can be diverted from another jail booking in the MRJC, SCORE or Kent City Jail.
- Individuals in need a place to sleep off the acute effects of substances and access other recovery-based care, such as case management and access to behavioral health treatment services or access to

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medical services.

- Individuals who are enrolled in BHO services and need a pre-crisis support in order to prevent a possible civil commitment/ITA or other preventable medical hospitalizations.
- Individuals experiencing homelessness who can use drop-in services and connect with housing resources and/or housing case management, Apple health enrollment and connections to other supportive resources needed to remain stable and crisis-free.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

- A reduction in the annual number of Familiar Faces cycling through our jails in King County, specifically the jails in South King County or those individuals existing in South King County areas who are Familiar Faces
- Increased access and penetration of individuals in South King County to behavioral health services
- Increased access of South King County individuals to access primary care and Apple health enrollment
- Reduced deaths in South King County due to behavioral health conditions and/or chronic homelessness
- Increased diversion access and system response for criminal justice stakeholders based in South King County, thus reducing the number of people with behavioral health conditions in our South King County jails.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

- ☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

There are long-standing, widely known issues with the lack of services and diversion opportunities available in the south region of King County. Many people of color and poor people reside in this part of the County and many are experiencing homelessness. Often, when these individuals come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies) they are taken to jail in lieu of addressing the root cause of the matter: access. Access to treatment, housing, jobs, support, healing and recovery and access to community of people who care and value them as people. At its founding, this diversion center in South King County addresses equity and social justice and appropriate access to justice but allowing individuals to not be criminalized and families be torn apart, for their social services needs/access needs, but rather be assisted to meet and fulfill those needs.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

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Regional partnerships with King County health, human services and criminal justice agencies with both human services and criminal justice, especially law enforcement and prosecutors, from the municipal jurisdiction in King County. Managed Care Organizations providing Medicaid (Apple Health) can be engaged to participate in care coordination and may be a source of important data to do this.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: \$ 5,000,000 per year, serving 8000 duplicated people per year

Partial Implementation: \$ per year, serving people per year

Full Implementation: \$ Unknown per year, serving # of people here people per year

Concept 51 (Duplicative submission of Concept 37)

Working Title of Concept: South County Diversion Service Expansion

Name of Person Submitting Concept: Jesse Benet, Dan Floyd, Brad Finegood, Travis Erickson, Susan Schoeld

Organization(s), if any: King County MHCADSD and Public Health—Seattle & King County

Phone: 206-263-8956

Email: jesse.benet@kingcounty.gov

Mailing Address: 401 5th Avenue, Ste. 400, Seattle, WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.

*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.

Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Provide a Crisis Diversion multi-service center in the southern region of King County that has multiple co-located on-site services to both serve individuals in behavioral health crisis who are coming into contact with south King County first responders, as well as those individuals in South King County who may need a location for preventative and pre-crisis support and/or outreach. This aligns with the Campus of Health aspect of the Familiar Faces future state vision (see attached) and allows for a co-location of many crisis receiving and stabilization services:

- On-site respite/crisis diversion
- Mobile crisis teams
- On-Site Sobering Services
- On-Site Withdrawal Management services
- On-site community/living room trauma-informed space for pre-crisis/crisis prevention time, peer ran groups, drop-in
- Overnight and short-term stay options
- Place for care management teams/case managers to meet with individuals
- Transportation and reentry support/access
- Housing supports and access
- Primary Care services on-site and coordination of ongoing access

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

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This addresses a resource and diversion lack in South King County for first responders working in many of the jurisdiction and unincorporated areas of the County that are centered/near Kent, Auburn, Renton and Federal Way. Law enforcement in these jurisdictions have limited options for taking individuals in any kind of behavioral health crisis or need for sobering to any location, but jail, so many individuals unnecessarily wind up in the Kent City Jail or SCORE Misdemeanor Jail instead. Current options require law enforcement officers to either drive into Seattle, which takes them off the streets and away from their duties for long periods of time; or potentially wait hours for a response from the Mobile Crisis Team.

3. How would your concept address the need?

Please be specific.

By providing an alternative to jails and emergency departments in the moment of crisis/contact with first responders, and then a focus on reentry support, linking individuals with behavioral health treatment, primary care and housing services with a warm hand-off, whenever needed. Ideally, and depending on the level of ongoing care and support an individual needs, they will be linked with a community-based integrated care management team that is working closely with diversion center staff and is able to provide services on-site at the diversion center and other community locations (the care management team model is not included in this concept paper as it is included in another concept paper as a separate strategy). This care management team or other case management services should be offering behavioral health, primary care and housing supports and linkages.

Mobile Crisis Teams:

The facility would house a Mobile Crisis Team (MCT), focused on responding to needs in the south end of King County. The team would operate 24 hours per day, seven days per week, and respond to first responder calls in the community to assist with people in mental health and substance use crisis. The MCT would be intended to be a resource for first responders that would provide crisis response and assist with stabilization services to address the need in the moment. The team would have the ability to intervene with individuals in their own communities, identify immediate resources on the scene and relieve the need for further intervention. The annual budget for the current MCT is \$1,569,514, which includes 25 mental health clinicians who are also chemical dependency professionals/trainees who provide 24/7/365 coverage across King County. Expecting that the addition of this program would not need an additional 25 clinicians to meet the need if the services and supports are dedicated to the south end of the County, a revised budget could be assumed at \$800,000, for a team of 13. The budget for the MCT also includes shared facility and overhead costs. In 2014, the MCT received 2016 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3070 referrals.

Crisis Diversion Facility:

Additionally, a Crisis Diversion Facility (CDF) program would be available for longer-term crisis stabilization needs. The CDF would include a 16 bed facility that would accept people age 18 and over in mental health and substance abuse crisis in order to divert them from the jail and hospitals. The facility would accept individuals 24 hours a day, 7 days a week, and individuals can stay for up to 72 hours. Individuals arriving at the facility would be able to be evaluated within three hours, with some being linked directly to services and released while others are admitted to the CDF. Services at the CDF would include crisis and stabilization services, case management, needs assessments, and linkage with community-based services. The annual budget for the CDF is \$3,515,143, which includes a minimum staff to individual ratio of 1:4. Actual CDF costs have been running on average about \$2,900,000 per year, with the highest cost in 2014 of \$3,157,774; so an anticipated budget could be estimated at \$3,200,000. The budget for the current CDF also includes shared facility and overhead costs. In 2014, the

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CDF received 3389 referrals (duplicated individuals), and is on track in 2015 to receive approximately 3280 referrals.

Drop-in Center/Harm Reduction Space:

This facility/campus would also provide space for individuals to go in a pre-crisis/preventative mode in terms of a “drop-in” center type of setting, staffed with peer support or even individuals in recovery who want to volunteer/participate in helping others experiencing behavioral health challenges/crises, creating both a peer specialist role/jobs and peer mentoring opportunities that support recovery and help individuals build new community, especially if they do not have a supportive/accessible one to “reenter.” The drop-in would also provide space to address personal hygiene (e.g. showers) in a gender neutral manner (single stall) in order to prevent sex segregation and marginalization of transgender and gender nonconforming people. Laundry facilities and access to meals and snacks on-site would also be part of the drop-in setting. Other services on-site would include In-Person Assistor service to help with Apple health Medicaid enrollment and on-site entitlement assistance from Washington State Department of Social and Health Services to help with access to food stamps, Housing and Essential Need (HEN) benefits Aged, Blind and Disabled (ABD) benefits, and facilitated access to Social Security Administration benefits (SSI, SSDI) for those who are eligible for these various entitlements. Transportation assistance (bus passes, taxi scripts and gas cards) will also be provided. Additional information is needed to identify the anticipated budget for this portion of the program.

Sobering Center:

Sobering services strengthen the availability, quality, and coordination of services for homeless persons with chronic substance use disorders. They serve as a safe and secure place for persons to sleep off the acute effects of intoxication and as a recovery access point where people receive case management services, outpatient behavioral health treatment, and assistance to move towards greater self-determination. Services are designed as low barrier, so people can access them without regard to funding or motivation for change. There would also be plenty of meeting space within the Sobering area or other community spaces for on-site culturally specific services and faith-based organizations to offer classes or on-site support and other types of resource-oriented, culturally responsive and trauma-informed settings to support stability, de-escalations and embrace recovery and connectivity. The current budget for Dutch Shisler Sobering Center (DSSC) which provides sobering, support and outpatient treatment services, along with case management services, is approximately \$1,500,000. In 2014, the DSSC served 2059 (duplicated individuals), and is on track in 2015 to serve approximately 1945.

In regards to question 9 below:

Small scale implementation would include the Mobile Crisis Team and the Crisis Diversion Facility components.

Partial implementation would include MCT, CDF and the Sobering Center components.

Full scale implementation would include MCT, CDF, Sobering and Drop-in center/Hygiene Facility components.

Anticipated number served would be duplicated across programs.

4. Who would benefit? Please describe potential program participants.

Individuals in South King County, especially in the cities of Kent, Auburn, Renton and Federal Way, would have a place to be taken when coming into contact with first responders, other than jail or a preventable Emergency Room visit. This would prevent criminal justice involvement and a record that would create

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barriers to housing and employment access.

Specifically, the following individuals would be served:

- Familiar Faces residing in or coming into contact with first responders in, South King County, who can be diverted from another jail booking in the MRJC, SCORE or Kent City Jail.
- Individuals in need a place to sleep off the acute effects of substances and access other recovery-based care, such as case management and access to behavioral health treatment services or access to medical services.
- Individuals who are enrolled in BHO services and need a pre-crisis support in order to prevent a possible civil commitment/ITA or other preventable medical hospitalizations.
- Individuals experiencing homelessness who can use drop-in services and connect with housing resources and/or housing case management, Apple health enrollment and connections to other supportive resources needed to remain stable and crisis-free.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

- A reduction in the annual number of Familiar Faces cycling through our jails in King County, specifically the jails in South King County or those individuals existing in South King County areas who are Familiar Faces
- Increased access and penetration of individuals in South King County to behavioral health services
- Increased access of South King County individuals to access primary care and Apple health enrollment
- Reduced deaths in South King County due to behavioral health conditions and/or chronic homelessness
- Increased diversion access and system response for criminal justice stakeholders based in South King County, thus reducing the number of people with behavioral health conditions in our South King County jails.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

- ☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

There are long-standing, widely known issues with the lack of services and diversion opportunities available in the south region of King County. Many people of color and poor people reside in this part of the County and many are experiencing homelessness. Often, when these individuals come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies) they are taken to jail in lieu of addressing the root cause of the

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matter: access. Access to treatment, housing, jobs, support, healing and recovery and access to community of people who care and value them as people. At its founding, this diversion center in South King County addresses equity and social justice and appropriate access to justice but allowing individuals to not be criminalized and families be torn apart, for their social services needs/access needs, but rather be assisted to meet and fulfill those needs.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Regional partnerships with King County health, human services and criminal justice agencies with both human services and criminal justice, especially law enforcement and prosecutors, from the municipal jurisdiction in King County. Managed Care Organizations providing Medicaid (Apple Health) can be engaged to participate in care coordination and may be a source of important data to do this.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: \$ 4,000,000 per year, serving 6300 duplicated people per year

Partial Implementation: \$ 5,500,000 per year, serving 8300 duplicated people per year

Full Implementation: \$ Unknown per year, serving # of people here people per year

Concept 64

Working Title of Concept: Kent Crisis Center

Name of Person Submitting Concept: Sonia Handforth-Kome

Organization(s), if any: Valley Cities

Phone: 206/605-9368

Email: shandforth-kome@valleycities.org

Mailing Address: 325 West Gowe Street Kent, WA 98032

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.

*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.

Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Valley Cities would like MIDD funding to establish a Crisis Center in Kent, Washington for residents of South King County who are suffering from severe mental illness and/or substance abuse or are in the midst of a crisis. . The Kent Crisis Center would be a new resource for South King County police, medics, mental health professionals and other first responders to use for individuals who are in crisis and might otherwise receive no help, or be taken to jail or a hospital emergency department. In addition consumers can self refer. The Kent Crisis center would operate 24/7, employ professional staff with a heavy emphasis on employed peers and have the capacity of 32 beds..

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

Our jails and emergency rooms and hospitals are over capacity. Many adults who find themselves in difficult situations could have resolution without entering these systems. A crisis center in South King County would assist in alleviating the pressure on police, first responders, and emergency rooms as an alternative to booking and boarding. In addition many consumers, who are well versed in these systems

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and have experienced the difficulty in accessing care without the loss of their rights, are deterred from using them. Consumer choice and voice to come to the center voluntarily could prevent hospitalizations.

3. How would your concept address the need?

Please be specific.

Currently there is not a crisis center in south King County that can address the needs of adults suffering from a mental health and/or substance abuse crisis that operates 24 hours a day/7 days a week and is staffed with trained professionals.

4. Who would benefit? Please describe potential program participants.

Adults who are over the age of 18 who are experiencing a crisis and live in South King County.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

We would collate data already collected from first responders, hospitals, jails and the county and would expect a decrease in the number of adults hospitalized and incarcerated in South King County. Quality Improvement projects would be centered around recidivism rates.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

- ☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Adults suffering from a severe mental illness or substance abuse problem who are in crisis are unjustly criminalized and stereotyped. It is not okay to lose your right to freedom because you are in crisis. This is fundamentally wrong.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Partnerships with all first responders in South King County will be critical as well as partnerships with area service providers. In addition we will partner with SCORE and the courts to identify those who would be better served in the crisis center.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: \$ # of dollars here per year, serving # of people here people per year
Partial Implementation: \$ # of dollars here per year, serving # of people here people per year
Full Implementation: \$ # of dollars here per year, serving # of people here people per year

#66

Working Title of Concept: South King County Crisis Center

Name of Person Submitting Concept: Sonia Handforth-Kome

Organization(s), if any: Valley Cities

Phone: 206/605-9368

Email: shandforth-kome@valleycities.org

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Mailing Address: 325 West Gowe Street Kent, WA 98032

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.

*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.

Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Valley Cities would like MIDD funding to establish a Crisis Center in South King County who are suffering from severe mental illness and/or substance abuse or are in the midst of a crisis. . The Crisis Center would be a new resource for South King County police, medics, mental health professionals and other first responders to use for individuals who are in crisis and might otherwise receive no help, or be taken to jail or a hospital emergency department. In addition consumers can self-refer. The Crisis Center would operate 24/7, employ professional staff with a heavy emphasis on employed peers and have the capacity of 32 beds.

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

Our jails and emergency rooms and hospitals are over capacity. Many adults who find themselves in difficult situations could have resolution without entering these systems. A crisis center in South King County would assist in alleviating the pressure on police, first responders, and emergency rooms as an alternative to booking and boarding. In addition many consumers, who are well versed in these systems and have experienced the difficulty in accessing care without the loss of their rights, are deterred from using them. Consumer choice and voice to come to the center voluntarily could prevent hospitalizations.

3. How would your concept address the need?

Please be specific.

Currently there is not a crisis center in South King County that can address the needs of adults suffering from a mental health and/or substance abuse crisis that operates 24 hours a day/7 days a week and is staffed with trained professionals.

4. Who would benefit? Please describe potential program participants.

Adults who are over the age of 18 who are experiencing a crisis and live in South King County.

5. What would be the results of successful implementation of program?

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

We would collate data already collected from first responders, hospitals, jails and the county and would expect a decrease in the number of adults hospitalized and incarcerated in South King County. Quality Improvement projects would be centered around recidivism rates.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

- ☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

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Adults suffering from a severe mental illness or substance abuse problem who are in crisis are unjustly criminalized and stereotyped. It is not okay to lose your right to freedom because you are in crisis. This is fundamentally wrong.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Partnerships with all first responders in South King County will be critical as well as partnerships with area service providers. In addition we will partner with SCORE and the courts to identify those who would be better served in the crisis center.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: \$ # of dollars here per year, serving # of people here people per year
Partial Implementation: \$ # of dollars here per year, serving # of people here people per year
Full Implementation: \$ # of dollars here per year, serving # of people here people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to MIDDConcept@kingcounty.gov, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at MIDDConcept@kingcounty.gov.