MIDD Briefing Paper

BP 100 Developmental Disabilities Crisis Diversion Housing

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: New Concept

SUMMARY:
This concept expands the number of crisis diversion beds for adult individuals with developmental disabilities from four to eight. The base program is funded by the Washington State Department of Social and Health Services (DSHS)/Developmental Disabilities Administration (DDA). This concept would add beds and move them beds from Cascade Hall to four co-located apartment units, with two bedrooms in each apartment. It would increases staff ratios in order to accommodate individuals with more challenging behaviors, and offers access to crisis beds to individuals with developmental disabilities who have law enforcement contacts, opening up the use of these beds as a pre-booking diversion option.

Collaborators:

Name	Department
Dan Peterson	WA State Developmental Disabilities Administration

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization

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

This concept expands the number of crisis diversion beds for adult individuals with developmental disabilities from four to eight. The base program is funded by the Washington State Department of

Social and Health Services (DSHS)/Developmental Disabilities Administration (DDA). This concept would add beds and move them beds from Cascade Hall to four co-located apartment units, with two bedrooms in each apartment. It would increases staff ratios in order to accommodate individuals with more challenging behaviors, and offers access to crisis beds to individuals with developmental disabilities who have law enforcement contacts, opening up the use of these beds as a pre-booking diversion option.

The proposal leverages existing monies from DSHS for DDA contracted crisis diversion housing in King County with new County MIDD II monies to expand the program. It simplifies referral protocols to promote access within a couple of hours instead of a day or two, reducing the time individuals wait in emergency rooms and making pre-booking diversion options viable for system partners. The New Concept strengthens partnerships with law enforcement, Law Enforcement Assisted Diversion (LEAD) staff, Crisis Solutions Center staff, King County Designated Mental Health Professionals, hospital emergency rooms and mental health crisis outreach teams to facilitate accessible referral procedures to these beds.

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):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☐ **System Improvements**

   Please describe the basis for the determination(s).

The Crisis Diversion Housing program would provide a resource and crisis diversion alternative to booking or hospitalizing an individual with a developmental disability when coming into contact with law enforcement or other first responders. It provides early intervention for individuals with developmental disabilities who are in crisis and in need of increased staffing and stabilization in a safe and secure environment. Individuals can be served in this model rather requiring hospitalization or committing a crime due to difficulties with impulse control.

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 individuals with intellectual and developmental disabilities (I&DDs) coming into contact with law enforcement are less culpable for their behaviors due to neurological, emotional, and intellectual conditions that impede the capacity for impulse control and an understanding of cause and effect. Such individuals exhibiting challenging behaviors are sometimes taken into custody rather than diverted to an emergency room for evaluation, even if there are crisis plans and behavior plans recommending an alternative to incarceration. Local jails have challenges housing vulnerable individuals. These cases can potentially tie up the courts when competency issues are raised, extending the length of jail stays. Individuals with I&DDs for the most part do not obtain behavioral and medical/psychiatric interventions in jail that may better address their issues.

Some individuals with I&DDs may exhibit symptoms of a mental disorder as defined in Chapter 71.05 Revised Code of Washington,[1] potentially meeting criteria for an involuntary civil admission at an evaluation and treatment (E&T), psychiatric unit at a hospital, or in an involuntary single bed certification in a medical hospital. Although short-term containment to prevent harm is sometimes needed, the diagnosis and treatment of individuals with developmental disabilities in inpatient settings is especially challenging. Individuals with developmental disabilities have a substantially higher number of medical conditions, are at substantially increased risk of abuse and exploitation, and are more apt to have neurological and/or genetic conditions, all of which can contribute to the observed symptoms leading to hospitalization.

Individuals with I&DDs present with substantially higher rates of mental disorders[2] that might elicit law enforcement contacts, resulting in a disproportionate rate of incarceration. The literature reflects a conservative estimate of the percentage of people with an intellectual disability and a co-morbid mental health disorder could be around 20 percent[3]. Such individuals sometimes meet the standard for involuntary detainment; however, they are often misdiagnosed. To date in 2015, 44 percent of individuals enrolled with DDA who were taken into custody in King County were charged with misdemeanor assault, and 38 percent of those arrested were found incompetent to stand trial or otherwise not adjudicated due to questions of competency.[4]

Crisis beds that are especially suited to address the support needs of individuals with I&DDs in behavioral crisis would involve trained staff who can provide informed observations that are necessary for improved diagnosis and treatment of the presenting issues, as well as a milieu conducive to crisis de-escalation. Maximum length of stay in the program would be 60 days.

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

This proposal increases options for first responders considering possible dispositions when encountering an individual with a developmental disability and a comorbid mental disorder. The resource would be available 24 hours per day/seven days per week (24/7) and, in addition to law enforcement, could be accessed via referrals from Crisis and Commitment Services and the Sound Mental Health Stabilization team. It can function as a least restrictive alternative to an involuntary detainment for some individuals with I&DDs. Additionally, it can function as an alternative to prolonged incarceration for individuals awaiting trial, or a temporary discharge setting from inpatient hospitalization for individuals who no longer benefit from inpatient hospitalization but are waiting for a safe disposition from the hospital. It provides a dedicated resource where clinical staff persons who are familiar with individuals with I&DDs, working with a psychiatric prescriber, can address unmet primary care, psychiatric, behavioral health, therapeutic and resource needs.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published

[1] http://app.leg.wa.gov/rcw/default.aspx?cite=71.05&full=true. Accessed 12/22/15.
[2] Cooper, SA et al (2007). Mental-ill health in adults with developmental disabilities: prevalence and associated factors. *British Journal of Psychiatry*, 190, 27-35.
[3] McNelis, T., Do We Need to Revisit our Concepts of Community Supports? NADD U.S. Policy Update, NADD Bulletin, Vol. XII, No. 1.
[4] Conversation with Dan Peterson, based on data kept by the Developmental Disabilities Administration, 12/18/15. Since 2002, there have been 792 incarceration events involving 192 DDA enrolled clients.

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.

Currently, the four bed crisis diversion program located at Cascade Hall operates at 95 percent capacity, and due to the vulnerability of the other residents in the facility, the program is less flexible than the expanded program being proposed. The Cascade Hall program cannot accept individuals who would be disruptive to the other residents in the facility, while the expanded program, situated in richly staffed apartment units would be designed to accept individuals with more challenging behaviors.

Crisis diversion models demonstrate cost savings as well as reduced behavioral health inpatient hospitalizations and emergency department use subsequent to treatment in crisis diversion settings: one study found that thirteen percent of individuals had a mental health specific hospitalization prior to crisis stabilization, while seven percent did following stabilization, a statistically significant difference. Also, 56 percent of patients in this cited sample had one or more emergency department visits prior to crisis stabilization, while 43 percent had at least one emergency department service following stabilization in a crisis unit, again statistically significant[5]. Literature on pre-booking diversion stabilization does not appear to exist; however, given the reduction in use of other crisis systems following a period in crisis stabilization, one could surmise that similar cost savings in jail bed days and contact with law enforcement would be evidenced.

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.**

   This approach is best categorized as an emerging practice. This approach makes fiscal and resource utilization sense, and helps to ensure that King County residents with I&DDs are identified at the point of an encounter with law enforcement and diverted whenever appropriate to a program in which they will receive services, supervision and support rather than incarceration. The prevalence rate for individuals with I&DDs is one to two percent in the general population, but four to 10 percent in prisons and jails, and incarceration does not appear to be an effective way of changing problematic behavior in this population.[6]

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?**

   DDA in King County has tracked local incarcerations of individuals with I&DDs. It would be expected to see a significant decrease in the average of annual incarceration events and total jail bed days per

[5] Bennett, A.L. & Diaz, J. (2013). Assessing the impact of crisis stabilization on utilization of healthcare services, Crisis Stabilization Claims Analysis: Technical Report.

[6] Petersilia, J. (2000). Doing Justice? Criminal Offenders with Developmental Disabilities. California Policy Research Center, Vol. 12, No. 4, pp. 1-4.

year with the implementation of a pre-booking diversion program for this population[7] The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) currently tracks all involuntary detainments for DDA enrolled clients, and could start tracking the number of inpatient days. With expanded crisis bed services, we would expect to see a possible reduction in involuntary treatment act (ITA) events and, more significantly, a reduction in local inpatient hospital bed days[8].

C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program: (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☐ **Families**
- ☐ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☒ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**
- ☐ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☒ **Women**
- ☒ **Other – Please Specify:** individuals with developmental disabilities who are eligible for DDA services, particularly individuals who may be homeless and have a mental or substance use disorder.

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 includes individuals 18 years of age or older enrolled with DDA and who can be diverted from arrest or civil involuntary detainment, or need a step down from jail or inpatient psychiatric hospitalization. The population also includes adult individuals enrolled with DDA who exhibit florid behavior that place them at risk of law enforcement contacts or civil detainment.

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: County-wide

[7] Conversation with Dan Peterson, based on data kept by the Developmental Disabilities Administration, King County DDA averages 61 incarceration events a year and in 2015, DDA enrolled clients experienced 677 bed days in jail, December 31, 2015.

[8] Conversation with Dan Peterson, based on data kept by the Developmental Disabilities Administration, there were 17 King County DDA enrolled clients who were detained under involuntary civil commitment criteria in 2015, December 31, 2015.

The proposal is for a supportive housing model within apartment buildings and, as such, will be physically located in one particular area of King County, but will have the capacity to serve individuals with intellectual and developmental disabilities (who are enrolled in DDA services) from any area in the County.

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.

DDA has successfully contracted with Community Psychiatric Clinic (CPC) for 14 years to provide crisis diversion bed services for individuals with I&DDs. During that period there were 483 crisis bed admissions and 14,604 crisis bed days provided through this contract.[9] CPC has demonstrated the skills to successfully provide crisis supports to clients with I&DDs and there is interest in continuing their involvement. DDA will continue to support their contract with Sound Mental Health (SMH) that provides crisis outreach and stabilization services for adults enrolled with DDA. MHCADSD will continue to support its contract with SMH that provides substance use disorder treatment services to individuals who are cognitively impaired and who are engaged with DDA services. Additionally, MHCADSD would look to partner with the Downtown Emergency Services Center (DESC), especially with their Crisis Solution Center (CSC) and outreach programs. MHCADSD staff will look at the protocols used by the CSC and potentially adapt them to describe who would be admitted to the crisis beds in a pre-booking diversion program – e.g., type of crime committed, degree of substance use, behavioral presentation, etc.

King County Crisis and Commitment will continue to be involved in assessing these individuals for involuntary detainment as needed. MHCADSD will remain in close contact with Public Health—Seattle & King County/Jail Health Services staff at the King County jail and contracted social workers at the South Correctional Entity (SCORE) to discuss disposition and support needs of individuals enrolled with DDA who are incarcerated. MHCADSD will continue its collaborations with local hospitals and E&T facilities to facilitate transitions from inpatient hospitalizations and continue the use of SMART911,[10] crisis plans, and collaborations with local jurisdictions that focus on reducing high utilization of first responders.

Additionally, MHCADSD will maintain collaborations with provider staff at the DESC who conduct outreach with the Seattle Police Department (SPD); collaboration with the LEAD program staff; and collaborations with SPD and other police departments within King County; Collaborations and partnerships will continue with the King County Office of the Prosecuting Attorney and with the DDA and their provider network.

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?

[9] Conversation with Dan Peterson, Division of Developmental Disabilities, December 21, 2015.
[10] http://www.kingcounty.gov/safety/E911/Smart911.aspx. Accessed 12/22/15.

The County has shown increasing interest, and is applying multiple efforts, to design new programs and initiatives to divert individuals from the criminal justice system whenever feasible and appropriate; it is hoped that doing so will be cost effective as well as a more humane response to the issue of incarcerating individuals with I&DDs for low level criminal offenses. Research indicates that individuals with I&DDs comprise one to two percent of the general population but make up four to 10 percent of the jail and prison population.[11]

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?

Multiple studies and interviews with informants indicate that it is challenging for law enforcement to identify when they are encountering an individual with an I&DD, and often these individuals are not identified as such during the court processes or when incarcerated. In order to overcome this barrier, the DDA is prepared to share a roster of enrolled individuals with mental health clinicians who provide outreach with the police departments in order to quickly identify that an individual has an I&DD and facilitate diversion of that individual to the Crisis Diversion Housing program for supervision, treatment, respite and support – rather than through the criminal justice system.

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?

In some cases an individual encountered by law enforcement is suspected of having an I&DD but, because that individual is not currently enrolled in DDA, they will not be eligible for this diversion program, creating two service standards for essentially the same population. Thus, individuals who have an I&DD who may not meet criteria for DDA enrollment will not be diverted from the criminal justice system, although they may benefit from treatment and supervision.

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?

King County will continue to incarcerate individuals with I&DDs at a disproportionate rate. There is nothing to be gained by incarcerating these individuals for low level criminal offenses and, once booked, these individuals are often victimized by other inmates. Due to their cognitive limitations, they are likely to have a difficult time understanding jail rules and may spend inordinate amounts of time in restricted housing/segregation. It is unclear as to whether incarceration is an effective strategy for changing problematic behaviors in this particular population.

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?

[11] Ibid, Petersilia, J. (2000).

Occasionally, individuals with I&DDs are diverted from arrest and taken to the Crisis Solutions Center (CSC); however, the CSC is rarely used for this population as many of these individuals have high care needs (including requiring assistance with activities of daily living), complex medical conditions, and require the expertise of clinicians who work with this population on an ongoing basis. The proposed cost of this program (to serve eight individuals) is roughly half that of the cost of eight beds at the Crisis Diversion Facility (a component of the CSC). The services for, and supervision of, individuals with I&DDs in the proposed Crisis Diversion Housing program will be more specialized and tailored to the unique cognitive and medical needs of this population.

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?

This New Concept most closely aligns with behavioral health integration efforts as well as the Health and Human Services Transformation initiatives. This Crisis Diversion Housing program allows greater flexibility in how services are provided to this vulnerable population, as well as improved health and social outcomes through improvements in coordination of care. Diverting individuals with I&DDs from the criminal justice system after they have engaged in low level criminal behavior, and placing them in a program that provides treatment, supervision, and services in their communities of support offers greater chances at stability, community tenure, and behavioral change.

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

Providing immediate linkage to services, supervision and support for individuals with I&DDs who encounter law enforcement via the commitment of a low level criminal offense is a practice rooted in principles of recovery and can prevent further trauma from occurring in their lives. These individuals, given the nature of their disabilities, often have limited impulse control and the skills necessary to mediate in stressful situations. This Crisis Diversion Housing program will immediately house, provide supervision, treatment and support for individuals with I&DDs who have encountered law enforcement and prevent them from being booked into jail and charged with low level criminal offenses, processes which often result in an individual experiencing further trauma.

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

The fact that individuals with I&DDs are incarcerated at approximately four times the rate (given prevalence numbers) is unjust. Once incarcerated, these individuals are often segregated (either due to inability to follow the rules or for their own protection) and are very often victimized by other inmates. The ability to provide supervision, treatment and support to these individuals is key to preventing recidivism and is a better solution for them (and the public) than involvement in the criminal justice system and incarceration. Individuals having difficulties with impulse control and frustration tolerance skills due to their I&DDs should not be held legally culpable for low level crimes. These individuals do not have the cognitive capacity to assist in their own defense or

understand the judicial system. Often, these individuals are not identified as having an I&DD upon encountering law enforcement or the criminal courts and jails.

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.)**?**

This proposal would utilize 15 full-time equivalents (FTEs) of clinical and residential staff, 16 hours per month of psychiatric prescribing (Physician Assistant or Advanced Registered Nurse Practitioner) staff, either four co-located two-bedroom apartments or two four-bedroom houses with funding for common utilities, food and other staples for daily living, a half-time administrator, administrative overhead (6.5%), and initial start-up funds to strengthen the facilities for crisis clients and to furnish the residences.

2. Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known. $1,390,000:

- 15 full-time equivalents (FTEs) of clinical and residential staff,
- 16 hours per month of psychiatric prescriber staff,
- Housing with funding for common utilities,
- Food and other staples for daily living,
- Half-time administrator,
- Administrative overhead (6.5%), and
- Start-up funds.

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

DDA will continue to contribute $341,000 a year, already budgeted for crisis diversion bed services in King County.

4. TIME to implementation: Less than 6 months from award

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

It is unknown whether a Request for Proposals (RFP) is required. If so, an additional four months would be needed to facilitate the process to full implementation.

b. What are the steps needed for implementation?

In order for this project to come on-line, the following would need to occur: 1) contract revision to adjust existing crisis bed contract to the model described herein; 2) obtaining crisis bed setting as described herein; 3) physical modification to ensure crisis bed setting is accessible; 4) hire and train staff for this project; 5) outreach to systems partners, especially law enforcement and Crisis and Commitment Services.

c. Does this need an RFP?

It is unknown whether an RFP is required or whether an existing contract can be amended via sole source waiver; if an RFP is required, an additional four months would be needed to facilitate the process to full implementation.

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?

DDA's contracts with SMH and CPC have been instrumental in preventing DDA enrolled individuals from being referred and admitted to Western State Hospital (WSH). Serving 30 percent of the population of Washington State within King County, these efforts, along with successful collaborations with MHCADSD system partners, have resulted in keeping long term stays for DDA enrolled individuals at WSH consistently at an average of seven individuals for the past 14 years.[12] This compares with an average of 33 individuals enrolled with DDA at State Hospitals for the rest (70%) of the State.

There is ample evidence to demonstrate that crisis intervention and diversion bed resources can reduce inpatient hospitalizations. By expanding this to also address the issue of DDA enrolled clients being taken into custody, a reduction of arrest events and jail bed days could be expected.

New Concept Submission Form

#100

Working Title of Concept: Developmental Disabilities Crisis Diversion Housing

Name of Person Submitting Concept: Michelle Bauchman, Administrator
Organization(s), if any: Region 2, Developmental Disabilities Adminstration
Phone: 206.568.5711
Email: BauchML@dshs.wa.gov
Mailing Address: Region 2 DDA Headquarters, 1700 E cherry Street, Seattle WA 98122

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.

Expand the number of crisis diversion beds for individuals with developmental disabilities from 4 to 8, and move the beds from Cascade Hall to four co-located apartment units, with two bedrooms in each apartment. Increase staff ratios in order to accommodate individuals with more challenging behaviors in the crisis beds, and offer access to these beds to individuals with developmental disabilities who have law enforcement contacts, opening up the use of these beds as a pre-booking diversion option. This option would help reduce DDA clients utilizing already overtaxed inpatient psychiatric and jail facilities where they are at risk for victimization, over medication, or where they do not receive services by staff who are familiar with the unique needs of this population. The proposed program will blend or braid together existing monies from DSHS for DDA contracted crisis diversion beds in King County with new

[12] Conversation with Dan Peterson, Developmental Disabilities Administration, December 21, 2015.

County MIDD II monies for this expanded program. It will also simplify referral protocols so that access can potentially be gained within a couple of hours instead of a day or two, reducing time individuals stay waiting in emergency rooms and making pre-booking diversion options viable for system partners.

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.

Many individuals with developmental disabilities who have law enforcement contacts are less culpable for their behaviors due to neurological, emotional, and intellectual conditions that impede the capacity for impulse control and an understanding of cause and effect. They may be exhibiting symptoms of a mental disorder as defined in RCW 71.05, and could potentially meet criteria for an involuntary civil admission at an E&T, psychiatric unit at a hospital, or in a single bed certified to hold someone involuntarily in a medical hospital. Individuals are sometimes taken into custody rather than diverted to an ER/ED for evaluation. Local jails have challenges housing vulnerable individuals. These cases tie up the courts when competency issues are raised, often extending the length of jail stays or taxing already overburdened forensic resources at state hospitals. Individuals with developmental disabilities for the most part do not obtain behavioral and medical/psychiatric interventions in jail that may better address their issues.

3. How would your concept address the need?
Please be specific.

This proposal increases options for first responders considering possible dispositions when encountering an individual with developmental disabilities exhibiting mental and/or substance use disorders. It provides a dedicated resource where clinical staff who are familiar with people with developmental disabilities, working with a psychiatric prescriber, can address unmet health, psychiatric, behavioral, therapy, and resource needs.

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

This program would target adults(18 years or older)who are eligible for DDA services, particularly individuals who may be homeless and have a mental and/or substance use disorder, as such individuals often come into contact with law enforcement and other emergency responders. The proposed program would allow for these individuals to be diverted from arrest or civil involuntary detainment, or serve as a step down from jail or inpatient psychiatric hospitalization for individuals already in the system.

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.

DDA encourages the use of SMART911, "Police and Fire Information Sheet", and Cross-Systems Crisis Plans which offer ideas to first responders about how to de-escalate behavioral issues with specific individuals or divert from an arrest. However data is not collected on pre-booking diversions. Data is collected on involuntary hospitalizations, crisis bed utilization, and incarcerations of DDA eligible individuals. Successful implementation would involve seeing a reduction in arrests, a reduction in jail bed days, and also a reduction in involuntary detainments for individuals with developmental disabilities. A baseline is available on much of this data for individuals already DDA eligible. Initial program goals would be to reduce arrests, involuntary hospitalizations, and jail bed days by 10% for DDA eligible adults in King County.

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?

Researchers conservatively estimate that approximately 15% of individuals with developmental disabilities have co-occurring mental health issues, with some estimates going as high as 30-35%. King County has an exemplary record of providing access to RSN enrollment for individuals with developmental disabilities. However, access to MH treatment for all individuals experiencing florid symptoms is limited by State funds for inpatient psychiatric care, and the fall back option is often incarceration for individuals with serious behavioral disorders. Incarceration of individuals with developmental disabilities can be especially harsh, due to the challenges of problem solving in new and chaotic circumstances, the very high risk of being targeted and victimized by others who are incarcerated, and the lack of appropriate care and intervention in jail settings. Occasionally some individuals benefit from short periods of confinement to inhibit harmful behaviors, however if it is possible to keep everyone safe with a diversion to a crisis bed, both the client and the community are better off. This concept fits directly with the goals of improving health, social, and justice outcomes for individuals with developmental disabilities.

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.

DDA has successfully contracted with Community Psychiatric Clinic (CPC) for 14 years to provide crisis diversion bed services for individuals with developmental disabilities. During that period there were 483 crisis bed admissions and 14,604 crisis bed days provided through this contract. CPC has demonstrated the skills to successfully provide skillful crisis supports to our clients. Additionally we would look to partner with DESC and any other entities involved in pre-booking diversion efforts to inform and provide training supports to law enforcement officers about the possibility of diverting individuals with developmental disabilities from an arrest. We would likely look at the protocols used for the Crisis Solution Center and perhaps adapt them to determine who would be admitted to the crisis beds – e.g. type of crime committed, degree of substance use involvement, behavioral presentation, etc. DDA has experience drawing up crisis bed contracts, however would be partnering with the County for this because of the use of blended or braided funding for this concept.

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

Pilot/Small-Scale Implementation: **$ 302,000 per year, serving 36 people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$ 1,034,000 per year, serving 80 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*.