MIDD Briefing Paper

BP 112 Existing MIDD Program/Strategy or New Concept Name: Behavioral Health Urgent Care Walk-in Clinic

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

SUMMARY: This concept would create an Urgent Care walk-in Clinic (UCC) for any adult resident of King County who is experiencing a behavioral health crisis and is in need of immediate assistance. The Clinic would be centrally located and accessible via public transportation. Individuals would self-refer by calling the Crisis Clinic's 24-hour Crisis Line or the peer-staffed Warm Line, or by coming directly to the Clinic during established business hours (seven days/week, 7am-10:30pm). No appointments will be necessary. Visitors will be encouraged to call ahead in order for UCC staff to help them get the most out of their visit, and to help determine if the UCC is the right place to meet their current needs.

Collaborators:

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

This concept would create an Urgent Care walk-in Clinic (UCC) for any adult resident of King County who is experiencing a behavioral health crisis and is in need of immediate assistance. The Clinic would be centrally located and accessible via public transportation. Individuals would self-refer by calling the Crisis Clinic's 24-hour Crisis Line or the peer-staffed Warm Line, or by coming directly to the Clinic during established business hours (seven days/week, 7am-10:30pm). No appointments will be necessary.

Visitors will be encouraged to call ahead in order for UCC staff to help them get the most out of their visit, and to help determine if the UCC is the right place to meet their current needs.

The UCC would coordinate closely with the Crisis Clinic Warm Line, which is currently open only Wednesday through Sunday nights (5pm-9pm), and is staffed by unpaid volunteers. This new proposal includes sustainable funding for the Warm Line to allow for the Crisis Clinic to employ peer specialist staff and expand Warm Line availability to seven days per week/7 hours per evening (3pm-10pm). Callers to the Warm Line needing additional support would be referred to the UCC.

The King County Urgent Care Clinic (UCC) for adults experiencing behavioral health crises will be closely modeled after the Mental Health Crisis Alliance's Urgent Care Clinic, which has been in operation in St. Paul, Minnesota for over four years (http://mentalhealthcrisisalliance.org). The Mental Health Crisis Alliance is a public-private partnership comprised of hospitals, health plans, nonprofit organizations, consumers, and three counties. The Alliance created this innovative, person-centered service based on a recovery model of care. It is a short term service designed to provide immediate relief to people in distress, and to help them maintain stability in their lives. The Alliance has received numerous awards, including the 2013 Minnesota Provider of the Year from NAMI Minnesota, the Commissioner's Circle of Excellence Award from the state's Department of Human Services, and a Local Government Innovation award from the Hubert H. Humphrey School of Public Affairs. In 2014 they received an award from the American Psychiatric Association, and the Alliance was a semi-finalist in the Innovations in American Government by the Harvard Kennedy School Government.

Like the Minnesota program, the goals of the King County UCC are to offer urgent care services to individuals experiencing a behavioral crisis to help them avoid involuntary detention, hospital emergency department (ED) visits, psychiatric inpatient stays, or involvement with law enforcement.

Services available at the King County UCC will include:

- Help with coping skills and crisis resolution planning;
- Support from peer recovery specialists who bring hope to others on their recovery journeys;
- Access to crisis psychiatry as necessary;
- Crisis stabilization services, as needed, for up to 30 days;
- Intake/referral for crisis residential services;
- Substance use disorder screening and referral;
- Family education and support;
- Referral to community services for needs beyond the immediate crisis;
- Coordination of care with an individual's current providers, as permitted by the client; and
- Crisis phone support

The King County UCC will be located in a welcoming, comfortable setting that includes an open and friendly reception area, private interview rooms, group rooms, a living room/open concept area, and a call center. It will be staffed during business hours by crisis behavioral health professionals, peer support specialists, and on-call prescriber professionals. People needing immediate medical care will be referred to EDs.

Services are voluntary and meant to be short-term, usually no more than 24 hours. Staff from the UCC will assist individuals with transition to supports and services in the community, with the goal of promoting the person's recovery and averting future need for the UCC or other more intensive services.

The creation of the King County UCC is envisioned as the first step in a longer term strategy to offer this type of service throughout the county, in various settings where both primary care and behavioral health services are available. Integrated primary care and behavioral health care Urgent Care Clinics will increase access to less intrusive and/or stigmatizing options for immediate assistance for people experiencing behavioral health challenges.

The full integration of primary care and behavioral health care is mandated to occur statewide by 2020. In King County the plan is to accelerate this transformation to fully integrated health care based on a stakeholder-designed service delivery model that is tailored for this community. Urgent Care Clinics would be one component of a comprehensive continuum of services. The first UCC will set the stage for design and implementation of additional UCC's, predicated on the learnings associated with the MIDD 2 funded UCC, and the refinement of the entire King County crisis response system for adults.

In a 2014 Substance Abuse and Mental Health Services Administration (SAMHSA) report, [1] the core crisis services in such a continuum are defined to include: 23-hour crisis stabilization/observation beds, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hot lines, warm lines, psychiatric advance directive statements, and peer crisis services. All of these formal services are currently available in one form or another in King County. An Urgent Care Center for behavioral health crises is a relatively new innovation, which combines components of 23-hour crisis stabilization beds; warm lines; advance directives and other consumer driven wellness plans; and peer crisis services.

This new concept proposal relates to: 1) existing strategy 10b, Crisis Solutions Center; 2) the proposed South County Crisis Center, which combines new concepts 37, 51, 64, 66; and, 3) existing strategy 1d, Next Day Appointments. These are described below in detail to highlight the integrated continuum of crisis services of which the Warm Line and UCC would be two new components.

<u>Existing Strategy 10b:</u>
The Adult Crisis Diversion Center strategy (Crisis Solutions Center or CSC) provides King County first responders with a therapeutic, community-based alternative to jails and hospitals when engaging with adults who are in behavioral health crisis. King County contracts with the Downtown Emergency Services Center to provide crisis diversion services at the CSC. The CSC has three program components; Mobile Crisis Team (MCT), Crisis Diversion Facility (CDF), and Crisis Diversion Interim Services (CDIS). The programs are intended to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community.

The MCT consists of a team of two mental health clinicians, trained in the field of substance use disorders, who provide crisis outreach and stabilization services in the community 24 hours a day, seven days per week (24/7). The team responds to requests from first responders in the field to assist with people in a mental health and/or substance use crisis. They intervene with individuals in their own communities, identify immediate needs and resources and, in most cases, relieve the need for any

[1] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. p5.

further intervention by first responders. The MCT is available for consultation or direct outreach to any location in King County and may assist individuals in crisis by providing or arranging for transportation.

The CDF is a 16-bed facility for individuals in mental health and/or substance abuse crisis who can be diverted from jails and hospitals, and voluntarily agree to services. The facility accepts individuals 24/7, with a 72-hour maximum length of stay. Individuals receive mental health and physical health screenings upon arrival. Services include crisis and stabilization services, case management, evaluation and psychiatric services, medication management and monitoring, mental health and substance abuse disorder assessments, peer specialist services and linkage to ongoing community-based services.

The CDIS is a 30-bed program co-located with the CDF. After a crisis has resolved at the CDF, individuals may be referred to the CDIS if they are homeless, their shelter situation is dangerous or has the potential to send them into crisis again, or they need additional services prior to discharge to help support stabilization. Individuals can stay at the CDIS for up to two weeks. Services include continued crisis and stabilization services, intensive case management, evaluation and psychiatric services, medication management and monitoring, mental health and substance abuse disorder assessments, peer specialist services, and linkage to community-based services, with a focus on housing and benefits applications.

Proposed new program South County Crisis Center (new concepts 37, 51, 64, 66):
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. 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. This allows for co-location and coordination of many crisis and stabilization services, and would be 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 run 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.

Existing Strategy 1d Next Day Appointments:
The Next Day Appointment (NDA) program is a clinic-based, follow-up crisis response program that provides assessment, brief intervention, and linkage to ongoing treatment. The goal of the program is to provide crisis stabilization and to divert individuals from psychiatric inpatient care.
The individuals served are those who are not currently enrolled in the King County mental health outpatient treatment system. The NDA program is designed to provide an urgent crisis response follow-up (within 24 hours) for individuals who are presenting in emergency rooms at local hospitals with a mental health crisis, or as a follow-up to the Designated Mental Health Professionals (DMHPs) who have provided an evaluation for involuntary treatment and found the person not eligible, or that they could be diverted from detention with follow-up services. The King County Crisis Clinic provides the centralized screening and authorization process for the NDAs. Currently there are five geographically distributed Community Mental Health Agency sites where NDAs are provided.
NDA Services include:

- Crisis intervention and stabilization services provided by professional staff trained in crisis management.
- Consultation with an appropriate clinical specialist when such services are necessary to ensure culturally appropriate crisis response.
- Referral to long-term (mental health or other) care as appropriate.
- Benefits counseling to work with NDA clients to gain entitlements that will enable clients to qualify for ongoing mental health and medical services.
- Psychiatric evaluation and medication management services, when clinically indicated, that include access to medications via prescription or direct provision of medications, or access to medication through collaboration with the individual's primary care physician.

The King County UCC and enhanced Warm Line would add a unique and innovative option to this continuum, providing an alternative to formal first responder interventions, with an emphasis on upfront, immediate peer specialist services.

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).

In communities where Urgent Care Clinics exist, people have rapid access to services and supports, including peer specialists, to avert the need for more intensive crisis response by law enforcement, involuntary detention authorities, EDs, and inpatient hospitals. Urgent Care Clinics are available to intervene earlier, and to offer alternatives that prevent future destabilization. They promote hope and recovery, and offer skills to promote resilience. Urgent Care Clinics are an innovative system improvement and operate in coordination with all other components of a community's continuum of crisis services.

Warm lines are for situations that are not considered emergencies but could potentially escalate if left unaddressed. As a result of warm lines and their operators, situations that may have resulted in a crisis-related trip to a local ED may be prevented. Since warm lines are staffed by people with lived experience and a personal understanding of recovery, callers are offered a message of hope from the unique perspective of someone who has had similar experiences.

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 crisis could have resolution without ever using EDs, hospitals, or law enforcement. A research study found that more and more individuals are seeking psychiatric care through hospital EDs, noting that 12.5 percent of adult ED visits in 2007 were mental health-related, as compared to 5.4 percent seven years prior[2]. 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 visits for other conditions.[3] The five year span between 2001 and 2006 showed that the average duration of psychiatric ED visits was 42 percent longer than those for non-psychiatric issues.[4] 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.[5] The trend in ED utilization has continued since this study was completed. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition (Agency for Healthcare Research and Quality, 2010).

Currently, King County individuals and their concerned family members have limited access to less restrictive options to support them when they or their loved one experiences a behavioral health crisis. Many of the calls to the Crisis Clinic 24-hour crisis line come from people who do not want to involve law enforcement, and/or do not want to experience the stress or cost of treatment associated with ED visits. According to the Crisis Clinic,[6] in the fourth quarter of 2015 alone, almost 250 people whom the Clinic referred to EDs due to their risk for self-harm could have been diverted to an Urgent Care Clinic instead. Many individuals who may have experienced difficulty with accessing services in the past, and/or have experienced the loss of their rights due to involuntary hospitalization are often reluctant to call for help. Warm Line support and the UCC would provide different avenues for these individuals. The system's definition of "first responders" could be revised to include Warm Line operators and Urgent Care Clinic staff (especially peer specialists); this "softer" response may encourage individuals to seek help earlier.

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

[2] 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

[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

[4] 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).

[5] 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] Telephone interview with Michael Reading, Director of Crisis Services, Crisis Clinic, Seattle, WA. January 2016.

There are very few Urgent Care Clinics in the United States dedicated to the behavioral health needs of community members. However, where those Clinics have been created, this innovation has been an important addition to that community's continuum of crisis services. In fact, according to Roger Meyer, Director of the Mental Health Alliance in St. Paul, an Urgent Care Clinic cannot be successful unless it is integrated with crisis call lines, mobile crisis outreach teams, crisis residential beds, and hospital EDs. [7] As part of that integrated continuum, an Urgent Care Clinic can divert from or more appropriately refer individuals to other components of that service array. With the addition of an Urgent Care Clinic to the King County continuum, people in crisis would receive individualized, person-centered services "on demand."

In the 2014 SAMHSA report on crisis services, it was noted that:

> Warm lines are telephone lines that are run by trained mental health consumers (i.e., peers) and staffed by people who are also in recovery (SAMHSA, 2010). A warm line is "a direct service delivered via telephone by a [peer] that provides a person in distress with a confidential venue to discuss their current status and/or needs SAMHSA, 2012). Unlike hotlines, warm lines are for situations that are not considered emergencies but could potentially escalate if left unaddressed. Peer telephone operators can offer compassion, and support callers on topics such as loneliness, anxiety, and sleeplessness. When individuals use warm lines, they are encouraged to talk through their concerns with operators and, in turn, operators may relate information about their own experiences to help the caller to address their own concerns. Operators can help callers that may feel isolated or "stuck" and, as a result, they may calm or reassure the callers. Operators refrain from offering advice; rather, they give a message of hope and provide resources. As a result of warm lines and their operators, situations that may have resulted in a crisis-related trip to a local ED before the call may be prevented (U.S. Department of Health and Human Services, 2010).

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 research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes.[8]

Results obtained for the service array provided by the Minnesota Mental Health Alliance, including the Urgent Care Clinic are promising:

[7] Telephone interview with Roger Meyer, Director of the Mental Health Crisis Alliance, St. Paul, MN. January 2016.

[8] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

In 2014 the team provided telephone support (similar to King County Crisis Clinic's 24 hour crisis line) to 20,000 callers. Face to face assessments at the Urgent Care Clinic were provided to 1503 people. Crisis stabilization services (follow- up care in the community for up to 30 days) were provided to 520 people. Access to "rapid psychiatry" and medications were provided to 733 people. Certified peer specialist services were provided to 357 people. Thirty one percent of those receiving direct services would have gone to the ED; 38 percent didn't have anywhere else to go; and 23 percent would have done nothing. Almost half of those who received psychiatric services would have otherwise gone to an ED to have those needs met. In a 2013 survey, 85 percent of clients strongly agreed that peers were a helpful part of the care team, and that they felt respected and involved in their own care.

Peer specialist services would be a component of the King County UCC services and is an essential feature of the proposed warm line. According to the 2014 SAMHSA report, the results associated with peer crisis services are also promising:

> An alternative to psychiatric ED or inpatient hospitalization, peer crisis services are operated by people who have experience living with a mental illness (i.e., peers) (Ostrow and Fisher, 2011). Peer crisis programs are designed as calming environments with supports for individuals in crisis. They are delivered in community settings with medical support. Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter term than crisis residential services.
>
> The number of research studies in this area is limited. However, the positive results from the few studies existing provide support for continued state and county mental health peer crisis services, and highlight the need for a more systematic study of the implementation efforts. Study populations in this review included adults with serious mental illness, as well as peer-run suicide prevention line callers for all ages. No literature was identified that discussed peer crisis services for consumers with substance use disorders.
>
> In a randomized investigation of a five-bed, peer run crisis hostel in Tompkins County, New York, Dumont and Jones (2002) evaluated a two-year demonstration. The results of this study were presented at the 2001 meeting of the National Association of State Mental Health Program Directors, and were reported in the Human Services Research Institute Outlook publication. The authors reported that "in nearly all areas, persons who had been assigned access to the crisis hostel were associated with both better outcomes and lower costs." The program was not published in a peer-reviewed journal and the details of the study are not available.
>
> In a more recent randomized control trial on peer services, researchers found that the average rate of improvement in symptom ratings was greater in the peer services group than in the hospital comparison group (Greenfield, Stoneking, Humphreys, Sundby, and Bond, 2008). The Greenfield et al. study involved random assignment of individuals with serious mental illness to one of two conditions: a consumer-operated, short-term crisis residential program (CRP); or "usual care," which in this case was a locked inpatient unit. CRP consumers had improved psychiatric symptoms, strengths, and treatment satisfaction. The peer-run alternative group had much greater service satisfaction compared to the usual care group. Findings suggest that short-term peer lead

interventions, together with available community outreach, are a viable alternative to standard hospital care.

The SAMHSA report also noted evidence of positive outcomes correlated with Warm Line services.

In 2011, Dalgin, Maline, and Driscoll administered telephone surveys to 480 warm line callers over a period of four years. They found that callers saw a reduction in both the use of crisis services and feelings of isolation. They also found that keeping telephone lines open after 5:00 p.m. was especially helpful, as they were available after most office hours.[9]

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

This concept is an emerging best practice. Crisis services are an important part of the continuum of publicly-funded mental health services, but have not been sufficiently researched to be designated as an evidence-based practice. Their use over the past several decades has played an important role in providing immediate access to critical psychiatric services as well as basic services such as emergency housing, food and clothing. One of the main goals of crisis services is to determine an individual's ability to access and use services to stabilize in the community. Crisis services also provide post-stabilization activities, including referral and linkage to outpatient services and supports.

The National Council for Behavioral Health has been providing training and consultation on access and retention, including walk-in access models and other same day/next day access models similar to those implemented by Urgent Care Clinics. Same day/next day access models to behavioral health services are considered a best practice, offering appointments when people need them improves access to care and operational efficiencies, in addition to increasing client engagement[10].

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?

- Decrease in emergency room use for behavioral health crises
- Decrease in involuntary detentions
- Decrease in psychiatric hospital admissions
- Decrease in calls to law enforcement and/or fire departments by persons experiencing behavioral health crises
- Increase in timely access to crisis assessments
- Increase in access to peer crisis services
- Increase in number of successful linkages to treatment and other supports post crisis episodes

C. Populations, Geography, and Collaborations & Partnerships

[9] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[10] http://www.thenationalcouncil.org/

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

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

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.

Any King County individual would have access to the MIDD-funded Warm Line. Any adult experiencing a behavioral health crisis may seek services from the UCC, although individuals enrolled with an outpatient agency may be referred to their provider for ongoing care. Individuals with acute medical needs would be referred to appropriate medical care.

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**: Seattle and County-wide.

The Warm Line will be accessible to anyone in King County. The UCC proposed in this paper will be the first of its kind in the region. It will most likely be located in the Seattle area. As this component of the service continuum is developed in the context of fully integrated healthcare, other UCCs will be sited throughout 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.**

As noted in B.2, neither the Warm Line nor the UCC can operate in isolation from the full continuum of crisis, inpatient, outpatient, housing, and residential services in King County. The public must be informed of the existence of these new resources. Formal partnerships will be needed with the community where the UCC is sited. Collaborative agreements and protocols will be needed with providers of other crisis services such as the CSC, hospital EDs, NDA providers, the new South County Crisis Center, and community behavioral health agencies.

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?**

Undoubtedly, the move to fully integrate primary care and behavioral health care by 2020 at the latest is a significant driver for development of urgent care clinics that are responsive to the behavioral health needs of those served. It is anticipated that in the future, both primary and behavioral health urgent needs would be addressed in every urgent care clinic. The development of the King County UCC is a progressive step in moving towards such fully integrated approaches.

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 behavioral health facilities such as the UCC can be challenging due to zoning regulations, accessibility factors, and neighborhood concerns. Thorough public engagement activities and the development of a neighborhood impact plan may help mitigate concerns. King County and the provider of the UCC will need to be involved in these activities.

There may be a small applicant pool from which to draw candidates for the Warm Line, given the increasing demand for peer specialists across all components of the behavioral health service continuum.

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?**

Creation of a single UCC in one location cannot meet the expected demand, once there is awareness of this resource. It is quite likely that demand will quickly outstrip the available resource. This could potentially increase the number of individuals in crisis who turn to emergency departments or first responders.

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?**

Excessive utilization of first responders and emergency departments would continue. Individuals who need lower level responses to avoid further escalation of a crisis would not receive the right service at the right time.

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 is no alternative to the establishment of a free standing UCC. This is a relatively new and innovative model of service delivery. Please see A.1 for more details about how this new concept program would be integrated with existing and other new program strategies.

The history of the Warm Line in King County has been fraught with challenges related to the use of volunteers, and the provision of necessary infrastructure supports by the host agency. To date, funding to create a sustainable Warm Line has not been available. There is no appropriate alternative approach to Warm Lines, as they are a unique, peer-driven supportive service essential to any person-centered, recovery oriented system.

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, including the Warm Line and the UCC, complements and expands the King County crisis services continuum. This new concept program will advance the goals of the Recovery and Resiliency Ordinance, Behavioral Health Integration, and Health and Human Services Transformation.

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

   Both components of this new concept are based upon the principles of recovery, resiliency, and trauma-informed care. Persons in recovery will staff the Warm Line, peer specialists will be key staff members of the UCC. Both the Warm Line and UCC staff will be trained in trauma informed approaches to supporting individuals in crisis. The UCC facility will be designed based upon trauma informed principles and will provide services using a trauma informed framework, as defined by SAMHSA.[11]

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

   Both the UCC and the Warm Line will be designed to meet people where they are, in the context of each person's culture. Services that are person-centered and adaptable promote equitable access and tailored responses. It will build upon the county's evolving work ensuring culturally competent services.

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.)**?**

   The UCC will need to be located in a facility that is accessible and welcoming, and provides space for all program activities. A full complement of staff, including peer specialists, behavioral health

[11] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. And, Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

crisis professionals, and prescribers will be needed. Specialized training and supports will need to be provided.

The Warm Line will be housed at the Crisis Clinic. A full complement of paid staff, including peer specialists and a supervisor will be needed. Specialized training and supports will need to be provided.

A public awareness campaign for the combined program will be needed (e.g., brochures, flyers, bus ads, etc.).

2. **Estimated ANNUAL COST. $1,500,001-$2.5 million Provide unit or other specific costs if known.**

- Capital funds to build and/or renovate a facility for the UCC—To be determined
- Program operational funding for the UCC—$1.5 million
- Warm Line funding for paid peer specialist staff and a supervisor, plus overhead and administration--$362,837

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

The 2014 SAMHSA report also described the dilemmas faced with funding crisis programs. In King County, while state and federal dollars support some crisis services for individuals, whether they are enrolled in public mental health services or not, additional funding has been needed to build the full continuum of services needed. Existing and future MIDD funding is one source of funding that promotes just such a continuum (including the proposed UCC and Warm Line).

The nature of comprehensive crisis systems, with their complex range of programs and services for addressing various individual situations, makes it difficult to finance crisis services within the constraints of one particular funding stream. Although many crisis services are provided from within the behavioral health system, some are hospital-based, and others are cut across the broader community (e.g., schools or the justice system). In many cases, crisis programs that are operated by different agencies or organizations have separate eligibility criteria and funding. In addition, there are multiple categorical funding streams to address specific problems or specific target populations, such as youth in foster care, elders, or individuals with developmental disabilities. For certain individuals, categorical funding results in the receipt of intended and needed services. However, through collaborative funding, funders of categorical dollars could also play a role in addressing the broader fundamental situation that often surrounds a crisis.

Funding that is tied to serving a specifically defined population can limit the financial feasibility of a program, particularly in rural areas or other areas that have a limited population base to draw upon. Also, funding that is tied to delivering units of pre-defined treatment to individuals who are eligible for specific types of insurance make it difficult for communities to build a continuum of crisis services. Due to the nature of behavioral health crises, many communities require a program with a “fire-house” staffing model that needs to respond to individuals immediately, often prior to establishing insurance status. These issues present limitations to states and communities who wish to build a continuum of crisis services.

Overcoming individual eligibility limitations imposed by categorical and single-service dedicated funding streams requires mobilizing multiple resources to address the diverse needs of individuals experiencing a behavioral health crisis. Such a collaborative funding approach would create an overall strategy that reconciles the many separate funding strands, and would have greater potential to meet the immediate needs of individuals in crisis, that extends beyond the scope of what a single system could have mobilized on its own (National Gains Center for People with Co-occurring Disorders in the Justice System, 2004).[12]

4. **TIME to implementation:** Choose an item.
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

- For development of the MIDD funded Warm Line at the Crisis Clinic, three to four months from award, based on hiring of peer specialist staff.
- For the creation of the UCC, six months to one year, depending upon procurement timelines, siting issues, and whether the facility is a new build, renovation, or expansion of any existing facility. In addition, recruitment and training of staff, development of the program model, drafting of collaborative agreements, a public awareness campaign, and facility licensing will be needed prior to initiation of services.
- An RFP will be needed to procure the provider of the UCC.

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?

[12] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

New Concept Submission Form

#112

Working Title of Concept: Behavioral Health Urgent Care Walk in Clinic

Name of Person Submitting Concept: Jim Vollendroff
Organization(s), if any: MHCADSD
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1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Urgent Care (walk in clinic) for individuals/general public in behavioral health crisis. This would offer an alternative to visiting the emergency rooms, mobile crisis teams and DMHP staff when someone is experiencing a behavioral health crisis.

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.

Lack of immediate access to services and lack of capacity. This is also an opportunity to intervene earlier before the problem escalates to needing full scale crisis response or hospitalization.

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

Lack of immediate access to services and lack of capacity

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

Individuals in behavioral health crisis and their families.

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.

Decrease in deep end services.

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?

Diversion of individuals from the deep more expensive level of care.

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.

Community behavioral health providers. Scale and budget to be determined.

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: **$ per year, serving 500 people per year**