BP 16 Immediate Community Care for Individuals Experiencing a Behavioral Health Emergency

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:
In King County, law enforcement is continually tasked with responding to community members who are experiencing behavioral health events or emergencies. During the response, it may be determined that the individual is experiencing symptoms or problems that could necessitate a visit to the emergency department (ED), and/or, if a crime has been committed, to jail. This program will allow assessment and intervention by a care team that responds to the individual in crisis, along with law enforcement officers at the site of their emergency. The team will provide on-site assessment and treatment initiation(e.g., medication management, assessment/provision of medication refills, provider-to-provider contacts) and, when needed, emergency case management services (e.g., interactions with Designated Mental Health Professionals (DMHPs), community mental health or substance use treatment providers, housing authorities, parents/family) in lieu of transport to an ED or a jail cell. The team is comprised of either a psychiatrist or an ARNP in Psychiatric Mental Health licensed by Washington State to practice independently and write prescriptions, and a Medical Social Worker, Licensed Independent Clinical Social Worker or Licensed Advanced Social Worker (herein this position will be referred to as an MSW).

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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?**

In King County, law enforcement is continually tasked with responding to community members who are experiencing behavioral health events or emergencies. During the response, it may be determined that the individual is experiencing symptoms or problems that could necessitate a visit to the emergency department (ED), and/or, if a crime has been committed, to jail. This program will allow assessment and intervention by a care team that responds to the individual in crisis, along with law enforcement officers at the site of their emergency. The team will provide on-site assessment and treatment initiation(e.g., medication management, assessment/provision of medication refills, provider-to-provider contacts) and, when needed, emergency case management services (e.g., interactions with Designated Mental Health Professionals (DMHPs), community mental health or substance use treatment providers, housing authorities, parents/family) in lieu of transport to an ED or a jail cell. The team is comprised of either a psychiatrist or an ARNP in Psychiatric Mental Health licensed by Washington State to practice independently and write prescriptions, and a Medical Social Worker, Licensed Independent Clinical Social Worker or Licensed Advanced Social Worker (herein this position will be referred to as an MSW).

When a call is received regarding an individual in behavioral health crisis, or with known behavioral health signs and symptoms that may result in public safety concerns, the team is engaged by law enforcement and works collaboratively with officers to intervene with this individual. When able, and after the scene has been determined to be safe by law enforcement, the psychiatric provider and MSW will perform a mental health evaluation, evaluate the individual's need for connection to social services, contact the individual's psychiatric mental health provider (if applicable) and obtain information about the current treatment plan (if applicable) and, when necessary, assess for transport to an inpatient psychiatric facility or the Crisis Diversion Facility for admission and needs assessment. Other possible services that the team may provide include:

- Assessment, and coordination, for admission to substance use disorder treatment, if indicated;
- Assessment for family resources/social support needs;
- Assessment for permanent housing or permanent supported housing;
- Assess need for transport to medical facility for medical care;
- Contacting primary care provider to review prescriptions;
- Review of outdated/expired medications with the pharmacist and discuss renewing, if appropriate; and
- Contact behavioral health provider to update on current condition and imminent needs.

A pilot program would be implemented with, and housed at, a local law enforcement agency in South King County, and could begin with two psychiatric providers and two MSWs working together on a part-time basis to establish level of service need. A 9-month evaluation of services could follow, and the program could be expanded based on results of the evaluation (measured by outcomes such as number of interventions attempted and completed, successful diversions from ED/Jail, and other metrics to be identified).

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).

This project will focus on 1) intervening early with individuals with behavioral health disorders who are in crisis, and diverting them from ED and jails (Early Intervention and Crisis Diversion) and 2) adding another aspect of the behavioral health system that is focused on immediate care in the community, with a service enhancement of providing medication services outside of a clinic or hospital setting (System Improvement/Enhancement).

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**

This program will respond to law enforcement interactions with individuals living in the community with behavioral health issues that are not addressed by other, voluntary methods. The Mobile Crisis Team (MCT), a MIDD I funded program based out of the Downtown Emergency Services Center's Crisis Solutions Center program, addresses some of the emergency behavioral health problems that occur in the community; however, they do not have the ability to assess medication or medical needs, and their services can be refused by the individual. In order to better serve this clientele in need of immediate care, it is proposed that working more closely with law enforcement will allow the team to quickly assess and determine service needs, and provide appropriate services while in the community setting. The combined approach will provide alternatives for individuals who may not be willing to agree to – or whose behaviors are outside the scope of – an outreach from MCT, but may be manageable on a voluntary basis with a combined law enforcement/provider response. This may also help avoid the use of jail or the ED, both time consuming and high-cost interventions, in cases where an MCT response is not appropriate and least restrictive options appear manageable through this specialized co-response model.

Many individuals who find themselves in difficult situations due to a behavioral health disorder or episode(s) of crisis could have resolution without ever entering local jails, EDs or hospitals. The criminal and crisis systems are often unable to adequately respond to these situations. A research study found that more individuals are seeking psychiatric care through local hospital EDs and noted that, in 2007, 12.5 percent of adult ED visits were mental health-related compared to 5.4 percent seven years prior.[1] Growth in these figures may have come about due to the difficulty some individuals experience in accessing community mental health services prior to a crisis, as well as the deinstitutionalization in the 1960s that caused a significant reduction in inpatient psychiatric capacity nationally that has continued until very recently.[2]

Criminal justice partners are realizing the impacts behavioral health conditions are having on the incarcerated population. During planning for the King County the Familiar Faces initiative, it was found that 94 percent of individuals booked into jail four or more times in a rolling twelve month period have

[1] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality, 2010, 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).

[2] 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).

some sort of behavioral health indicator. Of these, 35-40 percent had contact with the mental health or substance abuse treatment systems within the 15 month study window; about half had homelessness services (likely an undercount of homelessness), and only half obtained Medicaid during the study year.[3]

Many individuals who are heavily experienced in the criminal justice and crisis systems may have been deterred from utilizing appropriate and necessary care due to having experienced difficulty in accessing these services in the past, and/or having experienced the loss of their rights due to detainments or involuntary hospitalizations. This program would focus on identifying, and connecting individuals such as these to resources and supports that not only address crisis and pre-crisis needs, but also address the gaps and barriers that compound and exacerbate crises. The program allows for the provision of more upfront, preventative, human-centered services that assist individuals in accessing and utilizing appropriate and needed services and moving them towards recovery and stability.

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

This concept addresses the objective through the provision of immediate assessment and treatment for individuals who may be experiencing a psychiatric emergency, and helps divert them from repeated cycling through in-patient care settings or incarceration in local jails or prison. By providing an alternative to jails and ED in the moment of crisis/contact with first responders, this program can focus on providing the support services needed to help link individuals with behavioral health treatment, primary care and housing needs to services in their home community. Finally, decreasing ED visits for individuals in behavioral health crises that can be managed through this program would make more beds available for people with medical needs and acute behavioral health needs. It would also decrease costs to insurance providers such as Medicaid, and to hospitals.

The care team would be a resource for law enforcement that would provide crisis response and 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 resource needs (including medication assessment and prescriptions), provide appropriate connection to local resources and supports, and relieve the need for further intervention from law enforcement and/or other first responders.

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.**

This is a new concept for care provision in the community. The move to mobile sources of healthcare services is relatively new, and mobile care provided by ARNP (or Nurse Practitioners) is a fairly new concept in the medical literature.[4] This type of health care provision is usually associated with rural and low-income populations, and its focus has primarily been on providing services for non-psychiatric conditions (e.g., pediatric care, services to older adults, family health care); therefore, little formative research has been conducted on the effectiveness of care provided in this setting. There is evidence that

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

[4] Fraino, J. (2015). Mobile Nurse Practitioner: A Pilot Program to Address Service Gaps Experienced by Homeless Individuals. *Journal of Psychosocial Nursing and Mental Health Services, 53*(7), 38-43.

individuals who are chronically homeless or leaving prisons/jails experience persistent psychological distress, which may lead to problems upon their return to the community.[5] Supportive housing and recovery-based care can be instrumental in helping persons with mental illness avoid hospitalizations.[6] Those individuals who are discharged to supportive housing have lower 30-day readmission rates than those who are discharged to the street.[7]

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 were 51 percent more likely to be hospitalized after other variables had been controlled for, than users of community-based mobile crisis services."[8] 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."[9]

A study of jail diversion programs for individuals with mental health and co-occurring substance use disorders (SUDs) showed that jail diversion reduces jail days, links individuals to services in the community, and does not increase risk to public safety.[10] "Data from the six sites in the SAMHSA Jail Diversion Initiative s**u**ggest 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: 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 se**r**vices, 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…".[11]

This program will help identify and treat individuals living in the community who are in a mental health crisis but whom are likely to reject voluntary services, such as those offered by the MCT, and who might be better treated through an immediate assessment from licensed medical providers, therefore avoiding hospitalization and/or incarceration. This is *not* a forensic nurse practitioner who will collect evidence for the police. Rather, this role is for a psychiatrist or a nurse practitioner with psychiatric mental health certification to assess and treat persons with mental illness in the community, which makes this a new use of the ARNP role. It is expected that this will be a successful program as it will reach a population that uses maximum community resources and often requires either immediate psychiatric assessment conducted in the ED and subsequent hospitalization, or results in immediate jail booking. This program will provide immediate care and a necessary service, hopefully circumventing both hospitalization and/or incarceration. The funding request includes monies for evaluation of program effectiveness

[5] Thomas, E.G.,Spittal, M.J., Hefferman, E.B., Taxman, F.S., Alati, R., & Kinner, S.A. (2015). Trajectories of psychological distress after prison release: Implications for mental health service need in ex-prisoners. *Psychological Medicine,* Nov 9. 1-11. Epub ahead of print.
[6] McDermott, S., Bruce, J., Muir, K., Ramia, I., Fisher, K.R., & Bullen, J. (2015). Reducing hospitalisation among people living with severe mental illness. *Austrialian Health Review,* Sept 7. (Epub ahead of print).
[7] Doran, K. M., Ragins, K.T., Iacomacci, A.L., Cunningham, Al., Jubanyik, K.J., & Jenq, G. Y. (2013). The revolving hospital door: hospital readmissions among patients who are homeless. *Medical Care, 51*(9). 767-773.
[8] 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.
[9] Hugo, Malcolm; Smout, Matthew; Bannister, John, *A Comparison In Hospitalization Rates Between A Community-Based Mobile Emergency Service And A Hospital-Based Emergency Servic*e, Australian and New Zealand Journal of Psychiatry, *Vol. 36 Issue 4 Page 504 August 2002*
[10] 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.
[11] Ibid, Steadman, H. J. and Naples, M. (2005).

throughout the life of the pilot program. Additional funding must be obtained following the evaluation in order to continue to sustain the proposed level of service and evaluation.

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.**

The move to mobile sources of healthcare services is relatively new, and mobile care provided by a psychiatric provider is a fairly new concept in the medical literature (Fraino, 2014). Moreover, using a nurse practitioner with psychiatric mental health certification to assess and treat persons with mental illness in the community is a new use of the ARNP role.

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?**

- Increase the number of individuals with mental illness living successfully in the community;
- Decrease the number of individuals circulating through the jail system;
- Decrease the number of individuals circulating through local EDs;
- Identify individuals who have multiple interactions with law enforcement and local EDs;
- Identify individuals who are may be struggling with addiction or who may be less adherent to psychiatric medication regimens and provide necessary services;
- Identify elderly individuals who may be struggling with untreated dementia and need additional home services to improve their ability to live safely in the community;
- Identify individuals who may be in need of additional services such as permanent housing or additional social services that will help them develop a more stable living situation;
- Decrease the number of paramedic/firefighter interactions in the community with persons with behavioral health disorders;
- Identify populations who may be under-served for emergency psychiatric health needs (particularly individuals ages 14-20); and
- Increase care coordination across different systems (primary care, behavioral health providers, first responders, etc.).

This program would be tasked with collecting information on a wide array of client related data including demographics, referral sources (if not limited to one law enforcement jurisdiction), dispositions, and program length of stay/utilization. Data sources include: law enforcement/dispatch data on calls for service with negotiated agreements to be developed; law enforcement reports on current engagements or information regarding individuals in the program; programmatic reports on a monthly and/or quarterly basis (to be determined); internal data that the King County Mental Health, Chemical Abuse and Dependency Services Division (MCHADSD) collects on referrals, linkages and treatment admissions; booking and length of stay data already available to MHCADSD from municipal jails, county jails, and state prisons; and data available through negotiated agreement with the state Emergency Department Information Exchange (EDIE) and it's complementary PreManage product that allows hospital event data to be pushed to health plans, coordinated care organizations (CCO), and provider groups (including MHCADSD) on a real-time basis for specified member or patient populations.

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**	☐ **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.

This program will help identify and treat individuals in the community who are in a behavioral health crisis but who may not be considered, or deemed eligible, for MCT services and who might be better treated through an immediate assessment by a combined response team of law enforcement and licensed medical providers, in order to avoid hospitalization and/or incarceration.

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

It is recommended that the program be initially located in the Kent area as 1) it can be difficult for the King County Mobile Crisis team to reach clients in this area in a timely fashion; and, 2) the area houses the Maleng Regional Justice Center) and the South Correctional Entity (SCORE), and 3) it is an area where formerly incarcerated men and women are released back into the community, and may not have access to immediate psychiatric care services. Additionally, the Kent Police Department (PD) has noted their willingness to house programs that assist them in their responses with individuals with behavioral health disorders at their offices, and have stated that having more immediate access to resources when responding to these individuals would be useful.

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.**

Several partnerships are required for the success of this program. These include:

1) Initially, collaboration with Kent PD, and specifically the Kent PD community resource officers, a team of six law enforcement officers that work closely with individuals who are homeless and persons with behavioral health disorders in Kent; other PDs should the program be expanded to other areas of the county;
2) Collaboration with area pharmacies in order to notify them of the program, including access to prior prescriptions and a summary of previous prescriptions with their dates of expiration;
3) Partnerships with supportive housing services in the Kent area;

4) Collaboration with local community mental health providers such as Sound Mental Health, Valley Cities Counseling and Consultation, and Sea-Mar Behavioral Health clinics, as individuals who require Immediate Community Care may be receiving ongoing services from these providers;
5) Washington State Department of Social and Health Services;
6) King County Behavioral Health Organization (BHO);
7) King County Crisis and Commitment Services;
8) Local homeless shelters, such as Catholic Community Services Housing and Essential Needs;
9) King County BHRD;
10) University of Washington Bothell School of Nursing and Health Studies;
11) University of Washington School of Nursing (Seattle Campus);
12) Washington State Department of Corrections; and
13) Local EDs to provide historical hospital information that can assist the team in determining their response and options.

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 Immediate Community Care program. 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 this program. The services provided would be an initial step in the continuum of care, intended to provide immediate crisis stabilization services and promote access to services. The longer term goal of connection and ongoing maintenance of services, regardless of whether the individual's needs are related to mental health, substance use or co-occurring disorders, fits well with the integration of behavioral health care. Without the benefits obtained through healthcare reform, many of these individuals would have been deemed ineligible for Medicaid or other healthcare coverage based on exclusionary factors no longer in place. Without access to benefits, most of the therapeutically appropriate services needed for stabilization (e.g., treatment, medications, housing) would not be available to them, and they would continue to cycle through the hospital and jail settings. Additionally the Familiar Faces initiative links to the work of this program, as the Immediate Community Care model works to reduce the number of individuals with behavioral health needs cycling through the costly jail and hospital systems, often many of whom are ineligible for, fearful of, or unable to access services and supports in the community to help manage crises.

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?

Potential barriers to implementation might include the level of acute mental illness experienced by potential clients, which can result in behavior that interferes with the ability of the team to gain cooperation from the client, necessitating immediate admission to a hospital or jail. Additionally, there may be challenges from area providers of mental health care who may have difficulty understanding the nature of this level of care and how it relates to ongoing service provision. In order to overcome this challenge, the team must engage in strong education and collaboration efforts to bring area providers up-to-date with this level of service. Finally, a poorly funded program may result in having enough funding to provide the service, but not fully evaluate the effectiveness of the program.

The Immediate Community Care team will need to be accessible and easy to utilize by local law enforcement officers in order to avoid frustrations and non-use of the resource by law enforcement partners. Coordination and planning efforts to address policy and protocol structures that may be a barrier to utilization will need to be implemented.

Another barrier to implementation is the shortage of psychiatric health practitioners in the region. The unpredictable nature of when and how this service will be needed may make it challenging to efficiently use this precious, limited resource. Another challenge is the 24 hour nature of when crises occur, and the ability to have psychiatrists and/or psychiatric ARNPs available for on-site intervention.

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?**

One unintended consequence might be that, since individuals have received immediate care in the community, individuals may forego follow-up care with their primary care mental health provider. The number of potential program participants could be under-estimated, therefore overwhelming program funding.

In Washington State (and nationally), there is a dearth of substance use disorder (SUD) treatment beds available. For individuals who are seen through the program and who may be seeking immediate care and transfer to a SUD program, difficulties in placing individuals in SUD inpatient, detox, or residential programs could be a challenge for the program. The team could attempt to place individuals in permanent housing programs, only to find that there are no available beds.

Clients may end up receiving multiple prescriptions due to medications from primary care, behavioral health providers, and this team. Some people who should not receive medications (because they are not indicated) may end up getting them. If the intervention team is unable to discover the individual's medication history in the moment, including drug allergies and other medications they are taking, and prescribe a contra-indicated medication, there could be serious medical consequences. There may be an increase in referrals to EDs due to the detection of medical conditions that require urgent intervention. There may be an increase in DMHP referrals due to more immediate contact with these individuals (vs. transport to an ED, where people often have several hours to chill out, etc.).

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?**

Law enforcement and other first responders will continue to encounter individuals in dire need of immediate psychiatric assessment and/or community resource planning, have limited access to resources to assist in the field, and would continue to rely primarily on jail and hospital settings to address the needs of this population. Without the program, law enforcement officers will continue to attempt to engage individuals with behavioral health disorders in the field without sufficient resources or supports. Without the program, individuals requiring immediate assessment for mental health or SUD services will continue to live in unsupportive environments, and struggle with environmental, social, and behavioral health stressors, which are often affiliated with acute behavioral problems and crises in the community. This sustains the overdependence on law enforcement agencies to act as intermediaries for the mental health community.

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 within King County that provide similar services, specifically the Crisis Diversion Facility (CDF), MCT and the Dutch Shisler Sobering Center; however, most of them are based in downtown Seattle and are less accessible in the midst of a crisis (or pre-crisis) episode, especially for individuals in South King County. Many individuals who 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. Additionally, law enforcement may choose to not use a resource if the response time is significant (more than 30 minutes is often viewed as significant), and wait times for the MCT are averaging just under one hour.

Transportation is a real barrier because many individuals do not have access to vehicles of their own. Bus rides are expensive for individuals without resources and 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 these programs, 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 often the only available options in the moment beyond leaving the individual at the scene of the interaction. Hospitals have a few more options available to them including the 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.

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. For individuals who are enrolled in the King County Behavioral Health Organization (BHO), this also includes crisis response. The intent of crisis services is to respond to urgent and emergent mental health 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 include telephone care services only 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?**

This program is in line with the Sequential Intercept Model (SIM) under the premise that the earlier individuals can be intervened with, in their own communities, the more likely they are to stay out of the crisis and criminal justice systems and get the ongoing help they need. The Immediate Community Care program is an initial step in the continuum of care, and the SIM, intended to provide immediate crisis stabilization services and to promote access to community-based services. This program links to the Recovery and Resiliency – Oriented Behavioral Health Services Plan through the recognition that recovery can take time and multiple engagement efforts, and that continued efforts on the part of first responders and service providers is needed to support the recovery process.

The Immediate Community Care program should link with Behavioral Health Integration, especially given the anticipated high levels of co-occurring disorders in the population of focus, which will allow for more integrated and, hopefully, streamlined access to services.

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

There is a focus in local and national news on the number of individuals in jails and prisons with mental health and/or SUDs, as well as how law enforcement is responding to these individuals in the community. Individuals with behavioral health disorders engaging with first responders are often sent to costly resources such as EDs and jails, due to the symptoms of their disorder(s), and these environments are often re-traumatizing to individuals, especially if they have previously experienced the loss of their rights due to detainments or involuntary hospitalizations. The Immediate Community Care program is intended to provide an alternative response that reduces the over-reliance on the criminal and crisis systems to manage this population. This program will work to recognize that recovery can take time, and often multiple engagement efforts are needed, by both first responders and service providers, to build relationships and impact behavior change to support the recovery process.

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 related to the lack of services and diversion opportunities available in the south region of King County. Many people of color or lower socioeconomic status 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 crisis situation, lack of access: access to treatment, housing, jobs, support, healing and recovery, and access to a community of people who care and value them. At its founding, this program addresses equity and social justice by allowing individuals to not be criminalized for their social services needs/access needs, but rather be assisted to meet and fulfill those needs.

The Immediate Community Care program would focus on both reducing criminalization of behavioral health disorders, and reducing the reliance on jails and hospitals to address a community need. The program will work to coordinate and collaborate with a wide variety of systems and community supports that have not been available or responsive to the individual's needs, and work to break down barriers to access that may have prevented successful interactions with community based 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.)**?**

Program staff, office space, cooperative agreements with local law enforcement partners, and training for community partners on the program intentions and services.

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

Immediate Care Team including 2 psychiatrists or psychiatric mental health ARNPs, 2 MSW, and 1 administrative staff; office space, computing equipment including laptops, billing software, documentation software (electronic medical record); mileage reimbursement when personal automobiles are used to drive to care location; cell phones and wireless service plan; and insurance (malpractice and liability).

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

There is a possibility of funding some visits through local funding for mental health outpatient services. This would need to be arranged through the BHO.

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

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

The hiring of the Immediate Community Care program staff, and the development of collaborative agreements, policies and procedures between law enforcement partners and the care team/agency.

b. What are the steps needed for implementation?

Once funding is secured, the program can be implemented after the following are completed:

1) Advertising for and hiring of the Immediate Community Care team (ARNP, MSW, receptionist);
2) Development of policies guiding the program constructed with the psychiatric services team, law enforcement management/officers, and community stakeholders (specifically, policies and procedures need to be developed around information sharing and disclosure of protected health information, especially in a model of service care that is based on a team approach utilizing law enforcement and medical/behavioral health personnel);
3) Office set up (identifying space, obtaining insurance coverage, supplies);
4) Develop a tracking, reporting, and documentation system; and
5) Collaborative meetings with stakeholders described in Question 3.

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 could also work out of the South County Crisis Center (MIDD New Concept BP 37, 51, 64, 66 South County Crisis Center Schoeld), and provide a more intensive resource for first responders across South King County when engaging individuals who need more intensive medical/psychiatric supports in order to remain in the community and avoid hospitalizations. It could also link with the Crisis Intervention Team-Mental Health Partnership Project (MIDD Strategy expansion ES 17a BP 4).

New Concept Submission Form

#16

Working Title of Concept: Immediate Community Care for Individuals Experiencing a Mental Health Emergency

Name of Person Submitting Concept: Cheryl L. Cooke, PhD, RN
Organization(s), if any: Organization(s) Here
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Mailing Address: University of Washington Bothell, Nursing and Health Studies, Box 358532, Bothell, WA 98011-8532

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.

In King County, law enforcement is continually tasked with responding to community members who are experiencing mental health events or emergencies. During the response, it may be determined that the individual is experiencing symptoms or problems that may necessitate a visit to the emergency room, and/or, if a crime has been committed, to the King County Jail system. This program would allow assessment and intervention by a mid-level health care provider with prescriptive authority (Advanced Registered Nurse Practitioners [ARNPs]) to see the patient together with law enforcement officers at the site of their emergency, and receive an on-site assessment and treatment (e.g., medication management, assessment/provision of medication refills, provider-to-provider contacts) and, when needed, emergency case management services from a medical social worker (MSW) (e.g., interactions with DMHPs, community mental health or substance use treatment providers, housing authorities, parents/family) in lieu of transport to an emergency room or a jail cell. The pilot program could begin with 2 advanced registered nurse practitioners (ARNPs) and 2 MSWs working together on a part-time basis to establish level of service need. A 9-month evaluation of services could follow, and the program could be expanded based on this evaluation/reassessment (measured by outcomes such as number of interventions attempted and completed, successful diversions from ER/Jail, other metrics).

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 program will respond to law enforcement interactions with individuals living in the community with mental health issues that are not addressed by voluntary methods. The KCMH mobile crisis team addresses some of the emergency mental health problems that occur in the community, but their services can be refused by the person with mental illness and they are then taken to jail or to an emergency room for treatment, both time consuming and high-cost interventions. Working under the umbrella of law enforcement may change the voluntary nature of these interactions.

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

This concept addresses an unmet need of providing immediate, on-site community-based treatment to persons in need of emergency mental health treatment.

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

Potential program participants include homeless individuals with untreated mental illness, or who have recently stopped taking their medications but remain in the community. These patients may be instigating problems with local businesses, and this could be a joint law enforcement/mental health provider approach to dealing with persons with mental illness. The program would also benefit benfiting taxpayers by keeping people with mental illness out of the jail and acute care systems.

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.

Increase the number of individuals with mental illness living successfully in the community.
Decrease the number of individuals circulating through the jail system.
Decrease the number of individuals circulating through local emergency rooms.
Identify individuals who have multiple interactions with law enforcement and local emergency rooms.
Identify individuals who are may be struggling with addiction or who may be less adherent to psychiatric medication regimes and provide necessary services.
Identify elderly individuals who may be struggling with untreated dementia and need additional home services to improve their ability to live safely in the community.
Identify individuals who may be in need of additional services to such as secure housing or additional social services that will help them develop a more stable living situation.
Decrease the number of paramedic/firefighter interactions in the community with persons with mental illness.
Identify populations who may be under-served for emergency psychiatric health needs (particularly individuals ages 14-20).

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?

This concept addresses the objective by providing immediate assessment and treatment for individuals who may be experiencing a psychiatric emergency and help divert them from repeated cycling through in-patient care settings or incarceration in local jails or prison.

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 between first respondes such as law enforcement, firefighter/paramedics, mental health providers, jails, DMHPs, business owners will be essential to the success of this program.

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: $ 550,000 per year, serving 120,000 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*.