MIDD Briefing Paper

BP 58 Mental Health Crisis Consultation for Family Caregivers

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 briefing paper outlines the need for a behavioral health specialist that would provide information, referral, and temporary follow-up services to family caregivers of an older adult experiencing a behavioral health crisis. Family members may be overwhelmed by a loved one's symptoms and ignorant about the available treatment options and/or the involuntary detainment process. If an older adult is involuntarily hospitalized, the family may be confused and uncertain of their role regarding treatment decisions, including discharge and follow up treatment. Should the hospital discharge plans be poorly developed or communicated (which is not uncommon), families without experience of the mental health system are left stumbling about trying to navigate a large, fragmented network. All of these situations are further complicated by the frequent co-morbid medical conditions of older adult consumers.

Collaborators:

Name	**Department**

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

Name	Role	Organization
Joanne Donohue	Director (submitted proposal)	Senior Services Center
Andrea Yip	Planning Supervisor	Area Agency on Aging – Seattle & King County
Dick Crabb	Contract Monitor, GRAT	King County

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 briefing paper outlines the need for a behavioral health specialist that would provide information, referral, and temporary follow-up services to family caregivers of an older adult experiencing a behavioral health crisis. Family members may be overwhelmed by a loved one's symptoms and ignorant about the available treatment options and/or the involuntary detainment process. If an older adult is involuntarily hospitalized, the family may be confused and uncertain of their role regarding treatment

decisions, including discharge and follow up treatment. Should the hospital discharge plans be poorly developed or communicated (which is not uncommon), families without experience of the mental health system are left stumbling about trying to navigate a large, fragmented network. All of these situations are further complicated by the frequent co-morbid medical conditions of older adult consumers.

Per this proposal, a family member in such dire straits would request assistance through a central phone number. The behavioral health specialist would initially respond by phone, evaluate the situation and offer information and referral guidance. In such situations, the family may simply require treatment referrals or information about the steps involved in an involuntary hospitalization process. However, the specialist would also be available for face-to-face consultation, support and advocacy services should the situation be more complex or the family less able to organize the required resources. Such assistance could include facilitating communication between the family and hospital personnel or helping the family locate needed follow up services for their loved one. Services would terminate when the crisis is resolved and a plan of action is implemented. The behavioral health specialist would be available on the phone, in person at the hospital or in the home with an on call component when crises occur outside the work week.

This proposal shares similarities with a number of MIDD concept papers:

- MIDD-funded 1h Strategy**,** *Geriatric Regional Assessment Team (GRAT)*: GRAT provides "a specialized outreach crisis and mental health assessment, including substance use screening, that is age, culturally, and linguistically appropriate for adults age 60 years and older, who are King County residents, who are experiencing a crisis in which mental health or alcohol and/or other drugs are a likely contributing factor and/or exacerbating the situation…" The primary distinction between this proposal and GRAT is that GRAT typically conducts one assessment visit and then provides information and referrals. This proposal would increase the service options to include temporary ongoing supports to help the family and consumer navigate the service systems and enroll in the required treatment.
- Briefing Paper 123, *Outreach for Older Adults in Psychiatric Crisis*: This proposed concept is an outreach program targeting older adults in psychiatric crisis who are at risk for hospitalization or re-hospitalization. The program will consist of a team made up of Geriatric Mental Health Specialists (GMHSs), a Director and a consulting Psychiatric Nurse Practitioner. This team will provide outreach visits to older adults experiencing a psychiatric crisis to help coordinate and solidify outpatient services thereby diverting them away from emergency services.
- Briefing Paper 33, *Coordinated Care for High Risk Older Adults and Adults with Disabilities*: This proposal offers a team based model, composed of registered nurses and social workers, to coordinate care across systems for this high need vulnerable population. Building on the success demonstrated by King County Care Partners (KCCP) pilot program, this model would provide a community-based, multidisciplinary team to facilitate communication and coordination between systems, and utilize evidenced based approaches to support older and disabled adults with behavioral health issues in making positive and sustainable choices for their health and well-being[1]. Services would be offered for up to 12 months.

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**

[1] http://www.agingkingcounty.org/KCCP_WhatWeDo.htm.

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

Please describe the basis for the determination(s).

This concept could help divert a mental health crisis and reduce high-intensity, costly services (such as inpatient hospitalization) by providing the family the necessary information and referral services. The behavioral health specialist would also improve the system thru temporary ongoing care management services. He/she would help the family find and enroll their loved one in needed services thereby safely transitioning the older adult back into his/her community.

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.**

Thanks to advancements in medicine, education, nutrition and general living standards, adults who reach the age of 60 can now expect to live almost 25 additional years[2]. Approximately 16 percent of King County residents are adults 60 and older and their numbers are expected to grow to nearly 25 percent by 2025[3]. Although the majority of older adults do not suffer significant mental disorders, approximately 20 percent of adults 65 and older meet the diagnostic criteria for a mental disorder, including dementia[4]. The most common are anxiety disorders, depression and severe cognitive disorders. [5] Though the elderly make up 13 percent of the population, they account for nearly 16 percent of all suicides; the suicide rate for white males 85+ is more than four times the nation's overall rate[6],[7]. In addition, as many as 16 percent of the older adult population are at-risk or problem drinkers[8]. And the number of older adults requiring treatment for substance abuse treatment is expected to nearly

[2] Seattle-King County 2006-2007 Area Plan on Aging Update, Section B-1 Demographics http://agingkingcounty.org/docs/AreaPlanUpdate2006-07.pdf

[3] Area Plan on Aging, Seattle-King County Washington, 2012-2015, *New Partners for New Time*, *http://www.aarp.org/content/dam/aarp/livable-communities/plan/planning/area-plan-on-aging-seattle-king-county-washington-2012-2015-aarp.pdf*

[4] Karel, M.J, Gatz, M, Symer, M (2012) Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know. American Psychologist, Vol 67 (184-198).

[5] U.S. Dept. of Health and Human Services. Older Adults and Mental Health. In: Mental Health: A Report of the Surgeon Genera 1999.http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS. Karel, M.J, Gatz, M, Symer, M (2012) Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know. American Psychologist, Vol 67 (184-198);

[6] American Association of Suicidology, Elderly's Suicide Fact Sheet: Based on 2010 data. Accessed May 2014, http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-242.pdf

[7] Administration on Aging, Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/docs/Older%20Americans%20Issue%20Brief%204_Preventing%20Suicide_508.pdf

[8] Substance Abuse and Mental Health Services Administration (SAMHSA), Administration on Aging, Older Americans Behavioral Health Issue Brief 3: Screening and Preventive Brief Interventions for Alcohol and Psychoactive medication Misuse/Abuse http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/docs2/Issue%20Brief%203%20Screening%20Brief%20Interventions.pdf

triple in coming years[9]. Despite these treatment needs, behavioral health services are woefully under-utilized by older adults due to a complex array of factors, including fear of discrimination, social isolation, problem denial, poverty, transportation limitations, system fragmentation, and a shortage of trained professionals.

King County and the City of Seattle currently offer a number of programs that address these issues. The Area Agency on Aging for Seattle and King County (AAA) provides information and referral services (I&R) for older adults and the disabled through its Community Living Connections agency coalition. The MIDD-funded GRAT project provides comprehensive assessment, crisis intervention, and referrals to community resources for older adults struggling with mental health and/or chemical dependency issues. The MIDD-funded crisis diversion services offered by DESC are available to all individuals living in the Seattle area that meet the necessary criteria. The County also has a psychiatric hospital that specifically targets the geriatric population as well as a number of re-entry programs that assist individuals transitioning from the hospital or jails. Furthermore, King County funds a number of outpatient and residential programs specifically targeting older adults.

Unfortunately, the defined scope of these programs and the lack of coordination between them can create significant service gaps. For the uninitiated, understanding the roles, responsibilities and entrance criteria of each program and then navigating King County's large, complex behavioral health system can be a daunting exercise, especially when faced with a behavioral health crisis of a loved one. The AAA and GRAT provide important outreach and I&R services, but are not funded to offer temporary ongoing support. DESC crisis diversion services are limited to the Seattle area and do not specialize in the specific, sometimes complex needs of older adults. The County's re-entry programs are also limited in their ability to effectively manage this population due to their special needs, the general service demand and the programs' limited resources. Furthermore, treatment agencies, psychiatric hospitals, crisis response teams, and the legal system (which impacts the involuntary detention process) operate independently and oftentimes with little coordination and collaboration.

The psychiatric hospitalization of a loved one will typically stabilize the behavioral health conditions and provide temporary relief for both the older adult and family. Unfortunately, the hospital discharge process is sometimes abrupt with little advance notice. Post discharge treatment plans may lack specificity and/or be poorly communicated by hospital staff. In such situations, the consumer and family may struggle to locate community services that will mitigate a similar crisis in the future. In addition, the presence of co-morbid medical conditions that frequently afflict older adults adds to the complexity – and associated distress – of the situation. (Approximately 80 percent older Americans have at least one chronic medical condition and about 60 percent suffer from two or more[10].) Without support, the older adult and family may not have the tools and resources necessary to follow through on aftercare resulting in increased morbidity and mortality in this population as well as continued use of emergency, high-cost services.[11]

---

[9] Gfroerer, J., Penne, M., Pemberton, M., Folsom, R, 2003, Substance Abuse Treatment Need Among Older Adults in 2020: the Impact of the Aging Baby-Boom Cohort. Drug and Alcohol Dependence 69 (2003) 127 - 135

[10] Karel, M.J, Gatz, M, Symer, M (2012) Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know. American Psychologist, Vol 67 (184-198);

[11] Janice F. Bell PhD MPH, David Mancuso PhD , Toni Krupski PhD, Jutta M. Joesch PhD, David C. Atkins PhD, Beverly Court, MHA PhD, Imara I. West MPH, Peter P. Roy-Byrne MD. Care Management for Medicaid Clients with High Health Care Costs: Evaluation of One-Year Health and Social Outcomes. http://www.agingkingcounty.org/docs/KCCP_Abstract_Bell3-15-11.pdf.

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

The behavioral health specialist would act as the educator, navigator and advocate for the older adult and his/her family. The specialist would provide by phone timely and accurate information with the necessary referrals. Should more ongoing, intensive assistance be required, the specialist would become actively involved with face-to-face interventions that guide the consumer and family through the behavioral health system and – on occasion – advocate on their behalf. The specialist would act as a bridge between the service delivery systems and help ensure that the older adult is connected to needed services. On-call capacity would also allow for crisis response, should the need arise.

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 proposed concept is similar in intent to GRAT and therefore based upon similar evidence described in 1h MIDD concept paper. In 2002, Substance Abuse and Mental Health Services Administration (SAMHSA) designated the GRAT program as a "Promising Practice".[12] In describing the promising practices included in the "Outreach" section of its guidebook, SAMHSA wrote, "Just as outreach is essential to reach older adults with substance abuse or mental health needs, persistence is crucial to connect these individuals with services. These promising practices offer prime examples of the need to 'meet people where they are.' According to Raymond Raschko, developer of the gatekeeper concept, there are two general rules about seniors in need: The more at risk they are, the less likely they are to recognize the problem and ask for help; the more at risk they are, the less likely they are to get help unless someone else intervenes on their behalf."[13]

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

See above.

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?**

Anticipated outcomes and related data sources include the following:

- Number of individuals/families served
    - Data source – records of behavioral health specialist

[12] SAMHSA, Department of Health and Human Services (2002) *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems*, pp 41-44. DHHS Publication No. 02-3628

[13] SAMHSA, Department of Health and Human Services (2002) *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems*, p 30. DHHS Publication No. 02-3628

- Successful enrollment in identified services
    - Data source – records of behavioral health specialist and MHCHADSD IS
- Number of individuals diverted from high cost, intensive care (emergency rooms, hospitalization)
    - Data source – records of behavioral health specialist and perhaps DMHPs
- Decrease in the frequency and length of hospitalization admits
    - Data source – MHCADSD IS
- Consumer and family satisfaction of services by behavioral health specialist
    - Data source - satisfaction surveys and/or focus groups
- Fewer failed placements upon discharge from the hospital
    - Data source – reports of family members and institutional placements

C. Populations, Geography, and Collaborations & Partnerships

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

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

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.

As previously discussed, older adults will become an ever-increasing percentage of the King County population. The complexity of their behavioral health issues, the frequent presence of co-morbid medical conditions and the many barriers to treatment require effective early intervention approaches as well as ongoing support. Families are frequently overwhelmed trying to manage the many needs of their loved ones, resulting in depression and anxiety for them.

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

County-wide and home-based services would be provided by the behavioral health specialist. This staff person would meet with clients in their residence, or another community location, throughout King 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.**

This project's effectiveness would depend on productive partnerships with a number of public and private entities. Coordination with the current I&R services offered by AAA would be critical. Collaboration with crisis responders, such as King County's Crisis and Commitment Services, GRAT and DESC's diversion program, could help divert older adults from more costly treatment interventions. Other key partnerships would include psychiatric hospitals, especially Northwest Hospital Geropsychiatric Center, as well as mental health and substance abuse agencies in the King County behavioral health system. Other potentially important partners would include primary care physicians and related medical services, Adult Protective Services, and Home and Community Services.

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?**

A primary driver is the continued growth of King County's older adult population and the increasing need for behavioral health services. Monies used to divert individuals from more intensive services and to support the family care of loved ones are investments in healthier communities and long term savings.

The County anticipates that state and county efforts to integrate behavioral health and – eventually – medical care might reduce the need for the care management services of a behavioral health specialist. However, it is doubtful that the need for such "bridge builders" between service systems will be completely eliminated.

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?**

Introducing a new position into the current mix of King County's crisis, crisis diversion and I&R services, (such as those offered by GRAT, AAA, and King County's DMHPs) may confuse the community and service network. What are the roles and responsibilities of this position and how do they differ from these other entities? GRAT seems to be experiencing such a problem regarding the community's understanding of its scope. While the program is well known, there have been misunderstandings about

the type of service provided. GRAT is attempting to clarify its role and responsibilities through education efforts.

Rather than spend hours educating the community about this new service, it would seem more effective and efficient to integrate the behavioral health specialist into one of the already existing services. As examples, he/she could be embedded in AAA's information and referral system or used to expand current GRAT services.

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 potential consequence is the duplication of services among the different crisis diversion, re-entry and case management programs. It might be necessary to develop a system that tracks all older adult services throughout King County to avoid this type of situation.

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?**

The most obvious and direct consequences would be suffered by the older adult and his/her family member. They may be left without the services they desperately need resulting in increased morbidity and mortality in this population as well as continued use of emergency, high-cost services.[14]

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?**

As previously noted, this strategy recognizes many of the same gaps identified in other MIDD proposals. (See list below.) Merging these strategies or developing one or two that complement each other may be reasonable alternatives.

- MIDD-funded 1h Strategy**,** *Geriatric Regional Assessment Team (GRAT)*:
- Briefing Paper 123, *Outreach for Older Adults in Psychiatric Crisis*:
- Briefing Paper 33, *Coordinated Care for High Risk Older Adults and Adults with Disabilities*:

MHCADSD could also expand current re-entry programs, such as Peer Bridgers and the Transition Support Program (TSP), to include an older adult specialist. Such an approach would address the issues

[14] Janice F. Bell PhD MPH, David Mancuso PhD , Toni Krupski PhD, Jutta M. Joesch PhD, David C. Atkins PhD, Beverly Court, MHA PhD, Imara I. West MPH, Peter P. Roy-Byrne MD. Care Management for Medicaid Clients with High Health Care Costs: Evaluation of One-Year Health and Social Outcomes. http://www.agingkingcounty.org/docs/KCCP_Abstract_Bell3-15-11.pdf.

identified for hospitalization and post hospitalization follow-up services. This approach, however, would maintain the identified service gap for crisis diversion and I&R. In addition, these re-entry programs serve individuals diagnosed with mental health or co-occurring disorders but not those with substance use disorders only. Another potential alternative would be expansion of an existing program to provide family peer support for family members of older adults, as is done now with family members of youth.

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 model aligns with the Health and Human Services Transformation initiative by diverting the use of crisis-oriented services to focus on prevention and by eliminating disparities via unique care that is necessary for this population to thrive in their communities. The concept also supports Behavioral Health Integration ensuring coordinated care along the behavioral health service continuum

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

This program is consistent with the Recovery model, in that it focuses on helping those older adults most in need to improve their wellbeing, get the assistance needed to accomplish this, and to help older adults live as independently as possible.

Experiencing a psychiatric crisis can be trauma-inducing, especially when a crisis is complicated by compounding factors such as a medical condition, and when the individual lacks natural supports. This concept aims to minimize or potentially avoid the crisis for the individual and family while seeking out services identified as necessary. The concept is rooted in the principles of recovery and resiliency in that the team will connect the individual with holistic services and act as the individual's community as they transition into ongoing aftercare.

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

Almost 23 percent of older adults in King County are people of color and majority of older adults in King County living in poverty are people of color. Over 3,000 older adults and over 5,000 adults with disabilities used emergency shelters in 2014[15]. Older adults have special needs that are unlike other populations. They face extreme barriers such as inability to transport themselves and limited public transportation options, chronic disabilities that many times cause immobility, significant cognitive dysfunction, to name a few, that prevent them from being able to navigate the health system and seek the care they need without assistance. The concept aligns with a social justice and equity perspective by addressing the individual's unique needs and not requiring the county to usurp their civil rights with an involuntary hospitalization. Implementing a crisis support model that is designed to meet the needs specific of this special population will result in fewer crisis services and overall better individual health

F. Implementation Factors

[15] Aging in King County. Profile of the Older Population.

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

This concept would require 1FTE behavioral health specialist with geriatric training.

2. **Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.**

The primary expenses are the personnel costs related to behavioral health specialist. Non-personnel costs would include office space, transportation, training, phone, utilities, etc.

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

GRAT is currently supported by MIDD and federal block grant monies. Perhaps, federal block grant funds could also help fund this project. A collaboration with the I&R services of AAA might also generate city support for this proposal.

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

Implementation timeline and related factors depend upon the project design. Some options include the following:

- Expanding current GRAT services could be executed fairly quickly with an amendment to the current exhibit.
- Collaborating with the AAA to expand I&R services would require some time and effort to structure the partnership. One important question is whether the services would be contracted to a private provider or directly operated by either the city or county. An RFP process would be required if services are contracted with a private provider. Such a process typically takes a couple of months to complete.
- Directly contracting the work to one a provider in King County's behavioral health network would require an RFP process which, again, may take two to three months to complete. Once the contract is assigned, the hiring and training of staff would be fairly straightforward.

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?

New Concept Submission Form

#58

Working Title of Concept: Mental Health Crisis Consultation for Family Caregivers

Name of Person Submitting Concept: Joanne Donohue

Organization(s), if any: Senior Services (soon to be Sound Generations)
Phone: 206 727-6206
Email: joanned@seniorservices.org
Mailing Address: 2208 2nd Avenue, Suite 100, Seattle, WA 98121

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

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

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

Provide information, referral, advocacy, support and follow up to family caregivers going through a mental health crisis involving an older adult. The service would be provided by Senior Services through its Information and Assistance Program.

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.

There is a lack of support for family caregivers whose loved ones are going through a mental illness or substance abuse crisis. With rare exception, our medical and mental health systems remain siloed and this often leads to ineffective intervention particularlu with regards to older adults.

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

The need would be addressed by offering tailored consultation that might include any and all of the following: a. how to deal with an unsafe discharge, self care and setting boundaries, dealing with suicidal behavior, problem solving difficult placements, what to expect with involuntary placements, referrals to Alzheimer's Association, NAMI, mental health resources and other support as needed. A staff person would stay involved over a brief period of time to help the family member navigate and get connected to resources. The staff member would advocate as needed when family is overwhelmed or unable to do so. The service would be available on the phone, in person at the hospital or in the home with an on call component when crises occur outside the work week.

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

People (usually family members) going through a crisis while caring for someone with diagnosed or undiagnosed mental health issues. Indirectly the person in crisis would benefit from a more empowered and educated family member advocating for their well being.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

a.Fewer failed placements upon discharge: hospital readmit data and adult family home and assisted living discharge data. Data is available, but we would need willing partners to obtain it.
b.Caregivers reporting that they were better off as a result of the consultation: qualitative survey data.
c. Reduction of 911 calls for individuals enrolled in the program. Data is available, but

individuals would need to be flagged for tracking purposes and baseline data made available.

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?

By strengthening the informal networks that support older adults in a mental health crisis, we increase the likelihood that that placements and treatment will be successful.

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.

We would need a willing hospital partner, such as Harborview and a short list of adult family home providers who accept placements of older adults with mental health diagnoses, including dementia. The consultation service would pick up where the GRAT Team leaves off.

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: **$ 50,000 per year, serving 25 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*.