MIDD Briefing Paper

ES 17a 17a - **Crisis Intervention Team / Mental Health Partnership (CIT/MHP) Pilot Project and Seattle Police Department Crisis Response Team Expansion**

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number 17a (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form) 4
Type of category: Existing Program/Strategy REVISION & EXPANSION

SUMMARY: The intent of this existing, but never launched MIDD I strategy revision/expansion is to provide four dedicated MHPs in regionally identified locations across King County, and two DMHPs to serve the north and south ends of the County, for dedicated follow-up with law enforcement for individuals who have had recent crisis contacts and/or who utilize a high volume of law enforcement resources due in part to their behavioral health disorders. MHPs would be stationed at various law enforcement agencies on a rotating schedule to ensure local jurisdictions have access to a specialized follow-up provider who can assist with identifying and procuring appropriate and individually specific services to address the needs of people while reducing impacts on officer time responding to these individuals.

Collaborators:

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

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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?**

The original concept for this strategy was for implementation of a pilot program within the Seattle Police Department's (SPD) Crisis Intervention Team (CIT) Unit to include additional staffing of two mental health workers in this unit. One of the providers, a Designated Mental Health Professional (DMHP), would have the authority under King County to petition for involuntary treatment detentions. The other would be a therapeutic Mental Health Professional (MHP) with expertise in the services and resources available to assist individuals with mental health disorders, including those presenting symptoms of drug abuse. These two professionals, working in close concert with CIT Unit officers, were intended to respond immediately to field requests and have more time to spend on these cases. These teams were also intended to consult with patrol officers, detectives, mental health court staff, family members, service providers, the Washington State Department of Corrections, and others to navigate complex systems (e.g. mental health, drug treatment, health care, social service, police, and criminal justice). In the pilot phase, staffing coverage was to include overlapping shifts, Monday through Friday, between 8:00 a.m. and 7:00 p.m. This is the period when the CIT call load is heaviest. In addition, the pilot project was to include an evaluation component to capture and document the results of the project.

Strategy 17a was never implemented as an active strategy through the MIDD fund. In October 2010 the SPD launched a 24-month CIT/ MHP pilot program with funding from a 2009 Federal Justice Assistance Grant to establish a Crisis Intervention Response Team (CIRT) comprised of members of the CIT and a licensed MHP trained in crisis assessment, intervention, and resource referral. There were some changes to the original proposed structure, most notably no DMHP was included as a part of the team. Actual implementation included one MHP paired with a law enforcement officer to provide assistance with follow-up and, in a limited capacity, crisis response. The goal of the pilot program was to improve police response in situations involving individuals with mental health and/or substance use disorders (SUD) through specialized mental health provider response.

According to a program evaluation completed in 2012, the specific function of the MHP in CIRT evolved during the course of the pilot program. The role of the MHP was to work with cases involving individuals with mental health disorders when no probable cause for a crime was present, as well as with individuals who were considered high volume or "nuisance" cases to SPD. The role of the MHP also included working directly with the dedicated SPD CIT officers to triage cases to CIRT members for case disposition. During the implementation of the pilot, the MHP was increasingly involved in fieldwork, including "knock and talks" where CIRT officer and the MHP check-in on individuals with behavioral health disorders for inquiry and follow-up, as well as response to new incidents involving individuals with behavioral health disorders.[1] The City of Seattle continued the program after the two year pilot was completed, which functions at its original capacity of one MHP imbedded with the CIRT.

The MIDD II concept paper suggests adding an MHP to the SPD Crisis Response Team (CRT, the current iteration of CIRT). SPD currently has only one rotating Officer/MHP team responding to the field for in-progress calls. The CRT currently works normal business hours due to their limited availability. The proposed position (expanded team) would work evening hours and expand the coverage to 2:00 a.m., which is when the majority of other community resources (drop in centers, provider agencies, etc.) are closed.

This briefing paper expands on the concept paper request to include a wider scope for both SPD and other jurisdictions within King County. The additional expansion option would not be an expansion of the current SPD program, but a new regional approach through Interlocal Agreements across law enforcement jurisdictions. The expansion provides police officers access to MHPs who would be located

[1] Helfgott, Hickman, Labossiere, Seattle University 2012, *DESCRIPTIVE EVALUATION OF THE SEATTLE POLICE DEPARTMENT'S CRISIS INTERVENTION TEAM/MENTAL HEALTH PARTNERSHIP PILOT PROJECT Final Report.*

throughout King County and dedicated to law enforcement response needs. These MHPs will work with law enforcement to collaboratively respond in the field for incidents involving individuals in behavioral crisis or to address ongoing concerns regarding individuals with behavioral health disorders who frequently come into contact with law enforcement. Additionally, this expansion would include dedicated DMHPs to allow for more responsive requests to law enforcement to perform evaluations in the field, as well as law enforcement assistance to the DMHPs when performing their duties in the community.

The intent of this expansion is to provide four dedicated MHPs in regionally identified locations across King County, and two DMHPs to serve the north and south ends of the County, to provide dedicated follow-up with law enforcement for individuals who have had recent crisis contacts and/or who utilize a high volume of law enforcement resources due in part to their behavioral health disorders. MHPs would be stationed at various law enforcement agencies on a rotating schedule to ensure local jurisdictions have access to a specialized follow-up provider who can assist with identifying and procuring appropriate and individually specific services to address the needs of people while reducing impacts on officer time responding to these individuals. Additionally, police agencies would provide dedicated CIT officers to work with the MHPs and DMHPs to ensure coordinated and consistent collaborations. This proposal allows them to gain access to a MHP that can help with the more intentional and focused follow-up care to reduce calls for service involving individuals who have frequent contact with law enforcement due to their behavioral health needs. Law enforcement agencies would still be able to utilize the resources and supports of the Mobile Crisis Team (MCT) to address in-the-moment behavioral health crisis needs and provide 24-hour, seven days per week response.

Additionally, this program would allow for the current SPD-CIRT MHP to have counterparts in other areas of the county, for collaboration, consultation and back-up.

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 with individuals with behavioral health disorders who are, or who have frequently been, in contact with law enforcement due to signs and symptoms of these disorders, and diverting them from emergency departments (ED) and jails (Crisis Diversion/Early Intervention), 2) providing follow-up services and coordination to ensure access to and linkage with appropriate community social service providers, and to reduce law enforcement response for these individuals due to their behavioral health disorders (Recovery and Re-Entry), and 3) increasing opportunities for assessments, and detention evaluations if indicated, to occur in an individual's own environment (rather than the ED), thereby freeing up DMHPs and officers to respond in a more timely manner to the other needs in the community (System Improvement).

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.

In the police departments of cities in the United States with populations greater than 100,000, approximately seven percent of all police contacts, both investigations and complaints, involve a person believed to have a mental illness.[2] Many of these contacts also involve misuse of drugs or alcohol. It is a major challenge for police and other first responders to maintain the safety of everyone involved in these situations, while also resolving the situation so they can move on to other calls and duties.

In 2008, when the pilot was first considered, SPD officers generated approximately 50 written reports per week involving individuals with mental health issues, with 10 to 15 of these requiring follow up by the department's CIT Unit. For each report written, one to two additional contacts per week between officers and individuals with signs of mental illness are cleared by officers as "oral warning given," "assistance rendered," or "no police action possible or necessary." In total, SPD logged approximately 125 to 130 law enforcement contacts per week with individuals showing signs of mental illness. Numerous additional undocumented contacts with these individuals also occurred every week.[3]

In looking at the current needs related to law enforcement response, it becomes clear that police officers are engaging in frequent interactions with individuals with behavioral health disorders. Police officers are not social workers, but are often expected to be the first line response for individuals whose needs are related to behavioral health, not criminal offending.

In May 2015, SPD began tracking quantitative data around interactions with persons in behavioral crisis. In a recent program update, after collecting data obtained from a newly instituted crisis template that tracks interventions between SPD and individual in crisis, preliminary analysis of crisis contacts during the three month period after initiation of the crisis template shows that SPD officers responded to 2,464 crisis calls – a rate trending towards approximately 10,000 crisis calls annually.[4] Further review of data between May 15, 2015 and October 1, 2015 shows that the SPD logged 3,647 contacts with persons in behavioral crisis[5] (an average of 28 per day day). A total of 827 (22.6%) of those contacts were identified by officers as being a "chemically induced" crisis.

Similarly, the Auburn Police Department reports that their law enforcement officers have already responded to over 500 calls regarding individuals with mental health needs in 2015, and that number does not include calls where mental health and/or substance use disorders were identified upon arrival at the scene but were not the focus of the initial call for service. Most agencies, with the exception of agencies like SPD noted above, do not collect data on behavioral health needs if the focus or disposition of the call includes another primary outcome (i.e., criminal offense resulting in jail booking or citation). Looking beyond the borders of Auburn, South King County's population (excluding unincorporated King County) is approximately 560,000 and nearly equivalent in size to the City of Seattle at 616,500

[2] Deane, Martha; Steadman, Henry J; Borum, Randy; Veysey, Bonita; Morrissey, Joseph P. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services* Vol. 50, No. 1 January 1999: pp.99-101

[3] King County MIDD 17a Crisis Intervention Team / Mental Health Partnership (CIT/MHP) Pilot Project Strategy Implementation Plan

[4] Seattle Police Department Crisis Intervention Program Quarterly Update May 15, 2015 – August 15, 2015; Prepared by the Data Driven Policing Unit / Compliance Section

[5] The Seattle Police Department (SPD) defines behavioral crisis as, "an episode of mental and/or emotional distress in a person that is creating significant or repeated disturbance and is considered disruptive by the community, friends, family and/or the person themselves." This definition is inclusive of persons with mental health and/or chemical dependency issues.

residents, according to 2012 data.[6] It may be inferred that there are a similar number of calls for law enforcement response regarding individuals with behavioral health disorders, and that the need for the services provided through this program, could be expected across multiple jurisdictions countywide.

In the same time period since the CIT-MHP Partnership project was instituted, call numbers to King County Crisis and Commitment Services (CCS) have increased while DMHP staffing levels essentially remained the same (28 full-time DMHPs and six on-call/per diem DMHPs), with a recent increase in DMHP staffing of only 1 FTE and 1 temporary FTE in 2015 to address issues related to responding to concerns of psychiatric boarding and ensuring the legislatively mandated timelines for evaluations are met. With increased demand, it has been difficult for the CCS staff to respond timely to persons in crisis in the community. Often, the overworked DMHPs evaluate the individual many hours after the initial crisis occurred in a clinical setting removed from the initiating crisis. By that time the crisis has often resolved; however, the event still resulted in the individual having been involuntary detained by law enforcement at a local hospital ED, or booked into jail due to a lack of resources available to support the individual in the moment of their crisis.

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

The SPD has had a successful, nationally recognized CIT program since 1998 to address persons in crisis as a result of mental illness, and in 2015 over 40 percent of Seattle's 600 patrol officers have been CIT-certified in a 40-hour training course. The CIRT unit and SPD's CIT-trained patrol officers have assisted providers, family members, the Washington State Department of Corrections, and non-CIT trained police officers on the street, with strategies to address the complex issues involved when persons with mental illness come to the attention of law enforcement.

The purpose of the addition of the MHP and the development of the CIRT was to provide assistance to field officers when they encounter a person who may be experiencing a crisis resulting from a mental health and/or SUD. The SPD program works to improve police response in situations involving individuals with behavioral health disorders through specialized mental health provider response in the field including: assessment and referral of individuals to community based resources which may better meet their housing, mental health and/or SUD, and other needs, and avoiding the use of jail or hospital emergency rooms when appropriate.

Individuals with mental health disorders are at significant risk of interacting with the criminal justice system. The current SPD crisis intervention policy outlines a sequential intercept continuum, which focuses on law enforcement engagement earlier in a crisis cycle, before the behaviors reach a level where the criminal justice system/jail is the only appropriate referral. The addition of another MHP/Officer team to the SPD CRT Unit, as requested in the concept paper, who is able to deploy to in-progress emergencies, will increase the availability of the team to respond to incidents in the field. The CRTs will have more bandwidth to take ownership of the calls and follow them through resolution (e.g., engagement with social services/case management/housing/etc.). Additionally, more CRTs in the field will increase "behavior modeling" to patrol officers that is important for replicated success. While on scene of a behavioral crisis, the patrol officer(s) will be able to watch the CRT manage the call utilizing resources such as the MCT, Crisis Diversion Facility (CDF), Crisis Clinic, etc., as indicated, and bring the incident to an appropriate resolution. Officers will have a much higher likelihood of replicating the

[6] Source: King County Performance, Strategy and Budget office

efforts of the CRT at the next crisis call, as they have seen the process performed and observed the positive outcome first hand.

The addition of dedicated MHP and DMHP staff to provide in-the-field assessments and follow up – paired with local, dedicated law enforcement officers across King County – will allow for more timely evaluation of individuals countywide in order to better ensure appropriate follow-up and response. The patrol officers will be able to turn over these often complex and time-consuming calls to the team, which will evaluate, determine the appropriate response, and promptly refer. Patrol officers will be able to return more quickly to other 911 duties, and individuals in crisis will be better served. As a consequence, both efficiency and effectiveness will be enhanced for the police, the courts, the health care system and the individuals who need help.

The expanded concept may provide an option for law enforcement jurisdictions to provide better direct field support coverage for officers who are interacting with individuals exhibiting signs and symptoms of mental health related issues (in-progress and/or dynamic calls for service), in addition to follow-up work, on those days the MHP is working with law enforcement officers directly.

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 pairing of police with mental health providers is not a new concept. The approach has been successfully implemented in San Diego, Los Angeles, Houston, Portland, OR, Vancouver, B.C., and other cities, with varying response models.

The current SPD project was initially funded via a Federal Fiscal Year 2009 Justice Assistance Grant. The evaluation results of that grant-funded project were overwhelmingly positive. The ability for a police officer to receive real-time input from an MHP about rapidly evolving incidents involving persons suffering from symptomatic behaviors related to an acute crisis is invaluable. The input from the MHP ranges from suggestions on communication techniques to identifying shifts in the subject's behavior. Given the fluid and potentially volatile nature of these types of crisis situations the timely and accurate input from the MHP has significantly decreased the instances of the interactions escalating. The introduction of additional field support has shown a reduction of recidivism among those persons who have been identified as "High Utilizers" by the CRT. It has also been shown to be an effective tool for engagement with those with mental health issues who are hesitant to accept referrals for services by community providers.[7]

A pilot evaluation of the CIRT program was conducted in 2012 and was intended to describe the value added by the MHP during police encounters with individuals with mental health disorders, as well as the effectiveness of the CIRT program with regard to the role and function of the MHP. The current state of knowledge about CITs in law enforcement and partnerships with MHPs is primarily anecdotal. The CIRT evaluation was incident-based and descriptive in nature, and sought to measure on an incident-specific basis the degree to which the MHP plays a role in improving police-citizen relations in incidents where

[7] Presentation to SPD's Crisis Intervention Committee*. CRU Presentation Re: High Utilizers and How the CIU Respond to Staff and Community Requests*, Sgt. Eric Pisconski, SPD Crisis Response Unit, Sept. 17, 2015.

the MHP is involved, as well as perceived changes in the nature of these incidents as reported by responding officers. Data were collected for 290 cases from incident reports and supplemental reports on incident location, incident characteristics, officer descriptions of incidents, CIT follow-up, MHP follow-up, and case disposition. To provide an overall picture of the CIRT pilot and its effectiveness in relation to hypothesized outcomes, key variables were examined to describe the types of cases triaged to CIT, the nature of the cases, case disposition, and the role of the CIT officer and MHP in the case resolution. Key variables included: the nature of incident, repeat calls/contacts, incident location, case disposition, linkages to services, and case clearance time.[8]

The results of the descriptive evaluation of the CIRT pilot program suggest that the CIRT is relieving an otherwise substantial, unnecessary, and inappropriate burden on law enforcement officers by triaging cases to the MHP that would otherwise be taking up time of law enforcement personnel. Although comparable empirical benchmarks prior to the pilot program are not available, the descriptive information concerning repeat contacts, dispositions, time spent on cases, and the spatial distribution of incidents demonstrate that a substantial workload was appropriately shifted from patrol officers to the MHP. The finding that six percent of unique addresses accounted for 27 percent of MHP responses suggests that, based on these locations alone, the MHP is alleviating what would otherwise be a significant resource strain on patrol officers, and that even greater efficiency gains could be achieved with a more regionalized approach. The MHP averaged three contacts per case (with no repeat contact in 43 percent of cases), cleared cases in approximately 19 days, and spent about 50 minutes per case. About a third of cases (34.1%) were referred to non-law enforcement agencies to address mental health and/or substance use disorder needs. Anecdotally, when reviewing these empirical findings with program staff it was observed that these represented substantial improvements in the amount of time to case resolution, repeat contacts, and referrals to non-law enforcement resources. Based on these results, it appears that the anticipated benefits of adding a trained MHP to the CIRT were being realized and that the program has the potential for continued improvement in the quality of police response to persons experiencing mental health crises in Seattle.[9]

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.**

While there are many CIT units across the country, very few jurisdictions have implemented similar programs partnering law enforcement with MHPs where they hold full-time positions and are assigned cases. Knowledge about the current implementation of CITs in law enforcement and partnerships with MHPs is primarily anecdotal in nature. Evaluations of CIT programs to date have not included control groups with rigorous experimental methods because CIT and other such criminal justice interventions are implemented in real-world settings and, as such, have been very difficult to study.[10] Even so, many of the communities utilizing these types of teams are currently collecting information related to incident outcomes and recidivism details that may ultimately provide the data needed to assess how effective these programs truly are on a larger scale.

There are relatively few analytical studies with most evidence of success being primarily anecdotal. There are some initials studies, however, that have found these teams to be effective in resolving crisis situations in the community and successful in diverting individuals with mental illness from

[8] Ibid, Helfgott, Hickman, Labossiere, Seattle University 2012.
[9] Ibid, Helfgott, Hickman, Labossiere, Seattle University 2012.
[10] Ibid, Helfgott, Hickman, Labossiere, Seattle University 2012.

incarceration.[11] Evaluations of Houston's Crisis Intervention Response Team pilot program, which pairs a CIT-trained officer with an MHP who do both response and follow-up work, were reported to be 100 percent favorable and the program was adopted permanently in 2009 and has since expanded the number of responding teams available.[12] Additionally, a study done on jail diversion programs for individuals with mental health and co-occurring SUDs showed that jail diversion reduces jail days, links individuals to services in the community, and does not increase risk to public safety.[13]

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?**

Expected program results include the following:

- Reduced incarcerations and lengths of stay;
- Reduced emergency department utilization;
- Reduced psychiatric hospitalizations;
- Increased referrals and linkages to treatment;
- Reduction in recidivism with individuals identified as high utilizers of law enforcement response in the community;
- Reduction in 911 calls related to behavioral health incidents; and
- Decreased adverse events between police and citizens with behavioral health disorders.

As part of the design, the project will have an evaluation component to document and assess program outcomes, including the development of appropriate quantitative measures of performance. SPD-specific data on response and disposition could be quantified using a comparative analysis of individuals' behavior pre-intervention and post-intervention similar to what was accomplished by Seattle University while reviewing the original CRT BJA grant. Additional data sources include: 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).

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**
- ☐ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**
- ☐ **Veteran/US Military**
- ☐ **Homeless**

[11] Lamb, H.R., Shaner, R., Elliott, D.M., DeCuir, W.J., Foltz, J.T. (1995). Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, *46*, 1267-1271.

[12] 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.

[13] Ibid, Steadman, H. J. and Naples, M. (2005).

- ☒ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **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.

The population consists of individuals in behavioral health crisis who are coming to the attention of law enforcement due to mental health and/or SUD signs and symptoms as well as individuals who experience frequent engagements with law enforcement who are identified as having a behavioral health disorder that is impacting their functioning and safety, and who need additional services and supports to obtain and maintain stability in the community without the need for law enforcement response.

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

The current project is focused on the City of Seattle and, while the concept paper is expressly requesting additional services in this geographical area, continued conversation with SPD's CIT Coordinator has identified strategies and programmatic changes that support the initiation of this type of service throughout King County, without reducing the current structure or capacity of the CRT/MHP program. Expansion opportunities may also focus additional resources within the SPD program to respond to the concept paper proposal. Initial planning for the MIDD Strategy 17a included an expectation that the program would be expanded countywide if deemed successful in responding to the needs of the population served.

Data from other jail diversion strategies, such as the programs of the Crisis Solutions Center (CSC), support the need for a more regional approach. There have been 5,141 referrals to the Crisis Diversion Facility (CDF) (56 percent of the total 9240 referrals) and 3,462 referrals to the MCT (62 percent of the total 5,619 referrals) from agencies outside of the Seattle city limits, or where the referral agency is not limited to a geographic area (i.e. King County Sheriff's Office, Metro Transit Police, Sound Transit Police, and DMHPs). The agencies making referrals are located across the County, including the Cities of Shoreline, Duvall, Enumclaw, Federal Way, North Bend, Kent, Burien, Redmond, Black Diamond, Auburn, Issaquah, Bothell, and many more.

In reviewing the Familiar Faces initiative for frequent jail users in King County, there is a clear indication that a regional approach to address law enforcement responses to individuals with behavioral health disorders is needed. For the purpose of the initiative, "Familiar Faces" are defined as individuals who have four or more King County jail bookings in a one year period and a mental health and/or SUD. Based on data analysis, 94 percent of all people with four or more bookings in a year have a behavioral health indicator. Seattle and unincorporated King County lead in both raw number of arrests and arrests per 1,000 people; however, three additional high-concentration areas across the County also emerged: South King County (Auburn, Burien, Tukwila, SeaTac), Shoreline, and rural East King County (North Bend,

Snoqualmie, Carnation). In addition, despite having at least four bookings in the King County jail, over 40 percent of these individuals also had municipal jail episodes in King County during the same year.[14]

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.**

Partnerships to implement this program include: law enforcement agencies in King County; DMHPs, local community hospitals/EDs, community-based treatment providers, Crisis Solutions Center, housing and shelter programs, the Washington State Department of Social and Health Services, primary care providers, transportation agencies, and the King County Department of Community and Human Services.

Law enforcement agencies would need to identify an officer who is the point of contact (POC) for this program in their jurisdiction, and who would be the primary responder to be paired with the MHP. Additionally, they would need to identify and train officers to provide back-up for the POC in instances where that officer is on leave or in training and unavailable.

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

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 and behavioral health integration will impact the work of the CIT/MHP partnership. The services provided will be an initial step in the continuum of care, intended to provide collaboration and build relationships to increase 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, and, without access to benefits, most of the more therapeutically appropriate services needed for stabilization (e.g., treatment, medications, housing) would not be available and they would continue to cycle through the hospital and jail settings. Additionally, the Familiar Faces initiative links to the work of

[14] Eli Kern, Michael Stanfill, Marietess Koslosky, Public Health-Seattle/King County; Marla Hoffman, Debra Srebnik, Michael Csendes and Namasi Navaretnam, Department of Community and Human Services – Mental Health, Chemical Abuse and Dependency Services Division; **Familiar Faces** Current State – Analysis of Population September 28, 2015

this program, as the CIT/MHP model works to provide a community-based response to reduce the number of individuals with behavioral health needs cycling through the costly jail and hospital systems.

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?**

Local law enforcement agencies must be willing to identify and assign officers to this program if they want to participate as partners with the MHP. This would potentially take officers away from being dispatched to emergent/911 calls and reduce response times overall due to lower staffing levels on the days the MHP is in their jurisdiction.

There will be a high level of coordinated training needed for local law enforcement officers and the MHPs in coordinating response, expectations of each other's roles, basic law enforcement and mental health response options and protocols, crisis intervention, and community resources in order to ensure consistency across jurisdictions.

Each agency may want to individually determine how to utilize the MHP to respond to needs in their jurisdiction. Some may want the MHP to be a primary responder with law enforcement for in-the-moment crisis response; some may want the MHP to perform functions more in line with follow-up and support for the individuals with high law enforcement engagements. Risk management within different municipalities may come to different determinations about the scope of what the MHPs will be allowed to do in conjunction with their police departments. It may be difficult for the MHP to manage differing expectations of various jurisdictions. The MCT might be a more available and accessible option for in-the-moment crisis response, allowing for the program MHP to perform more of the follow up functions. If the MHP can assist jurisdictions with reducing high volume calls for service for certain individuals, this might allow for MCT response time to reduce because they won't need to respond repeatedly to the same individuals.

If a DMHP is unable to join the team, this proposal may not result in more diversion; conversely, the addition of a DMHP may lead to more detentions. Additionally, requests for DMHP response may overload the capacity of the position, or requests from law enforcement and/or CCS may require the DMHP to perform other duties than the position has the bandwidth to provide.

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

The availability of more diversion programs (all along the continuum) may reduce the number of encounters with law enforcement. The increase in, and availability of, DMHPs to help with in-the-moment community response to law enforcement, and to have dedicated CIT officers available to coordinate with DMHPs in performing the functions of their position (serving papers, etc., may reduce the wait time for DMHP assessments (a positive unintended consequence) and allow for more community-based assessments, although this may also result in more involuntary detentions, which is not the goal of the program. Similarly, there may be an increase of referrals from the team to hospitals or jails. Additionally, individuals may use this to meet their service needs, rather than utilize community behavioral health providers and/or primary care providers.

Another unintended positive consequence is addressing the safety needs of the DMHP when responding to individuals who have histories of violence and/or are at-risk of escalating behaviors due to the DMHPs decision to involuntary detain or revoke an individual on a least-restrictive order.

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

Individuals with behavioral health disorders will continue to utilize costly resources such as emergency departments and jails due to the symptoms of their disorder(s). Law enforcement and other first responders would have limited access to resources to assist in the field and would rely on jail and hospital settings to address the needs of this population. There continues to be focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or SUDs, as well as on how law enforcement is responding to these individuals. Without resources that officers can use as alternative options for addressing those in need appropriately, there will continue to be an over-reliance on jails and hospitals, as well as increased use of force, to manage this population. Another unintended consequence could be unnecessary or inappropriate use of force, potentially resulting in injury or death, as is all too commonly witnessed nationally.

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 to assist individuals in behavioral health crisis who repeatedly come into contact with law enforcement, specifically the CDF and MCT. However, neither the CDF nor MCT are intended to provide pre-crisis or on-going coordination 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 to appropriate services and supports in the moment is a real barrier, as many individuals do not have access to vehicles of their own, and buses are expensive for individuals without resources and travel times are often lengthy, depending on where in the County 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 CIT-MHP partnership could provide services in the individual's home and assist with transportation if a more structured environment, or direct connection to their current provider, was indicated in the moment.

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

access only to an individual, with limited outreach availability into the community to directly address a crisis need, and with little direct knowledge about the individual. Finally, enrollment in the BHO is limited to individuals eligible for publicly funded behavioral health services, and there are limited response options for other populations in need.

E. Countywide Policies and Priorities

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

The CIT-MHP 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 streamlined access to services. Additionally, the Familiar Faces initiative links to the work of this program, as the CIT-MHP model works to reduce the number of individuals with behavioral health needs cycling through the costly jail and hospital systems. Many of them are ineligible for, fearful of, or unable to access, services and supports in the community to help manage crises.

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 on 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 experiences are often re-traumatizing to individuals, especially if they have previously experienced the loss of their rights due to detentions or involuntary hospitalizations. The MHP-CIT program is intended to provide an alternative response that reduces the overreliance on the criminal and crisis systems to manage this population. This program recognizes that recovery can take time. 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.

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

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

There are long-standing, widely known issues related to lack of services and diversion opportunities available throughout King County specifically in regards to people of color and low socioeconomic status, many of whom are also experiencing homelessness. Individuals often come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies) and are taken to jail in lieu of addressing the root causes of the matter: lack of access to treatment, housing, jobs, support, and healing and recovery. Access to a community of people who care and value them is imperative. At its founding, this program addresses equity and social justice, and appropriate access to justice, by helping people avoid criminalization.

The CIT-MHP partnership will focus on both reducing the criminalization of behavioral health disorders, and reducing the reliance on jails and hospitals to address a community need. The program will also 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.

In addition, the CIT-MHP partnership's focus on promoting stability and assisting with housing supports and needs for individuals who are homeless or unstably housed, also supports the goals of King County's All Home initiative, which aims to make homelessness rare, brief, and one-time by addressing crises quickly and tailoring housing and supports to individual needs,[15] and addresses the state of emergency regarding homelessness declared by the City of Seattle and King County in November 2015.[16] Its individually tailored service designed to connect people to housing and services also relates to two determinants of equity identified by the King County Equity and Social Justice (ESJ) work: access to health and human services and affordable, safe, quality housing.[17]

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.)**?**

An agency to provide and hire the MHPs, law enforcement officers to be identified for participation in the program, Memoranda of Understanding between the law enforcement and mental health provider agencies, and training in crisis intervention and basic law enforcement/mental health practice parameters are necessary. The basic infrastructure for developing the program is presumably in place because of the founding work of the CIRT program and DESC that staffs the MHP position.

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

The request for the SPD expansion for reimbursement of MHPs' salaries and benefits to the procured community mental health provider is approximately $86,000. A regional approach assumes the costs for the additional 6.0 Full-time Equivalents (FTEs) proposed, as well as computer, phone and other programmatic needs. Officer time is also assumed for the days they are paired with a MHP.

[15] http://allhomekc.org/the-plan/#fndtn-brief-and-one-time accessed on 12/17/15.
[16] http://www.seattletimes.com/seattle-news/politics/mayor-county-exec-declare-state-of-emergency-over-homelessness/ accessed on 12/17/15.
[17] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2015/The_Determinants_of_Equity_Report.ashx?la=en accessed on 12/17/15.

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?**

Factors affecting the time to implementation include the hiring of the MHP staff, as well as the development of collaborative agreements and policies and procedures between law enforcement partners and the procured provider agency. This could also be a phased in project, if law enforcement agencies require additional support and planning to determine their level of participation.

    b. **What are the steps needed for implementation?**

1) Advertising for and hiring of the MHP;
2) Identification and training of the law enforcement officers assigned as POC;
3) Development of policies guiding the program constructed with the MHP provider agency, 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 behavioral health personnel.
4) Office set up (identifying space, obtaining insurance coverage, supplies);
5) Develop a tracking, reporting, and documentation system; and
6) Collaborative meetings with stakeholders.

    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 with, and/or out of, the South County Crisis Center (MIDD New Concept BP 37, 51, 64, 66 South County Crisis Center Schoeld), and provide a more effective 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 relates to the new concept “Immediate Community Care for Individuals Experiencing a Mental Health Emergency” (MIDD BP 16).

Initial implementation of an expanded regional program may include a pilot in one region of King County to identify and address operational and procedural issues that would arise with a cross-jurisdictional program. A potential strategy is to identify a city in South King County willing to dedicate a portion (0.5) of a 1.0 FTE officer, to coordinate with the regional MHP and provide follow-up response in the community for individuals whose behavioral health needs are impacting law enforcement and other first responders, and help connect individuals to the proper services to meet their needs. The officer/MHP team would respond to CIT calls for service throughout South King County as a supplement to current patrol officers, during which time the costs to support the officer would be paid with MIDD funds. A potential partner could include the Normandy Park Police Department, which has noted interest in, and commitment to, a program of this type; however, any jurisdiction that identifies interest would be considered as a potential partner for this pilot. Once it has been determined how best to coordinate the

team's response across jurisdictional boundaries, it could be expanded to the rest of King County and possibly the State of Washington, with the support of law enforcement partners.

Original Implementation Plan (never implemented as part of the MIDD)
October 6, 2008

Strategy Title: Crisis Intervention Team / Mental Health Partnership (CIT/MHP) Pilot Project
Strategy No: 17a
County Policy Goals Addressed:

- A reduction of the number of mentally ill and chemically dependent using costly interventions like jail, emergency rooms and hospitals;
- A reduction of the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency;
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults; and
- Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.

1. Program/Service Description

◊ **A. Problem or Need Addressed by the Strategy**

In the police departments of cities in the United States with populations greater than 100,000, approximately 7% of all police contacts, both investigations and complaints, involve a person believed to have a mental illness.[18] Many of these contacts also involve abuse of drugs or alcohol. It is a major challenge for police and other first responders to maintain the safety of everyone involved in these situations while also resolving the situation so they can move on to other calls and duties.

In Seattle, officers generate approximately 50 written reports per week involving individuals with mental issues, with 10 to 15 of these requiring follow up by the Police Department's Crisis Intervention Team (CIT) Unit. For each report written, one to two additional contacts per week between officers and individuals with signs of mental illness are cleared by officers as "oral warning given," "assistance rendered," or "no police action possible or necessary." In total then, SPD logs approximately 125 to 130 law enforcement contacts per week with individuals showing signs of mental illness. Numerous additional undocumented contacts with these individuals also occur every week.

The Seattle Police Department (SPD) has had a successful, nationally recognized CIT program since 1998 to address persons in crisis as a result of mental illness. A Police Sergeant oversees the work of two patrol officers assigned to the CIT. In addition, approximately one-third of Seattle's 600 patrol officers have been CIT-certified in a 40-hour course. The unit and its CIT-trained patrol officers have assisted providers, family members, the Department of Corrections and non-CIT trained police officers on the street, with strategies to address the complex issues involved when persons with mental illness come to the attention of law enforcement.

[18] Deane, Martha; Steadman, Henry J; Borum, Randy; Veysey, Bonita; Morrissey, Joseph P. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services* Vol. 50, No. 1 January 1999: pp.99-101

Since the program was instituted, call numbers have increased while King County Department of Mental Health staffing levels have remained the same (28 full-time Designated Mental Health Professionals and less than 10 part-time DMHPs). With increased demand, it has been difficult for these King County mental health providers to respond in a timely way to persons in crisis. Often, the overworked DMHPs evaluate the individual many hours after the initial crisis and in a clinical setting. Usually, by that time the crisis is over, but the individual has been detained and is at Harborview Medical Center or in jail.

The SPD proposes a 12-month West Precinct pilot project that dedicates mental health provider staff to providing "in field" assessments. These staff members, paired with CIT officers, will ensure more timely evaluation of individuals to better ensure appropriate follow-up. The patrol officers will be able to turn over these often complex and time-consuming calls to the CIT team, which will evaluate, determine the appropriate response, and refer promptly. Patrol officers will be able to return more quickly to other 911 duties, and individuals in crisis will be better served. As a consequence, both efficiency and effectiveness will be enhanced for the police, the courts, the health care system, and the individuals who need help.

The pairing of police with mental health providers is not a new concept. The model has been successfully implemented in San Diego, Los Angeles, and Vancouver, B.C., and other cities. The idea is currently being piloted by the Houston Police Department.

◊ **B. Reason for Inclusion of the Strategy**

According to the Implementation Timeline of the MIDD Implementation Plan, the proposed Crisis Diversion Center that will be funded with the tax revenues is slated to open in October of 2009. Having mental health providers available in the field will ensure more timely assessment and appropriate referral to services as the diversion center is developed and brought on line.

There will be police, health care, and criminal justice cost savings due to efficient use of police patrol time, fewer jail bookings, and lower health care costs, particularly associated with cases that do not result in involuntary detention and hospitalization. If the mental health providers can make the assessment on the street, significant costs associated with assessing at the hospital are also avoided (the time and costs of ambulance transfer, ER services, etc.). In addition to system cost savings, the services of mental health professionals in the field will ensure more successful outcomes for the individuals in crisis.

◊ **C. Service Components/Design**

Under the proposed pilot, the SPD CIT Unit would be staffed with two mental health providers. One of the providers, a DMHP, would have the authority under King County to petition for involuntary treatment detentions. The other would be a therapeutic MHP with expertise in the services and resources available to assist mentally ill individuals, including those presenting symptoms of drug abuse. These two professionals, working in close concert with CIT Unit officers, will be able to respond immediately to field requests and have more time to spend on these cases. These teams will consult with patrol officers, detectives, mental health court staff, family members, service providers, the Department of Corrections, and others to navigate complex systems (mental health, drug treatment, health care, social service, police, and criminal justice).

In the pilot phase, staffing coverage, working overlapping shifts, will be from Monday through Friday, between 8:00 a.m. and 7:00 p.m. This is the period when the CIT call load is heaviest.

The pilot project will have an evaluation component to capture and document the results of the project. (See Section 1F below.)

◊ **D. Target Population**

SPD's West Precinct includes the city's traditional core for Seattle business, tourism, and governmental services. Since the early 1990s, it has accommodated a disproportionate share of the city's residential growth under the regional Growth Management Planning Strategy. A large number of social service agencies in the West Precinct serve the city's street and homeless population, which includes substantial numbers of individuals with mental illness and drug abuse problems. This concentration of individuals makes the West Precinct the best geographic location for a pilot project.

◊ **E. Program Goals**

The objectives for the CIT/MHP project link back directly to the King County policy goals set forth above. The program goals are to:

- Get individuals in crisis more quickly connected with appropriate services that can help them achieve stability, including housing and social services for those who are homeless, and treatment for those suffering from mental illness and/or drug abuse.

- Reduce the wait time associated with assessing persons for possible detention due to mental illness and/or drug abuse.

- Decrease the amount of time patrol officers spend evaluating and assessing individuals who display symptoms of mental illness and/or drug abuse.

- Achieve other system cost savings through diversion from jail and costly hospital services and/or admissions.

◊ **F. Outputs/Outcomes**

As part of the program design, the CIT/MHP Pilot Project will have an evaluation component to document and assess program outcomes, including the development of appropriate quantitative measures of performance. Possible program results include the following:

- Reductions of mental health assessments by non-CIT trained patrol officers.

- Reductions of transports to Harborview for mental health assessments.

- Reductions of unnecessary ER visits and hospitalizations due to referrals by non-CIT trained patrol officers.

- Reductions in jail bookings where diversion would be appropriate.

- Increase in speedy referrals to appropriate services due to specialized and faster mental health provider response in the field.

2. Funding Resources Needed and Spending Plan

Two full-time mental health providers	$200,000
Lease and operating expense for one vehicle for MHPs	$25,000
Consultant contract for project evaluation	$25,000
Total Pilot Costs	**$250,000**

3. Provider Resources Needed (number and specialty/type)

◊ **A. Number and Type of Providers**

Two FTE mental health providers will be hired for this project, one a therapeutic/homeless specialist (MHP) and one with authority under King County to petition for involuntary treatment detentions (DMHP). (See Section 3C below.)

◊ **B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)**

Two weeks will be allotted for orientation and familiarization with SPD operational protocols and policies.

◊ **C. Partnership/Linkages**

SPD will contract with the King County Mental Health, Chemical Abuse and Dependency Services (KCMHCADS) Division to provide the mental health professionals for this project. KCMHCADS currently employs and designates mental health providers who are trained and have with the authority to do involuntary detentions of mentally ill individuals. The persons hired for this project will be detailed to SPD for work on this project. This arrangement could be extended beyond the pilot project, assuming availability of resources and favorable project outcomes.

The CIT mental health providers will have experience working closely with law enforcement. Therefore, they will be well positioned to assist with the Countywide CIT training that is being proposed. CIT also will assist with the development and work closely with the County's proposed Crisis Diversion Unit.

CIT will network and work closely with all social services, homeless and mental health providers to identify effective referrals for individuals in crisis encountered on the street. One major existing resource in this area is the Homeless Outreach, Stabilization and Transition Project (HOST) with the Downtown Emergency Services Center.

4. Implementation/Timelines

◊ **A. Project Planning and Overall Implementation Timeline**

Contracting with KCMHCADS Division can be completed within 30 days of notification of funding availability. Hiring MHP staff could be accomplished in two months. Basic orientation to SPD will take approximately two weeks.

All dates are contingent on notification of the award of funding. Assuming that occurs October 1, 2008, the contract with King County will be in place by November 1, 2008, new hires should be on board and ready for work by January 1, 2009, and CIT/MHP deployments for street service will begin by January 20, 2009.

◊ **B. Procurement of Providers**
As specified above in Section 4A.

◊ **C. Contracting of Services**

As specified above in Section 4A.

◊ **D. Services Start Date(s)**

As specified above in Section 4A.

New Concept Submission Form

#4

Working Title of Concept: Seattle PD; CRT Expansion

Name of Person Submitting Concept: Sergeant Daniel Nelson
Organization(s), if any: Seattle Police Department
Phone: (206) 684-8053
Email: daniel.nelson@seattle.gov
Mailing Address: 610 5th AVE Seattle, WA 98124; C/O SGT Dan Nelson – Crisis Intervention Coordinator
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.

I am proposing an expansion to the Seattle Police Department Crisis Response Team, which partners a mental health professional with a police officer to respond directly to the field for incidents involving persons in behavioral crisis. SPD currently has one (1) rotating Officer/MHP team responding to the field for in-progress calls. The CRT currently works normal business hours due to their extremely limited availability. The proposed position (team) would work evening hours and expand the coverage to include coverage to 2:00 a.m.; which is when the majority of other community resources (drop in centers, etc…)

are closed. The request is for reimbursement for MHP salary & benefits to the community mental health provider, who is supplying the MHP for this 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.

The Seattle Police Department (SPD) defines behavioral crisis as, "an episode of mental and/or emotional distress in a person that is creating significant or repeated disturbance and is considered disruptive by the community, friends, family and/or the person themselves." This definition is inclusive of persons with mental health and/or chemical dependency issues.

The Seattle Police Department began tracking quantitative data around interactions with persons in behavioral crisis on May 15, 2015. Between May 15, 2015 and October 1, 2015 the SPD logged 3,647 contacts with persons in behavioral crisis (an average of 28/day). A total of 827 (22.6%) of those contacts were identified by officers as being a "chemically induced" crisis. More data is available upon request.

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

This concept would provide better direct field support coverage for officers who are interacting with persons exhibiting signs and symptoms of mental health related issues (in-progress and/or dynamic calls for service). The introduction of additional field support has shown a reduction of recidivism among those persons who have been identified as "High Utilizers" by the Crisis Response Unit. It has also shown to be an effective tool for engagement with those with mental health issues who are hesitant to accept referrals for services by community providers.

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

The Seattle Police Department as well as the organization who is providing the mental health professional(s).

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.

Reduction in recidivism with "high utilizers" in the community. This would be quantified by doing comparative analyses of individual's behavior pre-intervention and post-intervention. This type of analysis was accomplished by Seattle University while reviewing the original CRT BJA grant.
The Seattle University final evaluation report is available upon request.

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?

Person(s) with mental health disorders are at a more significant risk of interacting with the criminal justice system. The current SPD crisis intervention policy outlines a sequential intercept continuum, which focuses on law enforcement engagement earlier in a crisis cycle, before the behaviors peak to a level where the criminal justice system / jail is the only appropriate referral. The addition of another MHP / Officer team (CRT Unit) deploying to in-progress emergencies will increase the rate of coverage hours of responding to

incidents in the field. The CRTs will have more "bandwidth" to take ownership of the calls and follow them through resolution (engagement with social services / case management / housing / etc.). Additionally, more CRTs in the field also heighten the level of "behavior modeling" to patrol officers that is so important for replicated success. An example would be CRT responding as a resource to a "crisis" event with patrol officers. While on scene, the patrol officers will watch the CRT manage the call (utilize resources -MCT / CDF / Crisis Clinic) and bring the incident to an appropriate resolution. Officers will have a much higher likelihood of replicating the efforts of the CRT at the next "crisis" event; as they have seen the process performed and observed the positive outcome first hand.

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.

Seattle Police Department / Community Mental Health Providers

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: $ per year, serving people per year
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ 86,000 per year, serving 1 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*.

Note: This Strategy was never implemented as part of the MIDD.

Strategy Title: Crisis Intervention Team / Mental Health Partnership (CIT/MHP) Pilot Project

Strategy No: 17a

County Policy Goals Addressed:

- A reduction of the number of mentally ill and chemically dependent using costly interventions like jail, emergency rooms and hospitals;
- A reduction of the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency;
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assisted providers, family members, the Department of Corrections and non-CIT trained police officers on the street, with strategies to address the complex issues involved when persons with mental illness come to the attention of law enforcement.

Since the program was instituted, call numbers have increased while King County Department of Mental Health staffing levels have remained the same (28 full-time Designated Mental Health Professionals and less than 10 part-time DMHPs). With increased demand, it has been difficult for these King County mental health providers to respond in a timely way to persons in crisis. Often, the overworked DMHPs evaluate the individual many hours after the initial crisis and in a clinical setting. Usually, by that time the crisis is over, but the individual has been detained and is at Harborview Medical Center or in jail.

The SPD proposes a 12-month West Precinct pilot project that dedicates mental health provider staff to providing "in field" assessments. These staff members, paired with CIT officers, will ensure more timely evaluation of individuals to better ensure appropriate follow-up. The patrol officers will be able to turn over these often complex and time-consuming calls to the CIT team, which will evaluate, determine the appropriate response, and refer promptly. Patrol officers will be able to return more quickly to other 911 duties, and individuals in crisis will be better served. As a consequence, both efficiency and effectiveness will be enhanced for the police, the courts, the health care system, and the individuals who need help.

The pairing of police with mental health providers is not a new concept. The model has been successfully implemented in San Diego, Los Angeles, and Vancouver, B.C., and other cities. The idea is currently being piloted by the Houston Police Department.

◊ **B. Reason for Inclusion of the Strategy**

According to the Implementation Timeline of the MIDD Implementation Plan, the proposed Crisis Diversion Center that will be funded with the tax revenues is slated to open in October of 2009. Having mental health providers available in the field will ensure more timely assessment and appropriate referral to services as the diversion center is developed and brought on line.

There will be police, health care, and criminal justice cost savings due to efficient use of police patrol time, fewer jail bookings, and lower health care costs, particularly associated with cases that do not result in involuntary detention and hospitalization. If the mental health providers can make the assessment on the street, significant costs associated with assessing at the hospital are also avoided (the time and costs of ambulance transfer, ER services, etc.). In addition to system cost savings, the services of mental health professionals in the field will ensure more successful outcomes for the individuals in crisis.

◊ **C. Service Components/Design**

Under the proposed pilot, the SPD CIT Unit would be staffed with two mental health providers. One of the providers, a DMHP, would have the authority under King County to petition for involuntary treatment detentions. The other would be a therapeutic MHP with expertise in the services and resources available to assist mentally ill individuals, including those presenting symptoms of drug abuse. These two professionals, working in close concert with CIT Unit officers, will be able to respond immediately to field requests and have more time to spend on these cases. These teams will consult with patrol officers,

detectives, mental health court staff, family members, service providers, the Department of Corrections, and others to navigate complex systems (mental health, drug treatment, health care, social service, police, and criminal justice).

In the pilot phase, staffing coverage, working overlapping shifts, will be from Monday through Friday, between 8:00 a.m. and 7:00 p.m. This is the period when the CIT call load is heaviest.

The pilot project will have an evaluation component to capture and document the results of the project. (See Section 1F below.)

◊ D. Target Population

SPD's West Precinct includes the city's traditional core for Seattle business, tourism, and governmental services. Since the early 1990s, it has accommodated a disproportionate share of the city's residential growth under the regional Growth Management Planning Strategy. A large number of social service agencies in the West Precinct serve the city's street and homeless population, which includes substantial numbers of individuals with mental illness and drug abuse problems. This concentration of individuals makes the West Precinct the best geographic location for a pilot project.

◊ E. Program Goals

The objectives for the CIT/MHP project link back directly to the King County policy goals set forth above. The program goals are to:

- Get individuals in crisis more quickly connected with appropriate services that can help them achieve stability, including housing and social services for those who are homeless, and treatment for those suffering from mental illness and/or drug abuse.
- Reduce the wait time associated with assessing persons for possible detention due to mental illness and/or drug abuse.
- Decrease the amount of time patrol officers spend evaluating and assessing individuals who display symptoms of mental illness and/or drug abuse.
- Achieve other system cost savings through diversion from jail and costly hospital services and/or admissions.

◊ F. Outputs/Outcomes

As part of the program design, the CIT/MHP Pilot Project will have an evaluation component to document and assess program outcomes, including the development of appropriate quantitative measures of performance. Possible program results include the following:

- Reductions of mental health assessments by non-CIT trained patrol officers.
- Reductions of transports to Harborview for mental health assessments.

- Reductions of unnecessary ER visits and hospitalizations due to referrals by non-CIT trained patrol officers.

- Reductions in jail bookings where diversion would be appropriate.

- Increase in speedy referrals to appropriate services due to specialized and faster mental health provider response in the field.

3. Funding Resources Needed and Spending Plan

Two full-time mental health providers	$200,000
Lease and operating expense for one vehicle for MHPs	$25,000
Consultant contract for project evaluation	$25,000
Total Pilot Costs	**$250,000**

3. Provider Resources Needed (number and specialty/type)

◊ **A. Number and Type of Providers**

Two FTE mental health providers will be hired for this project, one a therapeutic/homeless specialist (MHP) and one with authority under King County to petition for involuntary treatment detentions (DMHP). (See Section 3C below.)

◊ **B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)**

Two weeks will be allotted for orientation and familiarization with SPD operational protocols and policies.

◊ **C. Partnership/Linkages**

SPD will contract with the King County Mental Health, Chemical Abuse and Dependency Services (KCMHCADS) Division to provide the mental health professionals for this project. KCMHCADS currently employs and designates mental health providers who are trained and have with the authority to do involuntary detentions of mentally ill individuals. The persons hired for this project will be detailed to SPD for work on this project. This arrangement could be extended beyond the pilot project, assuming availability of resources and favorable project outcomes.

The CIT mental health providers will have experience working closely with law enforcement. Therefore, they will be well positioned to assist with the Countywide CIT training that is being proposed. CIT also will assist with the development and work closely with the County's proposed Crisis Diversion Unit.

CIT will network and work closely with all social services, homeless and mental health providers to identify effective referrals for individuals in crisis encountered on the street. One major existing resource in this area is the Homeless Outreach, Stabilization and Transition Project (HOST) with the Downtown Emergency Services Center.

4. Implementation/Timelines

◊ A. Project Planning and Overall Implementation Timeline

Contracting with KCMHCADS Division can be completed within 30 days of notification of funding availability. Hiring MHP staff could be accomplished in two months. Basic orientation to SPD will take approximately two weeks.

All dates are contingent on notification of the award of funding. Assuming that occurs October 1, 2008, the contract with King County will be in place by November 1, 2008, new hires should be on board and ready for work by January 1, 2009, and CIT/MHP deployments for street service will begin by January 20, 2009.

◊ B. Procurement of Providers

As specified above in Section 4A.

◊ C. Contracting of Services

As specified above in Section 4A.

◊ D. Services Start Date(s)

As specified above in Section 4A.