MIDD ES Briefing Paper

ES 10b Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number 10b (Attach MIDD I pages)
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy NO CHANGE

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

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Name	Role	Organization
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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 Adult Crisis Diversion Center strategy (herein referred to as the Crisis Solutions Center or CSC) provides King County first responders with a therapeutic, community-based alternative to jails and hospitals when engaging with adults who are in behavioral health crisis. King County contracts with DESC to provide crisis diversion services in King County at the CSC. DESC has a strong history of engaging

with individuals who are homeless, who experience mental health and substance use disorders, and who may be reticent in accepting traditional services. The CSC has three program components; Mobile Crisis Team (MCT), Crisis Diversion Facility (CDF), and Crisis Diversion Interim Services (CDIS). The programs are intended to stabilize and support individuals in the least restrictive setting possible, while identifying and directly linking them to appropriate and ongoing services in the community.

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

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

The CDIS is a 30-bed program co-located with the CDF. After a crisis has resolved at the CDF, individuals may be referred to the CDIS if they are homeless, their shelter situation is dangerous or has the potential to send them into crisis again, or they need additional services prior to discharge to help support stabilization. Individuals can stay at the CDIS for up to 2 weeks. Services include continued crisis and stabilization services, intensive case management, evaluation and psychiatric services, medication management and monitoring, mental health and substance abuse disorder assessments, peer specialist services, and linkage to community-based services, with a focus on housing and benefits applications.

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).

CSC programs were developed as pre-booking and/or pre-hospitalization diversion alternatives. The goal of these programs is to reduce the cycling of individuals with mental health or substance use disorders through the criminal justice and crisis systems. Individuals in behavioral health crisis are not always best served in jail and hospital settings. CSC programs allow for individuals to receive services to both stabilize crises in the moment and to address the situations that cause or exacerbate crises. By focusing on an individual's immediate needs, and through facilitating engagement in services and supports in the community, the CSC programs may be able to reduce the need for law enforcement involvement.

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.

The intent of the CSC programs is to offer law enforcement and other first responders – including Fire Department/EMS, Designated Mental Health Professionals (DMHPs), Emergency Department staff, and in some cases the Crisis Clinic – immediate access to community and facility-based services to provide crisis resolution and linkage to appropriate community-based care. The goal of these programs is to reduce the cycling of individuals with mental health or substance use disorders through the criminal justice and crisis systems and facilitate linkages to appropriate services to help meet their current and ongoing needs in the community. Additionally, individuals may be diverted by law enforcement officers through the CSC programs rather than booked into jail on a defined set of misdemeanor charges and low level felony drug offenses and, as part of their diversion agreement, will participate in services in order to divert any potential criminal charges. Please see question D4 for information on the potential impact of discontinuing this strategy.

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

Individuals tend to cycle through our jail and hospital systems quickly and end up back on the streets, often before the officer who took them to these locations even gets off shift. CSC services offer alternatives to these revolving doors. Any adult in King County in emotional or behavioral crisis that would benefit from crisis intervention and agrees to participate in the services may be referred to the CSC to help address the immediate crisis and provide necessary supports to facilitate engagement with community-based providers. The MCT, when feasible and available, contacts the individual's current care providers in an attempt to access services as soon as possible to support the individual's crisis and stabilization needs, as well as to provide information to the current provider on their engagement with the individual. The CDF and CDIS work to engage with existing providers to participate and assist in discharge planning. In addition, each program works to establish linkages and connections to services for individuals who are not currently enrolled in programs to assist with their identified needs. CSC employees take away barriers to treatment by linking individuals directly to services, coordinating all appointments, and taking the individuals to first appointments in the community. Such assistance is helpful in facilitating engagement in ongoing services.

CSC programs allow for individuals to receive services to both stabilize crises in the moment and to address the situations that cause or exacerbate crises. By focusing on an individual's immediate needs, the programs may be able to reduce need for law enforcement or other first responder involvement through facilitating engagement in community-based services and supports. Recovery is possible and can take multiple attempts. The CSC allows for individuals to obtain necessary services to help support their path to recovery, and allows for individuals to become known to the staff so that they can follow-up on previous plans and determine what needs to be done differently to make change possible and more likely for that individual. As such, the CSC accepts individuals on a repeat basis, as appropriate, and allows for the individuals and staff to follow-up on previously developed plans to determine what needs to be done differently to make change possible and sustainable for that individual.

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.

Delayed implementation of MIDD Strategy 10b has had a detrimental impact on outcomes analysis and reporting. In MIDD Year Five, only 285 individuals were eligible for first year outcomes analysis. For these program participants, the average number of days in psychiatric hospitals and admits to the Harborview emergency department (ED) increased between the pre and first post periods. As stated in the MIDD Year Five Annual report, "this trend is likely indicative of individuals being linked to needed services." Jail utilization increased over time for some program participants, but the 23 CDIS participants with any jail use decreased their average jail days from 39 to 20. Given the small sample size, this reduction of 48% was not statistically significant.

By MIDD Year Six Annual Report, 1,819 people who began services prior to October 2013 were eligible for outcomes analysis. Reporting focused on jail utilization only. Short-term increases in jail bookings varied by program participation, as illustrated in the annual report. Aggregate analysis of jail bookings and days for the individuals eligible for first year outcomes showed increases of 30 percent and 56 percent, respectively, over the short term. For the 290 people eligible for a second post period, however, aggregate jail bookings fell seven percent while days in jail rose only 19 percent when comparing the pre period to the second year after services began. This would indicate that the data were beginning to trend in the desired direction, although the sample size is very small. Most criminal justice programs evaluated by MHCADSD show similar trends, with bookings starting to reduce prior to jail days, and jail days not reducing until two or three years after the pre period.

At Harborview ED, first year outcomes with the larger sample (N=1,819) continued to show increased aggregate visits over the short term of 43 percent. On average, 2.4 visits in the pre period rose to 3.4 during the first post period. For the 290 individuals with two-year post data available, however, aggregate ED visits fell by 27 percent. This trend in a positive direction is shown by program participation below. Note that the groups shown are not exclusive, in that a person may have participated in more than one program component.

Aggregate Harborview ED Visits Declined in the Second Post Period

	Pre	Post 2	Percent Change
Any MCT (N=188)	393	347	-12%
Any CDF (N=129)	297	199	-33%
Any CDIS (N=76)	157	86	-45%
All Cases (N=290)	622	453	-27%

Average visits to the ED for the 167 people (out of 290 eligible) who had any visits in either the pre or second post period fell from 3.7 to 2.7, which was statistically significant. Those with CDIS participation were more likely to significantly reduce their ED visits than those without.

For psychiatric hospitalizations (which combined community inpatient psychiatric care and Western State Hospital days), the short-term trend was toward increased utilization. For example, 616 individuals had psychiatric hospitalizations in either their pre period, first post period, or both. On average, days hospitalized rose from 19 to 34, or 79 percent. By isolating those with longer term interventions, the trend began to turn, especially for those with more intensive CSC contact as shown in the table below. Note that the increase in psychiatric hospitalizations was driven by those receiving MCT services. Given that these services provided in a moment of acute crisis with police involvement, an increase in hospital

days may be seen as a positive outcome, as individuals are being linked to psychiatric treatment rather than being incarcerated.

Aggregate Days in Psychiatric Hospitals Decreased for Two CSC Program Components by the Second Post Period

	Pre	Post 2	Percent Change
Any MCT (N=188)	1,634	2,298	+41%
Any CDF (N=129)	985	412	-58%
Any CDIS (N=76)	775	308	-60%
All Cases (N=290)	2,218	2,567	+16%

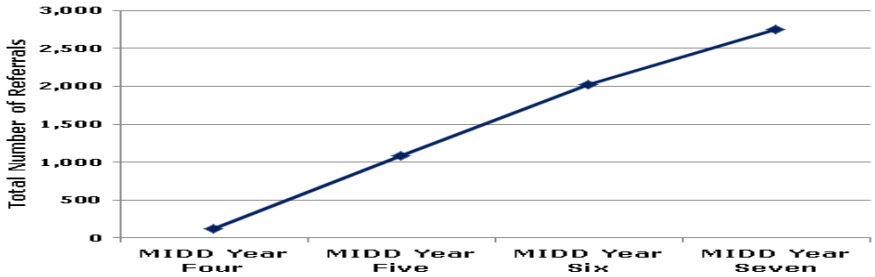
Linkages to treatment in the year following their first CSC visit were tracked for 1,819 people. At least 594 (33%) were linked to primary outpatient mental health benefits, another 89 (5%) were linked with secondary benefits, such as Assertive Community Treatment or supported employment, and 243 (13%) were linked to substance use disorder treatment. Further analysis revealed that a higher percentage of those who participated in the CDIS were linked to mental health treatment than those who did not have contact with the CDIS. Similarly, those with CDIS involvement had shorter lag times to such linkage.

CDIS Participation Increased Likelihood of Timely Treatment Linkages

	Total Participants	Number Linked to Mental Health Treatment	Percent Linked	Average Days to Linkage
CDIS	678	301	44%	116
No CDIS	1,141	382	34%	147

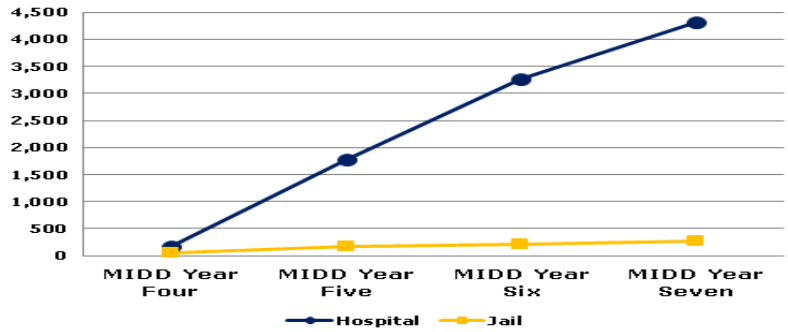
In a preliminary analysis using data for all MIDD years, two indicators of system-level performance were examined with data available from August 2012 to August 2015. The total number of referrals to mental health and substance use disorder treatment (which differs from the confirmed linkages reported above) increased annually as shown in the graph below. Note that multiple referrals per person were possible, but more than a single referral per CSC admission was rare.

CSC Referrals to Mental Health and Substance Use Disorder Treatment Increased Annually



The cumulative number of diversions from area hospitals and jails shows that, while hospital diversions were common, jail diversions were fairly rare. The provider had the opportunity to record only one diversion per admission to the CSC, so it is possible that the graphic below does not fully illustrate all potential diversions taking place.

Documented Diversions from Hospitals Outpaced Jail Diversions



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.**

Crisis services are an important part of the continuum of publicly funded mental health services available as they are intended to provide immediate access to critical psychiatric services as well as basic services such as emergency housing, food and clothing. One of the main goals of crisis services is to determine an individual's ability to access and use services to stabilize in the community. Crisis services also provide post-stabilization activities, including referral and linkage to outpatient services and supports. Mobile crisis teams appear to have an advantage over emergency departments in their ability to intervene in early and acute stages of a crisis, and provide the appropriate level of response and care to meet the individual's needs, whereas ED staff generally focus on determining whether criteria for inpatient treatment is met.[1]

A study by Guo, Biegel, Johnsen and Dyches published in 2001 evaluated the impact of a community-based mobile crisis intervention program on the rate and timing of hospitalization. The study found that "a matched sample of consumers who used hospital-based crisis services were 51 percent more likely to be hospitalized after other variables had been controlled for, than users of community-based mobile crisis services."[2] Another study, published in August 2002 in the Australian and New Zealand Journal of Psychiatry, found that "Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics."[3] In addition, a study done on jail diversion programs for individuals with mental health and co-occurring substance use disorders showed that jail diversion reduces jail days, links individuals to services in the community, and does not increase risk to public safety.[4]

The CSC utilizes the following evidence-based, research-based and promising practices identified by the WA State Department of Behavioral Health and Recovery (DBHR): Illness Self-management/Illness Management and Recovery, Integrated Treatment for Co-occurring Disorders, Medication Management,

[1] Maryland Health Care Commission, Plan to Guide the Future Mental Health Services Continuum in Maryland; White Paper, Best Practices: Crisis Response and Diversion Strategies; 2008.
[2] Shenyang Guo, David E. Biegel, Jeffrey A. Johnsen, and Hayne Dyches, *Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization*, Psychiatric Services, Feb 2001; 52: 223 - 228.
[3] Hugo, Malcolm; Smout, Matthew; Bannister, John, *A Comparison In Hospitalization Rates Between A Community-Based Mobile Emergency Service And A Hospital-Based Emergency Servic*e, Australian and New Zealand Journal of Psychiatry, *Vol. 36 Issue 4 Page 504 August 2002*
[4] 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

Cognitive Behavioral Coping Skills Therapy, Motivational Interviewing, Relapse Prevention, Seeking Safety, Twelve Step Facilitation, and Trauma Informed Care.[5]

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?**

- Reduced incarcerations and lengths of stay
- Reduced emergency department utilization
- Reduced psychiatric hospitalizations
- Increased referrals and linkages to treatment

The current strategy collects information on a wide array of client related data, including demographics, referral sources, dispositions, and program length of stay/utilization. Data sources include: the CSC's monthly and quarterly program reports; internal data that 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**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☐ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**

☒ **Other – Please Specify:** Individuals in behavioral health crisis coming to the attention of first responders.

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.

Individuals in behavioral health crisis who are cycling through jail and hospital settings due to symptoms of a behavioral health disorder and/or who are often admitted into inpatient psychiatric beds (voluntary and involuntary hospitalizations) and can be served in the community through least restrictive alternatives.

[5] Miller, Marna; Funia, Danielle; Kay, Noa (2015) Updated Inventory of Evidence-based, Research-based, and Promising Practices: *Prevention and Intervention Services for Adult Behavioral Health;* http://www.wsipp.wa.gov/ReportFile/1583/Wsipp_Updated-Inventory-of-Evidence-based-Research-based-and-Promising-Practices-Prevention-and-Intervention-Serivces-for-Adult-Behavioral-Health_Benefit-Cost-Results.pdf

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 CSC operates from their location in the International District in Seattle, however, the MCT responds to all areas of King County upon request of Fire Departments, Law Enforcement officers, DMHPs, and the unenrolled consumers referred by the Crisis Clinic. The CDF accepts referrals from all areas of the county. Additionally, the CSC is within close proximity of I-5, I-90, Harborview Hospital, and local Metro bus routes. First responder agencies county-wide are eligible to make referrals to the CSC programs. There have been 5,141 referrals to the CDF (56% of the total 9240 referrals) and 3,462 referrals to the MCT (62% 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. MCT referrals to the CDF, King County Sheriff's Office, Metro Transit Police, Sound Transit Police, and DMHPs) between August 2012 and September 2015. The agencies making referrals to CSD 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.

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.**

Continued partnerships are necessary to maintain this diversion and linkage program with: all first responder agencies in King County, including law enforcement and fire departments/EMS; criminal justice entities DMHPs, and hospitals; community-based treatment providers; housing and shelter programs, WA State Department of Veteran Affairs and the Department of Social and Health 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?**

The services provided through these programs are one step in the continuum of care, intended to provide immediate crisis stabilization services to individuals in crisis and to promote access to services for these individuals. The longer term goal of connection to, and ongoing maintenance of, behavioral health services, regardless of whether the individual's needs are related to mental health, substance use or co-occurring disorders, reflects 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 have been available to them and they would continue to cycle through the hospital and jail settings.

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?**

There should be no barriers to implementation as this program has been operational for the past three years.

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 program is already implemented; however, it could have potential impacts to the outpatient system due to an increase in referrals. Wait times for resources and services could increase if the outpatient system is unable to accommodate increasing numbers of referrals from CSC in a timely manner.

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 EDs and jails. 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 is a focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or substance use disorders, as well as on how law enforcement responds to these individuals. Without resources that provide officers with alternative options for addressing these needs appropriately, there will be an over-reliance on jails and hospitals to manage this population.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Prior to the implementation of the CSC programs, law enforcement and other first responders had limited options for diversion when encountering an individual in behavioral health crisis. Jails and hospitals were the only available options in the moment of the encounter beyond leaving the individual at the scene of the interaction. Hospitals had very few options available to them, primarily the Crisis Respite Program that can serve 20 individuals at any time but has limited referral hours, and the Medical Respite program for individuals with primary, co-morbid physical health needs.

Prior to the MCT implementation, calls for crisis outreach for all adults not currently enrolled in the publicly funded mental health system were being directed to the King County DMHPs, who performed both crisis outreach and evaluation for involuntary commitment. The volume of referrals for both crisis outreach and involuntary commitment investigations has increased in recent years, and DMHPs were not always able to respond immediately to crisis outreach calls. In addition, the expansion of commitment criteria under SHB 3076 implemented in July 2014, was expected to increase the number of commitment referrals significantly, which further reduces the ability of DMHP teams to respond to community crisis intervention needs in a timely fashion.

Another resource for individuals who are enrolled in the King County Regional Support Network (RSN, which represents the publicly funded mental health system) is the after-hours crisis response system. 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 consumer strengths, resources, and choice. The current crisis response system for individuals who are enrolled in the RSN 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 out crisis response services to other agencies for after-hours crisis response, which often

includes access to an individual telephonically with limited outreach availability into the community to directly address a crisis 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?

When the programs of the CSC were initially identified as a strategy under the MIDD, they were done commensurate with the Sequential Intercept Model, understanding that the sooner individuals can receive intervention in their own communities, the more likely they were to stay out of the crisis and criminal justice systems and get the ongoing help they need. The CSC is one step in the continuum of care that is intended to provide immediate crisis stabilization services, and promote access to community-based services. An understanding that recovery can take time and that continued efforts on the part of first responders and service providers is needed to support the recovery process.

The program linked with other King County Council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services. Additionally, Behavioral Health Integration will link to this effort, especially given the high levels of co-occurring disorders in the population served, which will allow for more integrated and, hopefully, streamlined access to services. This program already has removed barriers to access by allowing individuals in behavioral health crisis, regardless of whether the crisis is related to mental health, substance use or co-occurring disorders.

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

Many staff persons at the CSC are trained in Trauma-Informed Care, and are focused on meeting individuals where they are, rather than expecting them to be ready for services, housing, etc. The recovery aspect is indicated in their willingness to work with individuals on a repeat basis in order to work on motivation for treatment, while also focusing their efforts on what is important for the individual. The CSC recognizes that without basic needs being met, and a little human compassion, individuals will likely be moving from crisis to crisis, rather than moving to a path of recovery. Their focus is on the most pressing needs such as obtaining identification and health benefits, and completing housing applications, etc., shows their willingness to take the extra steps needed to ensure an individual has access to, and the support they need to engage in, the supports that will help them maintain stabilization.

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

The CSC is focused on both reducing the criminalization of behavioral health disorders, and reducing the reliance on jails and hospitals to address a community need. The CSC programs utilize trained and certified peer counselors at the facilities to assist with client engagement and to promote the recognition that recovery is possible by hiring staff that identify as being current or former consumers of mental health services. The Peer Counselors bring a level of understanding and empathy to help individuals engage with services and reduce feelings of alienation from others. The program also coordinates and collaborates with a wide variety of systems and community supports that have may not

have been available or responsive to the individual's needs, and works to break down barriers to access that may have prevented successful interactions with community-based services.

Demographic data for individuals served through the CSC programs through September 30, 2014 indicate that 60 percent of individual served at the CSC are white, 16 percent are African American/Black, five percent Asian and Pacific Islander, two percent Native American, and 17 percent are either multiple races, other races not identified, or unknown. These numbers indicate a higher level of non-white individuals being referred to the CSC programs than the demographic breakdown of the county as a whole. King County has a 70 percent rate of individuals who identify as White, 6.7 percent rate of individuals who identify as Black or African American, 17.2 percent who identify as Asian and Pacific Islander, 1.1 percent who identify as American Indian and Alaska Native, and 4.9 percent who identify as two or more races.

The rates of racial breakdown for unique individuals booked into the King County jail shows the differences in rates of admission to jail as compared to the CSC and the population as a whole across racial categories (65% white, 26% African American, 6.4% Asian and Pacific Islanders, and 2.4% Native American) indicating that although non-white individuals continue to come into contact with law enforcement at higher per capita rates than whites, it appears officers are working to divert non-white individuals at a rate that is comparable to the rate seen in jail booking. The work of the CSC does seem to be impacting the inequitable incarceration of non-whites, although much work remains to be done.

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.)**?**

All the resources needed to support the CSC programs are in place and only require ongoing funding to maintain services. The CSC supports over 100 staff, as well as a facility space that holds all three programs and vehicles to provide the needed transportation for clients to appointments in the community. Additional staffing to assist with the number of appointments being facilitated on a daily basis (15-25 on any given day, across all of King County, and sometimes beyond), may be warranted to ensure adequate availability of staff support to provide a warm hand-off or connection to a new service provider in the community while supporting the needs of the clients on-site at the CSC.

2. **Estimated ANNUAL COST. More than $5 million Provide unit or other specific costs if known.**

The CSC has an annual budget of $6.8 million, of which $6.1 million are MIDD funds. The CSC operates on a reconciled cost-reimbursement model, which covers staff salaries and benefits, facility operations, transportation, hygiene services (laundry, showers, etc.), room and board for individuals staying at the facility, and all other affiliated costs. The CSC supports over 100 staff members who provide services and supports 24/7; in 2014, the CSC served 5,044 unduplicated individuals, and they are on track to serve over 6,200 unduplicated individuals in 2015.

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

ESSB 5480 provides an additional $800,000 per year to support an expansion of the MCT in 2014 to address crisis outreach calls for adults not currently enrolled in the publicly funded mental health system. The goal was to reduce the need for psychiatric hospitalization by expanding crisis response to adults by professionals with expertise in less restrictive alternatives to civil commitment, thus reducing acute and long term psychiatric hospitalization. Improving response times for crisis intervention, and

having crisis response performed first by professionals who have access to less-restrictive resources and do not have detention authority, was also intended to reduce hospitalizations and jail bookings.

There may be some other funding sources available to support some portion of services at the CDF program. The CDF is licensed and certified as a Residential Treatment Facility by the State of Washington with a program capacity of 16 beds in order to potentially utilize Medicaid funds to support individuals who are Medicaid eligible.

4. **TIME to implementation: Currently underway**
   a. **What are the factors in the time to implementation assessment?** No factors in implementation as this is an ongoing strategy and can continue without interruption.

   b. **What are the steps needed for implementation?** No steps needed for implementation.

   c. **Does this need an RFP?** No.

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?

Original Implementation Plan
October 6, 2008

Strategy Title: Pre-Booking Diversion Programs

Strategy No: 10b – Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

Hospital emergency departments across King County are regularly overcrowded with individuals waiting for mental health or chemical dependency assessments and placement dispositions. In many cases, individuals who have been assessed as needing involuntary commitment have had to stay in emergency departments for up to three days waiting for admission to an involuntary inpatient unit. On any given day in jails throughout King County, an estimated 15 percent of inmates have a serious mental illness and 80 percent have substance abuse problems. Once in jail, individuals with mental illness stay much longer than inmates without mental illness, and the daily cost of serving them in the jail is much greater. Diverting individuals from the jail, when appropriate given the nature of the criminal offense and the potential risk to public safety, not only reduces costs for city and county governments, but also provides more appropriate and humane care.

◊ *B. Reason for Inclusion of the Strategy*

Creating a crisis diversion facility would give police options for diverting individuals who are in crisis due to mental illness and/or substance abuse from jails and hospital emergency departments. A crisis diversion facility, combined with mobile crisis teams and respite housing, would also link individuals in crisis with needed community services that would help keep individuals from constantly recycling through expensive emergency services.

◊ *C. Service Components/Design*

Establish a crisis diversion facility (CDF) where police and other first responders may refer/bring individuals in crisis for evaluation, crisis resolution and linkage to appropriate community-based care. Develop a mobile crisis team that can assist first responders in finding appropriate resources or transporting individuals to and from the diversion facility. Provide interim “respite” housing for homeless individuals ready to leave the CDF, but in need of temporary housing while permanent supported housing is being arranged. Includes data collection that will be linked to the high-utilizer database maintained by King County Mental Health, Chemical Abuse and Dependency Services Division.

◊ *D. Target Population*

Adults in crisis in the community who might otherwise be arrested for minor crimes and taken to jail or brought to a hospital emergency department. The exact criteria for diversion have not yet been established. Criteria will be established during a planning process involving community and criminal justice system stakeholders. Individuals who have been seen in emergency departments or at jail booking and who are ready for discharge, but still in crisis and in need of services, may also be eligible.

◊ *E. Program Goal*

Reduce admissions to jails, hospital emergency departments and psychiatric hospital units.

◊ *F. Outputs/Outcomes*

Estimated 3000-5000 admissions per year.
Outcomes will include linkages of individuals admitted to needed community treatment and housing, reduced admissions to emergency rooms, and reduced admissions to jails.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
April 2-3	Initial planning meeting with national consultants	$350
June-December 2008	Monthly planning meetings with stakeholders. Include visits to established successful diversion programs in other jurisdictions. Identify potential sites for diversion facility and strategy for securing site and building out facility. Determine strategy for crisis teams and respite/interim housing.	$ 10,000
	Total Funds 2008	**$10,350**
Jan – Mar 2009	Develop and issue Report For Proposal(s) (RFP). May consider one RFP for all services, or separate RFPs for each component of diversion strategy.	
March-October 2009	Phased-in selection of contractors, contracting, facility remodel, recruitment of staff, training, development of policies and procedures.	$4.5 million
November 1, 2009	Facility, crisis teams and crisis respite programs open for services	
	Total Funds 2009	**$ 4.5 million**
2010 and onward	Ongoing Crisis Diversion Program	$6.1 million
Ongoing Annual	**Total Funds**	**$6.1 million**

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

◊ *A. Number and type of Providers*

Still to be developed

May have one provider for all three components of strategy, or up to three providers providing separate but coordinated services

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

We have initiated a planning process that will continue through the remainder of 2008. The first meeting of the planning group was facilitated by consultants from the National GAINS Center and the Bexar County Jail Diversion Program, which was the recipient of the Gold Achievement Award from the American Psychiatric Association in the category of community-based programs. Partners in the ongoing planning process will include representatives from the criminal justice system (prosecuting attorneys, public defender, courts, jails, police), hospitals, community providers of mental health and chemical dependency services, housing providers, National Alliance on Mental Illness, Developmental Disabilities Division, Crisis Clinic, Department of Corrections, and King County Mental Health, Chemical Abuse and Dependency Services Division.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

-Monthly meeting of planning group:	May - December 2008
-Develop and issue RFP(s)	January - March 2009
-Phased-in selection of contractors, contracting, remodel, recruitment of staff, training, development of policies and procedures.	March - October 2009 facility
-Open facility, begin crisis teams and open respite housing	November 2009

◊ *B. Procurement of Providers*

Exact timeline to be determined

◊ *C. Contracting of Services*

Exact timeline to be determined

◊ *D. Services Start Date(s)*

November 1, 2009

MIDD Strategy 10b – Summary of the Revisions/Update to the Strategy
January 28, 2010

The purpose of this document is to provide an update to the oversight committee on the implementation of MIDD Strategy 10b – Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team. This strategy was included as a means provide divert adults with mental illness and chemical dependency from initial or further involvement with justice system, emergency rooms and hospitals.

Program Goal
This strategy seeks to improve the lives of those impacted by mental illness and substance abuse by providing therapeutic alternatives in the community resulting in reduced admissions to jails, hospital emergency departments and psychiatric hospital inpatient units.

Target Population
Adults (18 and older) in crisis in the community who might otherwise be brought to a hospital emergency department or arrested for minor crimes and taken to jail will be targeted. Exclusionary criteria for admission will include criminal charge/criminal history criteria and medical/behavioral criteria, as recommended by target population workgroups.
MHCADSD intends to contract with up to three (3) providers for the delivery of services under MIDD strategy 10b. The three (3) components include: 1. Crisis Diversion Facility, 2. Crisis Diversion Interim Services (CDIS), including respite beds, and 3. Mobile Crisis Team. MIDD strategy 10b services will be available county-wide; the strategy will serve 3,000-5,000 individuals per year.

Timeline and Staffing Update
The Request for Proposals (RFP) was released on August 6, 2009 with a due date of September 17, 2009. One component of the RFP, the Crisis Diversion Interim Services was awarded. The Crisis Diversion Facility and Mobile Crisis Team components will be re-bid through a new RFP. In addition, due to the planning, coordination, MIDD 10b sub-committee and management needed for all three components of this strategy, a Crisis Diversion Services Coordinator will be hired.

- November 2009 – January 2010: RFP revisions and related planning with MIDD OC and South County Cities
- January 2010 – March 2010: Revised RFP released, reviewed, proposal(s) awarded.
- April 2010 – 1.0 FTE Program Manager will be hired to coordinate the Crisis Diversion Services (CDS) strategy, staff the MIDD OC CDS strategy sub-committee and provide general support to the implementation of the MIDD plan (funding from MIDD Admin).
- April 2010 – September 2010:
    - Each successful proposer is expected to be at full staffing capacity, including location and licensure and certification requirements met, no later than six (6) months from the date the contract is executed.
    - Start-up phase: policies and procedures developed in partnership with the MIDD OC CD strategy sub-committee and selected providers, locations work toward permitting, zoning and other related citing requirements.
    - Public information campaign developed and begins in coordination with MIDD strategy10a Crisis Intervention Training project
- October 2010: Crisis Diversion Services open to the public.