ES 11b Seattle Mental Health Court
BP 118 10.77 Triage Project
BP 133 Incompetent and Uncommitted
BP 136 Seattle Municipal Court Dismiss and Refer Triage
Competency Continuum of Care

Existing MIDD Program/Strategy Review x MIDD I Strategy Number City of Seattle Mental Health Court 11b (City of Seattle *only*) **(Attach MIDD I pages)**
Type of category: New Concept

SUMMARY: This briefing paper proposes a Competency Continuum of Care to provide a system for evaluating individuals found not competent to stand trial in a criminal proceeding and provides outreach and engagement services, linkages, and respite supports for individuals who frequently encounter the criminal justice system, but for whom competency is at issue and detention in an inpatient psychiatric center is not warranted.

Collaborators:

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This briefing paper proposes a Competency Continuum of Care to provide a system for evaluating individuals found not competent to stand trial in a criminal proceeding and provides outreach and engagement services, linkages, and respite supports for individuals who frequently encounter the

criminal justice system, but for whom competency is at issue and detention in an inpatient psychiatric center is not warranted.

Part One – 10.77 Triage Project

The 10.77 Triage Project—as named by the 10.77 Triage Workgroup and based on Chapter 10.77 Revised Code of Washington[1] (RCW)—provides for a safer, more efficient and local evaluation process for individuals with severe and persistent mental illness who have been charged with a serious misdemeanor offense and are found not competent to stand trial. The Harborview Medical Center (HMC) offered to pilot the process in December 2013, although the project has never been funded. Initially, HMC provided at least two triage evaluations per week but, due to lack of funding, had to decrease the number of evaluations to one per week (or four per month). This briefing paper proposes funding HMC to provide all of the triage evaluations for this group of individuals; this will free-up the Designated Mental Health Professionals (DMHPs)—dispatched from King County Crisis and Commitment Services (CCS)—who are currently providing a portion of these evaluations, to respond more efficiently to a significant volume of referrals for involuntary treatment evaluation services.

10.77 Triage Project Background Information

As noted above, the first component in this briefing paper, 10.77 Triage Evaluations, provides for a safer, more efficient and local evaluation process for individuals with severe and persistent mental illness who have been charged with a serious misdemeanor offense and are found not competent to stand trial. The 10.77 Triage Workgroup, comprised of multiple stakeholders at all levels, has developed a new process for evaluating these individuals with mental illnesses in the jail versus an emergency department (ED) or Western State Hospital (WSH).[2] Since approximately 57 percent of these individuals already have outpatient services in place, the Triage evaluator is able to petition release to a safe outpatient plan for 40-50 percent of these individuals, hence diverting from unnecessary ED admission and hospitalization. The process works as follows: the individual's case is dismissed in criminal court and the defendant is referred for civil commitment. The HMC evaluator (who is a licensed clinical social worker) receives the order and evaluates the person in jail within a 72-hour window noted in the court order; the evaluation typically occurs within the first 24 hours.[3]

If the person is deemed to not meet the threshold for civil commitment, the HMC evaluator develops a safe plan for release in coordination with outside providers and release planners, and petitions the judge for release of the person to the community (termed a "no file"). If the person is deemed to meet the threshold for civil commitment, the evaluator will file a petition for a 90-day more restrictive order. In coordination with the County and local Evaluation and Treatment (E&T) facilities, the person is placed in the appropriate E&T for psychiatric care under Chapter 71.05 RCW, Mental Illness (encompassing the Involuntary Treatment Act) statute, for treatment.[4]

When the project was first developed, WSH had agreed to accept individuals whom the Triage evaluator believed to meet the threshold for commitment; however, WSH intermittently accepted these referrals

[1] Criminal/legal competency procedures: http://apps.leg.wa.gov/RCW/default.aspx?cite=10.77.
[2] http://www.kingcounty.gov/~/media/exec/PSB/documents/RLSJC/2015/July/10_77_ppt_RLSJ_Comm_version_FINAL.ashx?la=en.
[3] Per RCW 71.05.235, under certain conditions, the evaluations may be conducted by a professional person, defined as a " mental health professional and shall also mean a physician, psychiatric nurse practitioner, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter".
[4] Mental Illness and Involuntary Treatment Act statute: http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.

and stopped accepting (civil commitment referrals to the Center for Forensic Services) altogether in July 2014 due to lack of capacity. The majority of these individuals are treated and released locally, within their own community.

Part Two – City of Seattle Mental Health Court (only) 11b Existing Strategy

This second component of this briefing paper proposes a care manager position, which is a retooling of the existing City of Seattle Mental Health Court (MHC)[5] component of MIDD Strategy 11b that, prior to now, has consisted of a clinical position and function tied to the Seattle Municipal MHC. This existing strategy does not affect the King County Regional MHC revisions to Strategy 11b, which are addressed in *ES 11b BP 8 BP 93 Regional Mental Health Court Services and Continuous Improvement.*

The Competency Continuum of Care model provides for care management services for a particular group of individuals (25 each) who have frequent contact with the criminal justice system, and whose charges get dismissed in order that they receive an evaluation for civil commitment by the DMHPs. Despite repeated criminal charges and referrals for civil commitment evaluations, these individuals do not meet involuntary commitment criteria, and are often released back to the streets, only to repeat this cycle sometimes as frequently as every month. Most or all of these individuals are not engaged in the public mental health system. The care manager would be responsible for providing assertive outreach and engagement for these individuals to offer services, respite supports, assistance with entitlements and other essential needs, with the ultimate goal of reducing contact with the criminal justice system and the DMHPs.

Data kept by King County Crisis and Commitment Services (CCS) with regard to referrals from the court to DMHPs for civil commitment evaluations under the Involuntary Treatment Act indicate that a small group of individuals are returning to the same court with their charges repeatedly getting dismissed, and who do not meet involuntary commitment criteria. These individuals are not being detained, nor are they being linked to publicly funded benefits and services in the community. Rather, these individuals are committing low level criminal offenses, and are appearing in Seattle Municipal MHC on a frequent basis. As a result, this strategy is being revised and enhanced to provide outreach and linkage services into the community to locate and serve this group of individuals with the goal of preventing future criminal justice involvement (rather than continuing to purchase a clinical position tied to the Seattle Municipal MHC).

This component represents a revision and enhancement of existing Strategy 11b, and directly relates to existing Strategy 1b – *Outreach and Engagement to Individuals leaving Hospitals, Jails or Crisis Facilities*.

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).

Both aspects of this program would ensure that incarcerated individuals with mental illnesses receive the appropriate level of care and, if they do not require hospitalization (crisis services), are connected with appropriate outpatient services to address their primary and mental healthcare needs. It provides a more robust continuum and coordination of care (system improvements) by assessing the needs

[5] http://www.seattle.gov/courts/comjust/mh.htm.

presented by individuals encountered through the program, and linking individuals to services that best fit their needs.

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.**

Under RCW 10.77.088,[6] individuals who have committed a serious misdemeanor offense and are found not competent to stand trial shall be referred for a possible 90-day civil commitment, which mandates an evaluation in an E&T facility under Chapter 71.05 RCW. Historically, WSH accepted these individuals for such an evaluation. However, due to capacity issues in 2011, WSH began limiting the number of patients they would accept under this misdemeanor "flip" process (conversion from misdemeanor criminal case to civil commitment case under Chapter 10.77 RCW).

In response to WSH's lack of capacity, in June 2012, both King County Regional MHC and Seattle Municipal MHC made a decision to list HMC on such court orders so that individuals who were declined by WSH would still receive an evaluation at HMC under Chapter 10.77 RCW. Mental health evaluations began taking place in HMC's ED. The process was found to be inefficient and unsafe, mixing an often vulnerable and fragile ED population with persons charged with a serious/violent offense. Additionally, transporting every person to the ED for these evaluations contributed to the back-up of patients boarding in the ED, which must maintain capacity for persons in acute medical or psychiatric crisis, as well as for trauma patients arriving from throughout the multistate region. Non-emergency evaluations of this sort were not an appropriate use of the ED. During this time, a crisis in capacity for psychiatric beds emerged in King County, with HMC having nearly 1000 psychiatric boarders in 2013.

A stakeholder workgroup convened in early 2013 and participants agreed that a safer, more efficient process must be developed, and the "10.77 Triage Project" was born. As a result of lack of funding, HMC has decreased the number of triage evaluations to one per week. The DMHPs dispatched from CCS are currently evaluating the remaining referrals who are not seen by the 10.77 Triage Project.

The DMHPs will only evaluate for the initial 72-hour hold. The DMHPs are not required to petition the judge with an argument for a safe, less restrictive plan; although there is a non-emergent detention process, the DMHPs are required to consider imminence as one of the variables contributing to the detention decision – unlike the 90-day evaluation of persons found not competent who have committed a serious misdemeanor offense. Again, the DMHP evaluation process only evaluates persons for the initial 72-hour hold, not the longer 90-day commitment as is mandated in the statute.

If fully funded, HMC would employ a full-time Licensed Independent Clinical Social Worker (LICSW) and part-time Psychiatric Nurse Practitioner to respond to every civil commitment referral from the courts for individuals charged with a serious misdemeanor offense, ensuring that each individual receives the full evaluation for a possible 90-day commitment or release under Chapter 10.77 RCW. If not

[6] Placement Procedure in Non-felony Charge: http://apps.leg.wa.gov/RCW/default.aspx?cite=10.77.088.

implemented, the bulk of the evaluations would remain with King County CCS within the framework described herein.

As mentioned previously, the second part of this continuum provides for a care manager to serve up to 25 individuals who frequently come into contact with the criminal justice system, but for whom charges get dismissed. After charges are dismissed, this population is referred to CCS, but individuals typically do not meet involuntary commitment criteria; thus, they are released back to the streets without services or shelter. The primary goal of the care management position will be to locate, engage and link these individuals to services, respite supports and essential needs in order to reduce their contacts with the criminal justice and crisis systems. Currently, there is a position tied to the Seattle Municipal MHC; however, this position has not been able to positively impact outcomes of a group of people who are frequently returning to the MHC, getting charges dismissed, and ending up being released without services. If this strategy is not implemented, these individuals will continue to return repeatedly to the courts, and will not be linked to the services and supports they need to remain in their communities.

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

With WSH declining all misdemeanor civil commitment referrals, patients are evaluated locally and either released or placed at a local E&T for care. Initially, there was great concern related to local capacity, but the E&Ts coordinated a system for accepting these patients (also based on clinical need and bed availability) to ensure these patients are not boarded.

Benefits of the 10.77 Triage Project, versus DMHP evaluation, transfer to an ED or WSH for the evaluation, include the following:

1. Efficiency
    - **a.** The process for the evaluations takes significantly less time to complete in the jail than at WSH or in an emergency department.
    - **b.** The data indicate that approximately 57 percent of these persons have services locally, primarily from King County. From the King County Jail, the evaluator has ready access to providers in the community with whom to coordinate in order to create a safe and comprehensive, less restrictive plan for those persons who do not require hospitalization. This work would likely be more time consuming for WSH discharge planners, who must coordinate from a distance.
2. Safety
    - **a.** Providing the evaluation in the jail is a safe process, and mitigates risk of harm to staff and patients that could occur in an ED or admission unit at WSH.
    - **b.** Currently, this project is unfunded and HMC is only evaluating one referral per week or four per month, which requires the DMHPs to evaluate the remaining referrals. The DMHPs only evaluate for the initial 72-hour hold.
3. Cost effectiveness
    - **a.** Triage evaluation and filing of the petition requires, at a maximum, two providers versus a greater number of staff at an ED or at WSH.
    - **b.** Due to the fact that these evaluations take place in the jail, Jail Transport services are not required.
    - **c.** The triage evaluations prevent unnecessary costly admissions to Harborview's ED and WSH.
4. Improved Resource Utilization

   a. The triage process allows for more appropriate use of beds at WSH as well as local E&T beds, and positively impacts the ED single bed certification (a process that has replaced boarding for keeping detained individuals in beds not normally designated as psychiatric beds) numbers. Persons who are evaluated as not requiring hospitalization are released directly from jail to a safe plan in the community, without having to pass through the admission process at WSH and unnecessarily occupy a limited resource (forensic beds at WSH).
   b. The length of stay in the jail is also positively impacted, as the evaluation takes place within the first 24 hours of the order. Under the order, the individuals can stay in custody for up to 72 hours , not including weekends and holidays. Due to the fact that the person is not admitted to WSH or an E&T for this evaluation, the length of stay may be decreased by at least 48 hours (or more), resulting in jail day cost savings.

5. Compliance with Chapter 10.77 RCW
   a. As noted above, if fully funded, HMC would be able to respond to every serious misdemeanor, involuntary treatment referral and evaluate every individual for civil commitment or release under authority of Chapter 71.05 RCW. Consistent with Chapter 10.77 RCW, HMC may either petition for a longer commitment (90-day more restrictive order) or create a safe outpatient plan that a judge must approve before release. This is in contrast with the current process that routes the majority of referrals to the DMHPs for the initial detention evaluation (72-hour hold) and is not in compliance with Chapter 10.77 RCW.

The proposed care management position meets the needs of a group of individuals whose need for linkages and services are currently unaddressed. Although not criminally charged, these individuals have multiple contacts with the criminal justice system that, unfortunately, do not result in linkage to inpatient treatment, outpatient services such as mental health or substance use disorder treatment, medical care, and/or housing. The care manager would be able to locate and provide outreach, engagement and linkage services to these individuals with the goal of reducing criminal justice contacts.

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.

HMC and King County CCS collect data regarding all 10.77 Triage Project referrals, including decisions/outcomes of each evaluation. HMC also collects data regarding the individual's outpatient provider and less restrictive order status. As noted above, a majority of these persons were already connected with outpatient services. This project allows the Triage evaluator to ensure linkage with these providers. When the 10.77 Triage Project is utilized (versus the DMHP evaluation), there is enhanced linkage with outpatient services for those persons not requiring hospitalization, as required by statute (i.e. creating a safe and less restrictive plan that a Superior Court judge must review and approve before release).

This project has demonstrated that a very small percentage of referrals ultimately result in placement on a long term commitment to WSH. HMC tracks the length of stay of individuals admitted locally (approximately three to four weeks), which WSH acknowledges is shorter than the length of stay of

persons sent directly to WSH for evaluation under Chapter 10.77 RCW (specific data from WSH is not available for this paper).[7]

Despite the implementation of Strategy 11b in the City of Seattle MHC, a small group of individuals remain who return frequently to the MHC on new criminal charges, but who subsequently get released without any services or interventions designed to reduce their contacts with criminal justice and crisis systems. This competency continuum of care would incorporate a strategy to engage these individuals via a care management position in order to link them to services, entitlements, and respite supports. This group of individuals has not benefitted from the current strategy and remains unserved and in frequent crisis; thus, an enhancement and retooling of the existing strategy to reduce the criminal justice and crisis contacts for these individuals is being proposed.

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.**

This program is a local, emerging practice designed to assess individuals for inpatient treatment who have committed misdemeanor crimes. Providing evaluations, and outreach and engagement with the goal of serving individuals who are frequently in crisis and in contact with law enforcement will likely result in better outcomes than allowing the system to continue without any strategy for intervention in these processes.

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?**

In addition to diverting more individuals with mental illness from unnecessary ED and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization. The triage process ensures that persons who are already connected with outpatient providers are reconnected with these services. Additionally, if these individuals are not acute or not deemed dangerous/gravely disabled, this process creates a safe plan for direct release from the jail. HMC is currently tracking a majority of these data elements on persons evaluated under this project.

CCS keeps current data with regard to individuals who have criminal charges dismissed and are being referred for involuntary commitment evaluations. As a result of intervention with a care manager targeting the individuals most frequently coming into contact with law enforcement and crisis systems, the County would see fewer referrals being made to CCS and eventually a decline in the law enforcement contacts with these individuals.

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**
   - ☒ **Racial-Ethnic minority (any)**
   - ☐ **Black/African-American**

[7] Quarterly Collaborative Meeting discussion, November 12, 2014.

- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☐ **Families**
- ☐ **Anyone**
- ☒ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☒ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The target population consists of individuals judged not legally competent to proceed by the court who are being referred for an assessment for inpatient treatment. Care management would target those individuals most frequently being referred for involuntary commitment.

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 program will serve any adult resident of King County who commits a misdemeanor (and said crime categorized as a serious offense) and has been deemed incompetent by the court. The care management function (retooling of MIDD Strategy 11b) would be focused at the City of Seattle Municipal Court.

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.**

The 10.77 Triage Project has been in place for two years and HMC continues to convene the 10.77 Triage Project Workgroup. This group consists of representatives/partners from the City of Seattle Attorney's Office, public defense attorneys and social workers, CCS staff, Diversion and Reentry Services staff, HMC triage evaluators, court personnel, and the Washington State Behavioral Health Administration. The workgroup reviews data, discusses trends and systems issues, and collaborates with other initiatives in King County.

The care manager would collaborate with CCS with regard to those individuals most frequently referred for civil commitment evaluation, and would share information related to locating and serving those individuals. Partnerships with the jails, prosecutors, MHCs, and local behavioral health and housing providers would be necessary for successful implementation of this initiative.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

A major factor involved in this approach is the lack of bed capacity at WSH. In July 2014, WSH stopped accepting individuals who were incompetent and referred for an evaluation for civil commitment as the hospital lacked the bed capacity to serve these individuals. HMC piloted a process whereby they assigned an LICSW to provide the evaluation of the incarcerated person within the 72-hour window noted in the court order, and typically did the evaluation within the first 24 hours. HMC has been providing this service, although it has never been funded, since December 2013.

The mental health court clinician, under existing MIDD Strategy 11b, left the position in 2015 and it is currently vacant. This provided an opportunity to review the data and hold discussions with court partners, CCS, and HMC about an enhancement of this position in the context of health care reform and Behavioral Health Integration to more effectively meet the needs of some of the highest utilizers of the crisis and MHC 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?**

It is critical that all of the stakeholders agree to this process and collaborate with HMC and the courts in order that these services are provided in the most efficient manner. It would be most advantageous to have the cooperation of King County Jail Health Services so individuals requiring hospitalization could receive medical clearance via Jail Health as opposed to transporting the individual to an ED for medical clearance to be obtained. Currently, Jail Health Services provides the medical clearance for individuals being transported to WSH, but not for others going to local hospitals.

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?**

Unintended consequences are not evident; however, the number of individuals being served by the Seattle Municipal MHC may be reduced dramatically as fewer individuals are referred to CCS for civil commitment evaluation and more individuals are engaged and linked to needed services.

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?**

If the strategy is not implemented, there would be an increase in evaluations going to King County CCS, rather than having some of them provided by HMC. The services that are provided by CCS are not as robust as the services provided by HMC in that CCS evaluates for the civil commitment, and if the individual is not detained, there is no further action on the case. HMC provides enhanced services to individuals who are not detained, as they assist with linkages back to the enrolling provider agency, and for those individuals who are not served in the publicly funded mental health system, HMC evaluators make the referrals to provider agencies. Also, with the current process, there is no care management for the individuals who frequently come into contact with the court and CCS, and it is a disservice to those

individuals and to the system to continue to interface with those individuals and not provide them with the services and supports they need to remain in their communities.

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?**

The only alternative to having HMC evaluators provide the assessments is to have King County CCS staff provide all of these evaluations. CCS is often backlogged with referrals for assessments, thus the wait times for getting these assessments done may be longer than the current wait times evidenced by HMC.

This briefing paper merges the existing Strategy 11b with the currently unfunded 10.77 Triage Pilot Project to provide a more robust competency continuum of care.

E. Countywide Policies and Priorities

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

This proposal most closely aligns with Behavioral Health Integration efforts as well as the Familiar Faces Initiative[8] within Health and Human Services Transformation. This continuum of competency services addresses unmet needs in the system by serving those individuals in frequent contact with law enforcement and the MHCs as well as improved health and social outcomes through improvements in coordination and delivery of care and diversion from criminal justice and crisis systems. Providing services and supports to these individuals in their communities offers greater chances of stability, community tenure, and enhanced quality of life for these individuals. Current and pertinent initiatives and programs in King County include the following:

- 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle;[9]
- Coordinated Entry for All;[10]
- Health and Human Services Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and Communities of Opportunity (geographic focus options);[11]
- Law Enforcement Assisted Diversion (LEAD)[12] Operations and Policy; and
- 1115 Global Medicaid Waiver, options for Demonstration Programs.[13]

MIDD Strategy 1B downtown project fits well into Behavioral Health Integration as mental health practitioners work very closely with the King County Regional Support Network, which will become a Behavioral Health Organization in April 2016.

[8] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx.
[9] http://www.seattlepi.com/local/article/Murray-declares-civil-emergency-over-homelessness-6605652.php.
[10] http://allhomekc.org/coordinated-entry-for-all/.
[11] http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx.
[12] http://leadkingcounty.org/.
[13] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

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

Providing care, linkages to services and essential needs, and other interventions for individuals whose behavioral health needs are unmet and for whom frequent contact with law enforcement and with crisis services is a principle rooted in humane care, recovery, and a reduction of trauma often associated with law enforcement contacts when individuals have escalating symptoms. Law enforcement contact and incarceration should not substitute for behavioral health care in one's community. Some individuals do not have the ability to self-advocate and present to a community mental health center to address unmet needs and may need assertive outreach and engagement provided by a caring and experienced professional in order to engage and stop the cycle of crisis and incarceration.

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

As answered in response to question E.2. above, frequent law enforcement contacts, resulting in arrests, court appearances, and interruptions in medical and behavioral health care for those most disenfranchised from the entitlement, medical and behavioral healthcare systems is not justice, does not create safer communities, and does a disservice to those whose escalated symptoms can be addressed in the community via proper care and supports. Equal access to services and supports by all residents of King County in need of behavioral health services, including our most vulnerable citizens, is fundamental to this proposal.

F. Implementation Factors

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

The only resources needed to implement the evaluation portion of this strategy are staff: 1.0 full-time equivalent (FTE) LICSW, one part-time psychiatric nurse practitioner, one part-time administrative support person to coordinate involuntary treatment act paperwork, and a part-time supervisor.

In addition, a 1.0 FTE care manager position is needed to serve approximately 25 individuals. This position should be filled by a master's level mental health professional with substance use disorder treatment expertise/experience.

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

The estimated annual cost to implement this proposal is $266,800. Following is the cost breakdown of the FTEs identified above:

0.2 FTE psychiatric ARNP = $37,440
1.0 FTE LICSW = $92,400
0.2 FTE Administrative Support for ITA coordination = $12,480
0.1 FTE Supervisor = $12,480
1.0 FTE mental health professional/care manager = $100,000
Flex funds = $12,000 (for unmet expenses for transportation, motel vouchers, short term medications, clothes, etc. for the care manager's use.)
TOTAL = $266,800

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

HMC is seeking funding from the City of Seattle to augment a potential allocation from MIDD II funding in 2017. More information about this should be forthcoming as the City of Seattle proceeds with budget preparation in 2016. Funds for existing strategy 11b are in place currently. This proposal adds some flex funds to the existing strategy.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**

    HMC currently has the necessary infrastructure in place to continue this work. Thus, full implementation is feasible in less than six months.

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

    HMC will hire staff as soon as MIDD funds are awarded. Sound Mental Health (for the court outreach clinician) currently has the infrastructure in place as well.

    c. **Does this need an RFP?**

    No, a Request for Proposals (RFP) is not necessary.

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?**

There is a separate but related program being proposed through the MIDD briefing papers entitled Competency Stabilization Services Program (BP 124, Camelio) which will enhance the continuum of competency services provided in King County by providing for an outpatient resource for competency restoration for eligible defendants. There is also a new strategy, entitled Day Shelter for Mentally Ill Chemically Dependent Individuals, for day services that could be linked to this strategy and provide day time supports for individuals served in these programs.

Strategy Title: Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services provided to Individuals with Mental Illness and Chemical Dependency

Strategy No: 11b – Increase Services Available for New or Existing Mental Health Court Programs

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.

- 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*

The prevalence of people with mental illness in the criminal justice system is a nationwide problem. Estimates of the prevalence of people with mental illness in jails range from 5% to 16%, depending on the definition of mental illness that is used. On any given day in city jails throughout King County, an estimated 15% of inmates have serious mental illness. Once in jail, these individuals stay much longer than inmates with similar charges who are not mentally ill. Mental health court is an effective tool for engaging and keeping people with mental illness in community-based treatment. At the present time, access to mental health court is limited to just a few jurisdictions.

◊ *B. Reason for Inclusion of the Strategy*

Mental health courts are an essential component of a jail diversion continuum of service and have been shown to be effective in engaging clients in treatment and reducing future jail bookings. Mental health court services for misdemeanor offenders are now limited to individuals who commit offenses in unincorporated King County, the City of Seattle and the City of Auburn, through King County District Court, Seattle Municipal Court, and Auburn Municipal Court. Increasing access to mental health court throughout King County could improve mental health outcomes for people in the criminal justice system and reduce the prevalence of people with mental illness in jails across King County.

◊ *C. Service Components/Design*

This strategy will enhance services and capacities at existing mental health courts to increase access to these programs for eligible adult misdemeanants throughout King County. Service enhancements will include expanded mental health court treatment

services programming within the City of Seattle Municipal Mental Health Court and the City of Auburn Municipal Mental Health Court or may include the placement of a new Mental Health Professional (called a "court monitor" or "court liaison"). In addition, King County District Court Mental Health Court will be made available to any misdemeanor offender in King County who is mentally ill, regardless of where the offense is committed.

◊ *D. Target Population*

1. King County District Court Mental Health Court target population: mentally ill misdemeanor offenders with an AXIS I diagnosis in any King County municipality that is referred to the King County Prosecuting Attorney's Office for filing into the King County District Court Mental Health Court.
2. City of Seattle, Seattle Municipal Court target population: mentally ill defendants that are found not competent for trial, approximately 200 individuals annually.
~~3. City of Auburn, Auburn Municipal Court target population: mentally ill misdemeanor offenders with an AXIS I diagnosis.~~

◊ *E. Program Goals*

1. The King County District Court Mental Health Court program goals are to:
(1) protect public safety, (2) reduce the level of recidivism (considering frequency, offense severity and length of time between episodes) of persons with mental illness with the criminal justice system; (3) reduce the use of institutionalization for persons with mental illness who can function successfully within the community with service supports; (4) improve the mental health and well-being of persons with mental illness who come in contact with Mental Health Court; (5) develop more expeditious case resolution than traditional courts; (6) develop more cost-effective / efficient use of resources than traditional courts; (7) develop more linkages between the criminal justice system and the mental health system; and (8) establish linkages with other community programs that target services to persons with mental illness.

2. City of Seattle, Seattle Municipal Court program goals:
Connect incompetent SMC defendants with treatment, housing, and other services.

~~3. City of Auburn, Auburn Municipal Court program goals: Reduction in jail, hospital, emergency services costs; reduced recidivism; and linkage to needed treatment, services and housing.~~

◊ *F. Outputs/Outcome*

1. King County District Court Mental Health Court outputs/outcomes:
   a. Provide MHC services to ~~200~~ 115 additional offenders referred from King County cities
   b. Decrease length of stay in jail
   c. Decrease jail recidivism among participants.
   d. Identify and coordinate resolutions among 2 or more KC jurisdictions for 60 city offenders (= to 30%) who are referred to MHC
   e. Establish and provide minimum of 50 days of MHC services in South End and Eastside of King County

2. City of Seattle, Seattle Municipal Court outputs/outcomes:
The outputs will be number of defendants contacted and number of service connections made. Outcomes will include reduced recidivism at SMC for those clients working with the new court liaison. SMC is prepared to assist with evaluation processes and can provide SMC recidivism data.

~~3. City of Auburn, Auburn Municipal Court outputs/outcomes:~~
~~To be determined~~

2. Funding Resources Needed and Spending Plan

$1,295,252 is available annually

Dates	Activity	Funding
To be determined	King County District Court Regional Mental Health Court expansion to all municipalities in King County	$1,210,252
To be determined	City of Seattle, Seattle Municipal Court expansion	$85,000
~~To be determined~~	~~City of Auburn, Auburn Municipal Court expansion~~	~~$17,000~~
	Total funding	$1,295,252

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

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy):*

1. King County District Court Mental Health Court
King County District Court Regional Mental Health Court (KC RMHC): This strategy may provide funding for new judicial and court services staffing ~~and overhead~~. In addition, KC RMHC will develop and provide access to services related to housing, treatment and emergency needs within available resource parameters.
King County District Court Probation Division: 2 FTE Mental Health Specialist Probation
King County Prosecuting Attorney's Office: 1 FTE Senior attorney, 1 FTE Paralegal, 1 FTE Victim Advocate ~~and administration overhead~~.
King County Office of Public Defense: 1 FTE Senior attorney, 1 FTE Social Worker.
King County Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division contracted positions and treatment services: 1 FTE MHC court monitor, 1 FTE MHC Peer Counselor

2. City of Seattle, Seattle Municipal Court
This strategy will include expanded mental health court treatment services programming within the City of Seattle Municipal Mental Health Court or may include the placement of a new Mental Health Professional (called a "court monitor" or "court liaison").

~~3. City of Auburn, Auburn Municipal Court~~
~~This strategy will include expanded mental health court treatment services programming within the City of Auburn, Auburn Municipal Court or may include the placement of a new Mental Health Professional (called a "court monitor" or "court liaison").~~

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

1. King County District Court Mental Health Court

Dates:	Activity:
Within 90 days of Council approval	The process for cases to be referred to the KC Prosecutor could be implemented within 90 days of Council approval. Some cities will be more conversant with this process and thus able to utilize the MHC sooner. During the 90-days pre-implementation, activities would include hiring of personnel, providing training to cities, developing protocols and tracking/data systems for referrals, outcomes, problem solving, scheduling and conducting MHC in identified locations, etc. Contract negotiations with the county will include defining the eligible population to be served through MIDD MHC funds.
6-9 month phased-in start up	Based on the experience when the KCDC RMHC began in 1999, it is hypothesized that a 6-9 month period will be necessary as a "ramp up", during which time MHC staff are involved in training and consultation with the city partners.

2. City of Seattle, Seattle Municipal Court (SMC)

Dates:	Activity:
June 2009	SMC would need to work with King County to expand the current contract and MOA with Sound Mental Health. King County staff successfully and quickly expanded other contracts with SMH for other MIDD strategies. SMC expects that similar turnaround time would be possible with an additional liaison, with services starting by June, 2009. Contract negotiations with the county will include defining the eligible population to be served through MIDD MHC funds.

~~3. City of Auburn, Auburn Municipal Court~~

~~Dates:~~	~~Activity:~~
~~To be determined~~	~~The City of Auburn currently holds a mental health court calendar. In addition, Auburn contracts with organizations to provide both in-patient and intensive care treatment. Auburn expects that that implementation would be quick and seamless. Contract negotiations with the county will include defining the implementation start date and eligible population to be served through MIDD MHC funds; currently the Auburn Municipal Court mental health calendar includes defendants without an AXIS I diagnosis and defendants with chemical dependency as the primary presenting issue.~~

◊ *C. Partnership/Linkages*

1. King County District Court Mental Health Court
The King County District Court, Mental Health Court will continue to partner with the King County Mental Health, Chemical Abuse and Dependency Services Division, other criminal justice agencies, community mental health service providers and housing programs. In addition, KCDC, MHC will establish partnership with any municipalities in King County wishing to refer MHC cases to the KC Prosecuting Attorney's Office.

2. City of Seattle, Seattle Municipal Court
The City of Seattle, Seattle Municipal Court will continue to partner with the King County Mental Health, Chemical Abuse and Dependency Services Division, other criminal justice agencies, community mental health service providers and housing programs.

~~3. City of Auburn, Auburn Municipal Court~~
~~The City of Auburn, Auburn Municipal Court will continue to partner with the King County Mental Health, Chemical Abuse and Dependency Services Division, other criminal justice agencies, community mental health service providers and housing programs.~~

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. King County District Court Mental Health Court
To be determined

2. City of Seattle, Seattle Municipal Court
To be determined

~~3. City of Auburn, Auburn Municipal Court~~
~~To be determined~~

◊ *B. Procurement of Providers*

1. King County District Court Mental Health Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

2. City of Seattle, Seattle Municipal Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

~~3. City of Auburn, Auburn Municipal Court~~
~~To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009~~

◊ *C. Contracting of Services*

1. King County District Court Mental Health Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

2. City of Seattle, Seattle Municipal Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

~~3. City of Auburn, Auburn Municipal Court~~
~~To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009~~

◊ *D. Services Start Date(s)*

1. King County District Court Mental Health Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

2. City of Seattle, Seattle Municipal Court
To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009

~~3. City of Auburn, Auburn Municipal Court~~
~~To be determined by adoption of revised strategy after receipt of MIDD Oversight Committee report in April, 2009~~

#118

Working Title of Concept: 10.77 Triage Project

Name of Person Submitting Concept: 10.77 Workgroup

Organization(s), if any: Organization(s) Here

Phone: 206-818-4282
Email: laurac@uw.edu
Mailing Address: Laura Collins, HMC Psych Administrator, Box 359896, 325 9th Ave. Seattle 98104

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.

This concept provides a safer, more efficient and local evaluation process for persons with mental illness who have been charged with a serious misdemeanor offense and are found not competent to stand trial. The 10.77 Triage Workgroup, comprised of mulitiple stakeholders at all levels, has developed a new process for evaluating these mentally ill persons in the jail, vs. an emergency department or Western State Hospital. Since approximately 57% of these individuals already have outpatient services in place, the Triage Evaluator is able to petition release to a safe outpatient plan for 40-50% of these persons, hence diverting from unnecessary ED use and hospitalization.

The process works as follows: the defendant's case is dismissed and the defendant is referred for civil commitment. The HMC evaluator (LICSW) receives the order and evaluates the person in jail within the 72 hour window noted in the order, typically within the first 24 hours.

If the person is deemed to not meet the threshold for civil commitment, the evaluator develops a safe plan for release in coordination with outside providers and release planners, and petitions the judge for release of the person to the community (termed a "no file").

If the person is deemed to meet the threshold for civil commitment, the evaluator will file a petition for a 90 day More Restrictive Order. In coordination with the County and local Evaluation and Treatment (E&T) facilities the person is placed in the appropriate E&T for psychiatric care under RCW 71.05 (Civil commitment statute) for treatment.

When the project was first developed, WSH (Western State Hospital) had agreed to accept persons whom the Triage Evaluator believed to meet the threshold for commitment, however WSH intermittently accepted these referrals and stopped accepting (these civil commitment referrals) altogether in July 2014, due to lack of capacity. In turn the majority of these individuals are treated and released locally, within their own community.

2. What community <u>need, problem, or opportunity</u> does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Under RCW 10.77.088, misdemeanants who have committed a serious offense and are found not competent to stand trial shall be referred for a possible 90 day civil commitment, which mandates an evaluation in an Evaluation and Treatment facility (E&T) under RCW 71.05. Historically Western State Hospital (WSH) accepted these individuals for this evaluation. However due to capacity issues in 2011 they began limiting the number of patients they would accept under this misdemeanor flip process.

In response to WSH's lack of capacity, in June 2012, both King County Regional Mental Health Court (RMHC) and Seattle Municipal Mental Health Court (SMHC) made a decision to list Harborview (HMC) on these orders so that individuals who were declined by WSH, would still receive an evaluation under 10.77. These evaluations began taking place in HMC's Emergency Department (ED). The process was found to be inefficient and unsafe, mixing an often vulnerable and fragile ED population with persons charged with a serious offense. Additionally, transporting every person to the ED for these evaluations contributed to the back-up of patients boarding in the Emergency Department, which must maintain capacity for persons in an acute medical or psychiatric crisis, as well as for trauma patients arriving from throughout the multiple state region. Non-emergent evaluations of this sort were not an appropriate use of the ED. During this time, the capacity crisis for psychiatric beds was also rising in King County with Harborview at the top with close to 1000 psychiatric boarders in 2013.

A stakeholder workgroup convened in early 2013 and agreed that a safer, more efficient process must be developed, which ultimately was named the "10.77 Triage Project." Harborview offered to pilot the project. This pilot has been in place since December 9 2013.

Currently this project is unfunded. In turn, Harborview has decreased their number of Triage Evaluations to one per week, or four per month. The DMHP's are currently evaluating the remaining referrals. The DMHP's will only evaluate for the initial 72 hour hold. With their process, the DMHP's are not required to petition the judge with an argument for a safe less restrictive plan, and although there is a non-emergent detention process, the DMHP's are also required to consider imminence as one of the variables contributing to the detention decision – unlike the evaluation for the 90 day commitment. This process is not in compliance with the requirements laid out in RCW 10.77 for evaluation of persons not competent who have committed a serious misdeamenor offense. Again, the DMHP evaluation process only evaluates persons for the initial 72 hour hold, and not the longer 90 day commitment as is mandated in the statute.

If fully funded, Harborview would employ a full-time Licensed Independent Clinical Social Worker and part-time Psychiatric Nurse Practitioner to respond to every civil commitment referral from the courts for individuals charged with a serious misdemeanor offence, ensuring that each individual receives the full evaluation for a possible 90 day commitment/or release under RCW 10.77.

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

With WSH declining all misdemeanor civil commitment referrals, patients are evaluated locally, and either released or placed at a local E&T for care. Initially there was great concern related to local capacity, but the E&T's coordinated a system for accepting these patients (also based on clinical picture and bed availability) to ensure these patients are not boarded.

Benefits of the Triage Project vs DMHP evaluation, transfer to an ED or WSH for the evaluation:

1. Efficiency:

a. The process for the evaluations take significantly less time to complete in the jail than at WSH, or in an emergency department.

b. Our data indicates that approximately 57% of these persons have services locally, primarily from King County. In turn, from King County Jail the evaluator has ready access to providers in the community to coordinate with re: creating a safe and comprehensive less restrictive plan for those persons who do not require hospitalization. This work would likely be more time consuming for WSH discharge planners, who must coordinate at a distance.

2. Safety:

a. Providing the evaluation in the jail is a safe process, and mitigates risk of harm to staff and patients that could occur in an ED or admission unit at WSH.
b. Currently this project is unfunded. In turn, Harborview is only evaluating one referral per week, or four/month. In turn the DMHP's evaluate the remaining referrals. The DMHP's will only evaluate for the initial 72 hour hold.

3. Cost effectiveness:
a. This Triage evaluation and filing of the petition requires at maximum only two providers , vs a greater number of staff at an ED or WSH.
b. Because these evaluations take place in the jail, Jail Transport services are not required.
c. These triage evaluations prevent unnecessary costly admissions to Harborview's ED and WSH.

4. Improved Resource Utilization:
a. The triage process allows for more appropriate use of beds at WSH and as well as local E&T beds, and positively impacts the ED boarding numbers. Persons who are evaluated to not require hospitalization are released directly from jail to a safe plan in the community, without having to pass through the admission process at WSH, and unnecessarily occupy a forensic bed.
b. Length of stay in the jail is also positively impacted, as the evaluation takes place within the first 24 hours of the Order. Under the order, the individuals can stay in custody for up to 72 hours not including weekends and holidays. Because the person is not admitted to WSH or an E&T for this evaluation, length of stay may be decreased by at least 48 hours or more resulting in jail days savings.

5. Compliance with the Statute (RCW 10.77):
As noted above, if fully funded, Harborview would be able to respond to every serious misdemeanor civil commitment referral and evaluate every individual for civil commitment or release under 71.05. In line with RCW 10.77, Harborview may either petition for a longer commitment (90 day more restrictive order) or create a safe outpatient plan that a superior judge must approve before release. This is in contrast with the currently unfunded process that routes the majority of referrals to the DMHP's for the initial detention evaluation (72 hour hold) and is not in compliance with RCW 10.77.

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

Persons with mental illness who have been charged with a serious misdemeanor offense and have not been found not competent.

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.

In addition to diverting more persons with mental illness from unnecessary ED and psychiatric hospitalizations, this process provides a more efficient, safe, cost effective process as well as improved resource utilization. The Triage process ensures that persons who are already connected with outpatient providers are reconnected with these services. Additionally, if these persons are not acute or not deemed dangerous/gravely disabled, this process creates a safe plan for direct release from the jail. Harborview is currently tracking a majority of the above data related to persons that they are evaluating under this project.

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?

The Triage project improves health by ensuring that incarcerated mentally ill individuals receive the appropriate level of care, and if they do not require hospitalization, are connected with the outpatient services to address their health and mental health needs. The Triage Evaluation process ensures that their social and justice outcomes are enhanced and protected, with a more thorough examination and coordination effort in either creating a safe outpatient treatment plan in the community or quickly connecting them with inpatient level of care under RCW 71.05, if indicated.

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.

King County Mental health and Chemical Dependency Division, Mental Health Courts (District and Seattle Municipal), King County Jail, King County Superior Court (ITA Court), Public Defense and Prosecution, Harborview Medical Center, NAVOS, Fairfax, Cascade.

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: $ already providing this for 2+ years without reimbursement. In turn Harborview is only able to provide 48 evaluations per year, serving 48 people per year
Partial Implementation: $ We are willing and able to move directly to full implementation per year, serving approximately 168 people per year
Full Implementation: $ 154,800 per year, serving 168 people per year

Seattle City Attorney

Peter S. Holmes
SEATTLE CITY ATTORNEY'S OFFICE 701 FIFTH AVENUE, SUITE 2050, SEATTLE, WASHINGTON 98104-7097 (206) 684-8200 FAX (206) 684-8284 TTY (206) 233-7206 an equal employment opportunity employer

October 31, 2015

#133

Working Title of Concept: Incompetent and Uncommitted

Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097
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.
Develop and operate intense multi-dimensional wrap-around services for misdemeanor criminal defendants of all ages determined to be incompetent to stand trial and not eligible for involuntary commitment.

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.
Several times a month we dismiss criminal charges against individuals who are found incompetent to stand trial. But these same individuals are also not eligible for civil commitment. As a result, many of them do not receive the mental health services that they need. This service would develop a way to reach these individuals and to get them the mental health and other services that they need, to prevent repeated criminal law violations and other public safety problems. In 2011, 2012, and 2013 we dismissed about 150 cases a year for mental incompetence in the West Precinct alone.

3. How would your concept address the need?
Please be specific.
People who are mentally ill but not competent to stand trial on criminal charges often cannot be civilly committed for a variety of reasons. Yet they have significant recidivism rates. They continue to commit crimes, but police are challenged to arrest them and incarcerate them knowing they cannot be prosecuted. Prosecutors are challenged to prosecute them when they know they will have their charges dismissed for criminal incompetency. When they are incarcerated, they can be released from jail in poorer health than when they went into jail. And then they do not get the mental health services they need to maintain their health when out of custody.

4. Who would benefit? Please describe potential program participants.
Police agencies, fire agencies, hospitals, Designated Mental Health Providers, individual patients, jails, and the general public.

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.
Diversion of the mentally ill out of our criminal justice system because they are receiving the mental health services they need and no longer committing crimes.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)
X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
X **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?
To be able to help people of all ages get the mental health services they need when the public cannot civilly commit them and treat them against their will. This helps the people with the mental illness, and it helps those who encounter them over and over again with no real means of getting them the help they need. Keeping these people out of the criminal justice system and jail is a long-term harm reduction strategy for them and the community.

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.
Sound Mental Health, Community Psychiatric Clinic, police and fire agencies, juvenile probation, Department of Health and Human Services.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.
If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.

Seattle City Attorney

Peter S. Holmes
SEATTLE CITY ATTORNEY'S OFFICE 701 FIFTH AVENUE, SUITE 2050, SEATTLE, WASHINGTON 98104-7097 (206) 684-8200 FAX (206) 684-8284 TTY (206) 233-7206 an equal employment opportunity employer

October 31, 2015

#136 New Concept Submission Form

Working Title of Concept: Seattle Municipal Court Dismiss and Refer Triage

Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097

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.
Fund Seattle Municipal Court Dismiss and Refer Triage.

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.
When an in custody defendant held on a non-serious charge is found incompetent, the case is dismissed without prejudice and the defendant is referred to the DMHPs for evaluation within 72 hours. This practice has not changed in many years.
In custody defendants held on a serious charge, on the other hand, were historically transported to WSH for possible civil commitment. Due to capacity issues WSH began declining these referrals in 2012. In response to WSH's lack of bed space, both Seattle Municipal Court and King County District Court made a decision to place these defendants at HMC for evaluation when declined by WSH. The evaluations were taking place in the Emergency Department. This process was found to be inefficient and unsafe, mixing an often vulnerable and fragile Emergency Dept. population with persons charged with serious offenses.
A stakeholder workgroup convened in 2013 and agreed that a safer, more efficient process was necessary. HMC offered to pilot the 10.77 Triage Project and it has been in place since December 2013.

3. How would your concept address the need?
Please be specific.
Under the Triage Project, defendants were evaluated by a HMC evaluator (a licensed MSW) for possible civil commitment. If the defendant did not meet the threshold for commitment, the HMC evaluator developed a safe plan for release (no file). If the defendant met the threshold for commitment, the evaluator filed a petition for a 90 day More Restrictive Order and the patient was transported to an Evaluation and Treatment Facility. Initially, HMC designated 2 evaluators to cover these referrals. Because the evaluators were unable to complete all of them, HMC began covering

only the first 2 D&Rs of each week and the rest were evaluated by the DMHPs. HMC eventually lost 1 of its evaluators, and currently HMC is seeing only the first D&R of the week; the DMHPs are covering the remainder.

4. Who would benefit? Please describe potential program participants.
Since the inception of the Triage Project, every defendant on a D&R has been seen for possible civil commitment by either a Triage Evaluator or a DMHP. This system has shown to be more efficient and cost effective than automatically transporting every defendant to WSH for the evaluation. Initially, there was some concern about hospital placement since WSH has continued to decline these defendants for lack of bed space. However, the local Evaluation and Treatment facilities (such as HNC, NAVOS, and Fairfax) have cooperated to develop a coordinated system for accepting these patients.
In addition to the patients, the health, safety and welfare of the general public is better served.

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.
Start your answer here.
All criminal defendants will have timely access to licensed and professional mental health services, as required by law..

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)
X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
X **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?
All of the patients served by this project have mental health issues that contribute to some criminality. This would provide the opportunity needed to obtain care and treatment, become healthy again, and stop re-offending.

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 Municipal Court, Harborview, King County DMHPs, King County Jail, Seattle Police, Seattle City Attorney's Office, Public Defenders, King County Prosecutor's Office, Western State Hospital.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.
If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.