MIDD Briefing Paper

NC 131 Increase Evaluation and Treatment Capacity via Capital and Startup Funds

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)

New Concept X (Attach New Concept Form) 131 Certified E&Ts for All Ages

Type of category: New Concept

SUMMARY: This concept aims to address an enduring inpatient psychiatric capacity crisis in King County and Washington State by providing capital and startup funds for additional certified evaluation and treatment (E&T) capacity in this community – the optimal treatment setting for most patients whose mental health-related risk rises to the level of imminent danger to themselves or others. Currently, due to a severe shortage of E&T beds as well as other resource scarcity detailed in section B1, many individuals who have been detained by designated mental health professionals (DMHPs) are temporarily placed in community hospital emergency departments or other non-psychiatric units via single bed certification (SBC) while they are awaiting a certified evaluation and treatment (E&T) bed.

The original new concept called for E & T capacity for all ages; the focus of this paper is overall capacity.

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

Name	Role	Organization
Darby DuComb		Seattle City Attorney's Office
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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 concept aims to address an enduring inpatient psychiatric capacity crisis in King County and Washington State by providing capital and startup funds for additional certified evaluation and treatment (E&T) capacity in this community – the optimal treatment setting for most patients whose mental health-related risk rises to the level of imminent danger to themselves or others. Currently, due to a severe shortage of E&T beds as well as other resource scarcity detailed in section B1, many

individuals who have been detained by designated mental health professionals (DMHPs) are temporarily placed in community hospital emergency departments or other non-psychiatric units via single bed certification (SBC)[1] while they are awaiting a certified evaluation and treatment (E&T) bed.

Washington State certifies certain programs, called evaluation and treatment, to provide short-term involuntary inpatient psychiatric treatment as required under the Involuntary Treatment Act (ITA) whenever detention standards are met and less restrictive alternative treatment is not appropriate. E&T programs are designed to provide a treatment environment that is specifically suited to the needs of people who cannot maintain safety in the community and are in need of involuntary mental health care. Usually these beds are used for the 72-hour detention and 14-day commitment periods. Many voluntary psychiatric units in community hospitals do not hold this certification for involuntary E&T services.

In King County there are currently five facilities with certified E&T Programs: Fairfax Hospital in Kirkland, which serves adults and is also the only E&T serving adolescents; Harborview Medical Center in Seattle, serving adults; Navos in West Seattle, serving primarily adults; Northwest Hospital Geropsychiatric Center in Seattle, serving almost exclusively older adults; and Cascade Behavioral Health in Tukwila, serving adults, which was newly certified in 2015.

As described in section B1, significantly more involuntary treatment capacity is needed as part of a broad and intensive effort in King County to ease access. Beyond bringing more inpatient beds online, this work also includes developing community-based alternatives to divert individuals from involuntary care or discharge involuntary patients more quickly and successfully, and addressing access to state hospital beds.

This paper specifically addresses the role MIDD could potentially play in boosting E&T capacity in King County. MIDD funds allocated to this concept could be used to help expand E&T capacity of any kind, in response to changing community needs and new opportunities. This could include beds serving adolescents, adults, individuals with co-occurring medical conditions, or older adults.

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):

Increasing E&T capacity, thereby decreasing the use of SBCs, would assist people who are in crisis to get the help they need more quickly than can occur in the current under-resourced and overstretched inpatient system. As significant investments in this area would have collateral benefits throughout the service system that would deliver better outcomes for many people with significant behavioral health needs, the system improvements area is another appropriate category for this concept.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

[1] Regulations governing SBCs were revised in response to the 2014 *D.W.* ruling that invalidated boarding, to require timely and appropriate mental health treatment for all individuals detained in SBC status, creating significant new responsibilities for community hospitals that accept such patients. This revised WAC is discussed in section B1.

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.**

"Psychiatric boarding" or "boarding" has become shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment[2] – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as emergency departments (EDs) until a psychiatric bed became available. This has been a nationwide problem that had been affecting Washington and King County since at least 2009. The effects, historical context, and gradual onset of this phenomenon are discussed at length in the reports of the Governor and Executive's Community Alternatives to Boarding Task Force (CABTF), available via the link below.[3] Key analysis and conclusions from theses reports are summarized here as context for this concept.

Psychiatric boarding is widely recognized as a major treatment access crisis that hurts patients and drives resources away from community-based and preventive care. Nationally, studies show that prolonged waits in emergency departments for psychiatric patients are associated with lower quality mental health care, as the chaotic emergency department environment increases stress and can worsen patients' conditions[4] and due to the fact that needed psychiatric services are often not provided.[5] More and more people are seeking psychiatric care via hospital emergency departments,[6] possibly as a result of the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally.[7]

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, prohibited holding involuntary psychiatric patients in non-psychiatric settings solely due to lack of inpatient capacity at certified E&T facilities. The Court found that funding limitations or capacity shortages in certified E&T facilities are invalid reasons for detaining a person while delaying the provision of appropriate mental health care.[8]

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[2] Key terms and processes involved in involuntary treatment in Washington state are defined and summarized in the two progress reports of the Community Alternatives to Boarding Task Force (CABTF), especially the background section of CABTF progress report 1 (June 2015).

[3] CABTF reports are available at www.kingcounty.gov/mhsa, under "What's New." Much of the need analysis and policy context provided in this briefing paper is summarized from those reports.

[4] Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding: Office of Disability, Aging and Long-Term Care Policy*. Retrieved from http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf.

[5] American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey (2008), as cited in Abid, Z., Meltzer, A., Lazar, D., Pines, J. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[6] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality (2010), as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[7] Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[8] *In re the Detention of D.W., et al.* Case 90110-4. Washington State Supreme Court, retrieved from http://www.courts.wa.gov/opinions/pdf/901104.pdf.

Five years prior to the ruling, in response to the already-escalating involuntary treatment capacity problem in Washington, a single bed certification (SBC) process had been created to provide temporary certification that allowed individual patients detained under the state's Involuntary Treatment Act (ITA) to be served in non-E&T hospital settings such as medical units, voluntary psychiatric units, or when necessary, emergency departments. Though this provision kept people in behavioral health crisis safe when E&T beds were not available, it also became a mechanism by which far too many people were held in settings that did not adequately meet their behavioral health care needs. The initial rule creating SBCs did not articulate any specific requirements for the person's care, but since December 2014, SBCs may now only be used to hold a person involuntarily when the hospital is willing and able to provide timely and appropriate mental health treatment to the person. As a result, SBCs now depend on the voluntary participation of a community hospital or other appropriate facility in providing psychiatric services. King County hospitals have been much more receptive than most in the state to the added responsibility that comes with SBC requests since the *D.W.* ruling. There is broad agreement that even the legally allowable use of SBCs to provide "timely and appropriate treatment" to people in crisis is a temporary stopgap, neither a preferred nor a long-term system solution.

In King County and Washington, the psychiatric boarding/single bed certification phenomenon has been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time the treatment need is very high, the population is growing quickly, and laws are changing increasing the likelihood of involuntary detention.

The number of available civil state hospital beds where patients committed under the ITA receive long-term treatment if needed, dropped 25 percent (a loss of 250 beds) between 2006 and 2011. They remain at these historically low levels.[9] Furthermore, the number of community hospital and E&T facility beds in Washington certified for involuntary patients also fell by 31 percent (a loss of 194 beds) between 2000 and 2007, as many independent community hospitals closed their certified psychiatric units or reduced the number of available beds. Seventy-six of those beds were gradually restored over the next few years, but this still left a net reduction of 118 beds (19 percent) as recently as 2013.[10] 2014 brought a major increase of 159 involuntary inpatient beds statewide, as the state and local communities have begun to add new resources to address the psychiatric boarding crisis, which has brought the total number of beds statewide back to approximately the same levels as in 2000.[11] However, current capacity needs far exceed what was required 16 years ago.

The dramatic reduction in inpatient resources during the mid-2000s contributed to Washington's overall ranking of 46th among states in per capita short-term mental health facility capacity (including both community hospital beds and E&T beds), according to a 2015 analysis by the Washington State Institute for Public Policy (WSIPP) of data from Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Mental Health Services Survey (N-MHSS).[12]

[9] Legislative Evaluation and Accountability Program Committee. Operating Budgets for fiscal years 2007-14, Mental Health Program sections, retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

[10] Burley, M., & Scott, A. (2015). *Inpatient psychiatric capacity and utilization in Washington State* (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

[11] Burley, M. & Scott, A. (2015).

[12] Burley, M. & Scott, A. (2015).

Major cuts to flexible non-Medicaid mental health funds from the state ($40.9 million statewide, or 34 percent since 2009)[13] have also significantly affected treatment access. These non-Medicaid funds are prioritized for crisis, involuntary commitment, residential, and inpatient services and play an important role in creating and maintaining a comprehensive continuum of community-based care, and also enable King County to facilitate treatment access for individuals who do not have Medicaid. Meanwhile, many Involuntary Treatment Act (ITA) policy changes have been implemented in recent years, most of them designed to make it easier to detain people in crisis involuntarily and/or to extend inpatient stays for these individuals.[14] And finally, the population of King County grew by an estimated 20 percent between 2000 and 2014.[15]

All five E&T facilities in King County have operated at or near capacity on a daily basis for several years, serving a mix of voluntary and involuntary patients. As of May 2015 on average only 209 out of the 341 certified E&T beds (61 percent) were actually occupied by King County ITA patients, with 85 beds serving voluntary patients and 47 used by ITA patients from other counties.[16]

On top of these enduring acute care capacity challenges, access to beds at Western State Hospital (WSH) for individuals who require long-term treatment has been severely curtailed in 2015. As a result of these developments at WSH, movement of patients on long-term 90- and 180-day treatment orders from local King County E&T facilities or community hospitals into long-term treatment beds at WSH remain severely limited, thereby leaving fewer acute care beds available for community members who needed them. Due to these evolving conditions at WSH, in November 2015 the independent E&T facilities that serve King County reported that 54 acute care ITA beds – out of the 208 that facilities reported were typically available for King County ITA patients as of November 2015[17] – were occupied by individuals on more restrictive long-term orders. Thus, only about half of the certified beds online at the time of this most recent survey were actually available for involuntary acute care.

E&T facilities consistently reported a trend of increase in late 2015 in the number of patients on long-term more restrictive orders and patients waiting for WSH beds, and some reported a corresponding overall increase in length of stay for their patients, as community resources were likewise less available. As a result of all of these factors, local E&Ts' capacity to admit and treat new King County patients has been significantly reduced. This results in an impact to both the patient who remains in a care setting

[13] Legislative Evaluation and Accountability Program Committee. Enacted Budget Bills, 2008-2015, Mental Health Program sections (204), retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

[14] Burley, M. (2011). *How will 2010 changes to Washington's Involuntary Treatment Act impact inpatient treatment capacity?* (Document No. 11-07-3401). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1092/Wsipp_Inpatient-Psychiatric-Capacity-in-Washington-State-Assessing-Future-Needs-and-Impacts-Part-One_Full-Report.pdf.

[15] U.S. Census Bureau State and County QuickFacts, retrieved from **http://quickfacts.census.gov/qfd/states/53/53033.html**, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from **https://www.census.gov/census2000/pdf/wa_tab_6.PDF**.

[16] King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) surveys of evaluation and treatment (E&T) facilities, March 2015 and May 2015.

[17] There was some difference in the total number of certified beds available in at King County facilities between these two E&T facility surveys – 341 in spring 2015, as compared to 305 in November 2015. This can be attributed, in part, to Fairfax Hospital's decision to temporarily close one of its units, designed for individuals with more intensive needs, due to concerns about patient acuity and staff safety. In mid-November 2015, Fairfax Hospital reported that it was working strategically to restore these beds by January 2016.

not designed specifically for his or her needs, and to the individuals who do need that level of care but must wait in another setting, most often being held on an SBC.[18]

A concerted community effort to respond to the 2014 *D.W.* court ruling that mandated timely and appropriate psychiatric treatment for all involuntary patients, led by King County and the Governor and Executive's jointly convened Community Alternatives to Boarding Task Force (CABTF) along with community partners, had significant immediate impact on SBC use. Between October 2014 and May 2015, an average of 64 percent of involuntarily committed people were placed directly into E&T beds as intended by the ITA. However, these gains have eroded in the months since as SBC use in King County has begun to rise again – despite the fact that there was no change in the detention rate for local DMHPs. As noted above, more individuals have been waiting in King County's E&Ts for beds at WSH even when they have been identified by local inpatient providers and courts as in need of long-term treatment at the State hospital. As a result, there has been less space in E&T facilities to accommodate individuals in the community or in emergency departments who need emergency and acute E&T services.

King County's experience with frequent but relatively brief SBC use is the result of its strong partnerships with community hospitals throughout the County. Even though they do not all have certified E&T beds (or adequate capacity of certified E&T beds), these facilities, including their psychiatric units, medical units, and emergency departments, have opted to join in the collaborative effort to provide timely and appropriate involuntary mental health care to all people who need it.

Community hospitals are independent entities. As a result, they voluntarily participate in this work – by accepting SBCs and bringing psychiatric care to their patients wherever they are. Counting on these partnernerships, King County DMHPs' typical practice is to request SBC authorization whenever a patient cannot be placed into an E&T within three hours, to ensure that timely and appropriate care is provided while an optimal placement is secured. King County actively coordinates with many of these hospitals through a regular task force focused on patient placement, and works to address any concerns quickly when they arise.

As State hospital and intensive community resources continue to be insufficient to meet the need and/or difficult to access, this increases the demands on community hospitals with regard to the number of patients on SBCs that they are asked to accept, including the proportion of people on their units who are in psychiatric crisis. Although as of this writing all community hospitals in King County are still willing to assist with this work, most report that they are feeling overstretched, vulnerable, and concerned about the safety of their patients and staff. As a result, the shared partnership in serving SBC patients may be at risk. Increased capacity, direct support for hospitals who are serving people on SBCs, and innovations to ease access to alternative placement choices are all critical to hospitals' continued partnership in this effort.

As one part of the solution to this ongoing short- and long-term inpatient treatment access crisis, King County is partnering with several providers to increase the number of certified E&T beds in and around King County over the next one to two years. About 20 beds for individuals with co-occurring medical

[18] For some patients, such as involuntarily committed children treated at the Seattle Children's psychiatric unit (which is not a certified E&T, but is designed specifically to meet the psychiatric needs of children), or adults who are receiving ongoing medical treatment concurrent with their psychiatric care at a non-E&T facility, keeping a person on an SBC for the duration of their stay may provide a more clinically appropriate treatment experience, and better outcomes, than transferring him or her to a less-than-optimal E&T bed. In these cases, individuals' entire treatment stays may occur in SBC status. As a result, although overall SBC utilization in King County is a helpful estimate of inpatient capacity needs, it remains a proxy measure.

concerns at MultiCare Auburn are most likely to be the first to become available in early 2016, followed by a net increase in mid-2016 of eight medically complex beds at Swedish Ballard. Although they will be certified E&T beds, these new resources will not be solely for involuntary patients, as some will be used by voluntary or out-of-county patients. Two freestanding (non-hospital) E&Ts in south King County, initiated by King County in partnership with the State and community providers, could follow late in 2016 or early in 2017. These facilities would be operated by Valley Cities Counseling and Consultation as well as the Telecare Corporation, and would admit exclusively involuntary patients.

It is notable that the vast majority of planned new beds – 68 out of a potential 76 beds – are slated for south King County, where relatively few resources are currently available.

Estimated Number of E&T Beds	Provider Agency	Planned Location	Specialty Care, if any	Estimated Time Frame for Bed Availability
20	MultiCare	Auburn	Medically complex	February 2016
8 (net)[19]	Swedish	Ballard (Seattle)	Medically complex	Mid-2016
16 to 24[20]	Valley Cities	Kent[21]	None	Late 2016 to early 2017
16 to 24[22]	Telecare	Federal Way	None	Late 2016 to early 2017

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

This concept would provide local funding to pair with investments by State partners and others to enable the construction and startup of the King County projects above or future E&Ts that may be initiated to bring King County's capacity up to level that contributes to a functional service continuum.

Traditional funding sources, namely Medicaid along with some flexible non-Medicaid state funds used for Medicaid-ineligible patients as well as newly allocated state single bed certification funds designed to help with growing inpatient psychiatric costs, generally pay for treatment for patients in E&Ts – although for the growing number of patients who require complex care provided by an E&T program within a larger medical center, Medicaid ony covers part of the total cost of care.[23]

[19] As part of Swedish's transition into its planned new 22-bed unit at its Ballard location, 14 beds will be closed at Swedish Cherry Hill, for a net increase of 8 beds in the number of potentially available beds.

[20] The number of beds will depend on continued "in lieu of more expensive hospital services" authority, which provides a reprieve from the Institutions for Mental Disease (IMD) exclusion rule affecting facility size (Social Security Act, Section 1905, 42 U.S. Code 1396d). See http://leg.wa.gov/JointCommittees/ABHS/Documents/2014-11-14/2a%20-%20ABHS%20TF%20prelim%20report%20merged%20draft.pdf. As long as the State's current temporary waiver authority is extended, which since October 2014 has permitted Medicaid to be used in facilities larger than 16 beds in lieu of more expensive hospital care, these facilities would operate with 24 beds. If the "in lieu of" authority is removed by this Federal administration or any successor, both facilities would need to reduce their capacity to 16 beds to ensure that Medicaid can still pay for care.

[21] In response to siting challenges at its originally planned Woodmont behavioral health campus site in Des Moines, possible alternative locations for the Valley Cities E&T facility and services were being considered in and around the Kent area as of the writing of this paper.

[22] The number of beds will depend on continued "in lieu of more expensive hospital services" authority. See footnote above.

[23] Personal communication from Darcy Jaffe, Harborview Medical Center, January 2016.

To start up a new facility, however, many special costs are incurred that cannot be funded by Medicaid: siting, design, construction, and startup including hiring and training staff. (Many of these same costs are incurred not only for new facilities but for building new units or bed capacity within existing hospital-based inpatient psychiatric programs.) As an example of the potential cost, according to late 2014 estimates, capital costs can reach $7.5 million for a standalone E&T facility such as the Valley Cities and Telecare projects above.[24]

The state legislature, as it did in 2015,[25] periodically may provide funding for such projects at a larger scale than MIDD can. Private philanthropy may also provide some resources. However, local investments by MIDD in E&T capacity, deployed nimbly and strategically under a program umbrella such as this one, could fill gaps between state investments in E&T capacity or enable facility startup to proceed when other funding has not yet been released.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The degree to which this approach will address the identified need will depend upon the number of facilities that can be supported with available funds. The evidence of the need for additional E&T capacity in King County, along with the expected impacts on other levels of the service system, is described in detail in B1 above.

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

Certified evaluation and treatment facilities are, by law, the standard of care for acute involuntary inpatient treatment in Washington state. Services provided in these facilities follow established treatment approaches designed to stabilize individuals in severe mental health crisis. This concept proposes simply to support expansion of these essential services.

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?**

As the SBC crisis is reduced, in part due to the launch of these new E&T facilities along with innovative diversion initiatives, thousands of citizens will benefit, especially those who have had to wait in non-

[24] "Increase Inpatient Psychiatric Capacity in King County: Two New E&T Facilities plus Hospital Bed Conversion." 2015 King County legislative priority briefing paper, updated November 3, 2014.

[25] As part of an overall statewide capital investment of nearly $36 million for behavioral health projects, the final 2015 State capital budget included $8 million specifically designated for community inpatient psychiatric facilities in King County, including $5 million for the Woodmont facility in south King County and $3 million for the Swedish Ballard site.

psychiatric settings for inpatient care to become available. By reducing pressure on the inpatient system, these initiatives will also make intensive community-based care easier to access.[26]

Measures could include increases in the rate of direct E&T placement, and decreases in average time patients spend in in SBC status awaiting an E&T bed. As noted above, data is already currently gathered on direct E&T placement rate. In addition, periodic surveys of SBC lengths of stay performed by patient placement coordinators at the Crisis Clinic could be routinized and made more rigorous, including mechanisms for regular data tabulation, in order to provide another measure of the effect of increased capacity on the need for SBCs.[27]

C. Populations, Geography, and Collaborations & Partnerships

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

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

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

The primary clients who would be served by this program would be individuals who have been committed to involuntary psychiatric treatment at an E&T facility, but due to current resource scarcity cannot access such care immediately.

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**:

[26] "Increase Inpatient Psychiatric Capacity in King County: Two New E&T Facilities plus Hospital Bed Conversion." 2015 King County legislative priority briefing paper, updated November 3, 2014.

[27] A summer 2015 survey by Crisis Clinic patient placement coordinators found that many King County patients are placed in an E&T bed within a day of the request for an SBC, and the vast majority of them are placed in a bed that matches their needs within three days. Because no placement delay is acceptable, King County and its partners urgently continue to seek necessary placement for each patient until a bed designed to serve their individual clinical needs can be found. Such a survey could be transformed into a standardized reporting requirement in order to track progress in delivering access to E&T services faster.

As noted in section B1, there is a particular need for expanded E&T capacity in South King County. However, this program would be designed to have the flexibility to support E&T construction and startup anywhere in the county, as capacity anywhere benefits patients everywhere.

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.**

E&T facility startup requires strong collaborations with State partners such as the state DSHS Division of Behavioral Health and Recovery, legislators, host cities and neighborhoods, and community providers or hospitals who would be contracted to build the new facilities and provide the E&T 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?**

Significant expansion of community-based diversion and discharge resources could potentially reduce the need for or scope of this program, as any of those changes could result in fewer patients in community hospitals in SBC status or needing E&T services. However, due to the inpatient shortage described in B1 above, increased E&T capacity will be needed regardless of the degree of community-based innovation and capacity-building that may occur.

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?**

Siting E&T facilities, and other behavioral health crisis services, remains an enduring challenge, as communities struggle to reconcile the need for more services in their local area with fears and stigma associated with people in behavioral health crisis. As has occurred recently with the Woodmont project that was deferred and subjected to potential relocation even after significant investments by the provider and the state in proceeding toward implementation, siting issues can significantly delay or derail a project even when there is broad agreement and political will among policymakers and providers.

Another potential implementation barrier may be partial funding of a facility. If MIDD provides some but not all funding due to its limited resources, as would be appropriate in many cases given the expense of each facility and the responsibility of the state to participate in launching these facilities, service implementation may have to wait until the full cost of facility launch has been secured from a variety of sources.

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?**

It is conceivable that MIDD funding for E&T construction and startup might be deployed quickly through this program even when other potential funding resources may eventually become available from less nimble sources such as the state budget or institutional philanthropy.

Inpatient capacity falls so far short of need in King County and Washington that there is little to no risk of funding too much E&T capacity.

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?**

As noted in B1 above, detained individuals could continue to be held in less than optimal settings for longer periods of time than necessary. Community hospitals' willingness to partner in accepting and caring for individuals in SBC status may erode, which would create a compliance crisis as it relates to the *D.W.* ruling.

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?**

Alternative approaches to additional E&T capacity include continued and sustained efforts to boost innovative high-intensity community-based services that could reduce the need for involuntary treatment by diverting individuals from the involuntary system entirely or enabling their expedited discharge to make room for other patients. However, a comprehensive approach to the capacity crisis will include both community alternatives and new evaluation and treatment beds.

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 links strongly to the work of the Community Alternatives to Boarding Task Force (CABTF) to design and recommend system improvements to reduce involuntary treatment demand.

It supports the individual/family-level goal of the Health and Human Services Transformation Plan to improve access to person-centered, integrated, culturally competent services, where, when, and how people need them.

This concept also reflects the Veterans and Human Services Levy goal of reducing unnecessary emergency system involvement.

The concept also supports the goal of All Home to make homelessness brief and one-time by addressing crises as quickly as possible and assessing, diverting, prioritizing, and matching people with housing and supports.

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

Making investments to move closer to sufficient E&T capacity would reduce delay and confusion for people in severe psychiatric crisis and deliver the trauma-informed and specially tailored services they need immediately upon their involuntary commitment. This would help take our community's system toward the vision of the 2012 King County Recovery and Resiliency Ordinance, which promotes service delivery within a "trauma-informed, recovery and resiliency focused system that offers respect, information, connection and hope."[28]

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

This concept directly addresses a key determinant of equity identified as part of the County's equity and social justice (ESJ) work. It would improve access to health and human services for individuals who are in crisis and would otherwise often receive only the minimally required care in a non-optimal setting while they are waiting for an E&T placement.

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.)**?**

As noted above, the capital and startup costs for a standalone E&T facility has been estimated at about $7.5 million. E&T programs embedded within larger medical centers or behavioral health campuses, which could also be supported under this concept, may be available for slightly less in some cases. However, as has been the case with the attempt to move forward with a multiservice Woodmont campus Des Moines, these larger projects can be more difficult to site successfully.

2. **Estimated ANNUAL COST.** More than $5 million per funded E&T facility
Provide unit or other specific costs if known.

The specific breakdown of capital and startup expenditures for any particular project was not available at the time of this writing. In any case this would be greatly variable depending on the particular circumstances of each E&T site considered for funding.

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

State capital funding, such as the $8 million provided for inpatient psychiatric capacity projects in 2015, could be a significant potential funder for new E&Ts. However, this funding rarely fully funds a facility, so contributions from MIDD may still be helpful even for state-funded projects. Private philanthropy may also play a role in launching such projects.

[28] http://www.kingcounty.gov/~/media/health/mentalHealth/Recovery/Documents/130502_Recovery_Ordinance_11-6-12.ashx?la=en

If the County elects to pursue voter approval of an additional 0.1 percent local sales tax for housing and related services under 2015's Engrossed Substitute House Bill 2263,[29] such funds could be used for E&T facility construction and/or startup. However, there is no indication at the time of this document's writing that such a new tax will be pursued in King County, or that voters would approve it.

Ongoing operational funding for E&T services would come from non-MIDD sources including Medicaid and flexible state non-Medicaid, and/or state single bed certification funds designed to help with growing inpatient psychiatric costs.

4. TIME to implementation: At least a year from award

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

As noted above, full funding and siting of new E&T facilities is challenging and can take can take as many as several years, depending in part on the level of neighborhood support. At best, such projects take at least a year to come online.

b. What are the steps needed for implementation?

Once funding and siting is resolved, steps to implementation include design, construction, and hiring and training staff.

c. Does this need an RFP?

An RFP would be required to identify appropriate providers and sites for new E&Ts.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

This paper links with briefing paper 45 Partnerships with Community Hospitals to Serve Patients on SBCs, which contains much of the same need analysis information because it is addressing the same problem of inpatient psychiatric care access and quality, but at a different point in the care continuum. Effective programs intervening in community hospitals while people are in SBC status could potentially reduce referrals to E&Ts. It also relates to briefing paper 12 105 Hospital Step-Down Step-Up Program, another strategy to reduce hospital lengths of stay and thereby improve E&T access.

New Concept Submission Form

[converted from PDF]

New Concept #131
Working Title: Certified E&T Beds fro All Ages

Seattle City Attorney's Office

[29] http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2263-S.SL.pdf

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 more state certified Evaluation and Treatment Centers to meet the bed needs in King County for adolescents and adults. At last count, the County was short about 45 beds a day for the evaluation and treatment of mental illness for adults alone.

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.
Competency evaluations and treatment for our mentally ill must take place in state certified evaluation and treatment centers. Yet we do not have enough of them in King County.

3. How would your concept address the need?
Please be specific.
By providing adequate bed space for adolescents and adults experiencing mental illness.

4. Who would benefit? Please describe potential program participants.
Police agencies, Fire agencies, hospitals, Designated Mental Health Providers, individual patients, jails, and the health, safety and welfare of 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.
Success would mean timely evaluations, no boarding in hospitals, no wait times for in-patient mental health treatment, and plenty of room at local state certified Evaluation and Treatment Centers.

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 get the mental health services they need when they need them will greatly reduce stress, public safety problems, family problems, and result in greater treatment success by getting people they treatment they want and need when they want it and need it.

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.
Harborview, BHC Fairfax, Navos, and NW 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*.