BP 98 Developmental Disabilities and Crisis Response System Collaboration

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept x (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This new concept proposes a collaborative system improvement between the King County Division of Developmental Disabilities (KCDDD) and the King County Behavioral Health and Recovery Division (KCBHRD)[1] to improve the behavioral health crisis system's response to adults with developmental disabilities (DD). This concept calls for providing real-time technical assistance, consultation, and intervention services by DD behavioral health experts to several components of the crisis and related service systems. This concept proposes three distinct service components where DD behavioral health experts would be available to both augment services and teach staff of the adult crisis response programs more effective and efficient ways of responding to an adult with a DD who is in crisis.

Collaborators:

Name	Department
Susan Schoeld	DCHS

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

Name	Role	Organization
Denise Rothleutner	Director	DCHS-DDD
Susan Schoeld	MIDD Crisis Diversion Program Manager	DCHS-BHRD
Dave Murphy	Criminal Justice Initiatives Manager	DCHS-BHRD

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 new concept proposes a collaborative system improvement between the King County Division of Developmental Disabilities (KCDDD) and the King County Behavioral Health and Recovery Division

[1] BHRD was formerly known as the King County Mental Health Chemical Abuse and Dependency Services Division [MHCADSD].

(KCBHRD)[2] to improve the behavioral health crisis system's response to adults with developmental disabilities (DD). This concept calls for providing real-time technical assistance, consultation, and intervention services by DD behavioral health experts to several components of the crisis and related service systems. This concept proposes three distinct service components where DD behavioral health experts would be available to both augment services and teach staff of the adult crisis response programs more effective and efficient ways of responding to an adult with a DD who is in crisis.

The three proposed service strategies are:

1. Service Strategy 1: Provision of on-call, DD behavioral health experts available to provide real-time technical assistance, consultation, and intervention services to increase the capacity of the Crisis Solutions Center (CSC) Mobile Response Team (MRT) in engaging adults with a DD who are in crisis. On-call DD behavioral health experts will provide a surge capacity to the CSC MRT that is currently not available when the team responds to a first responder's[3] call regarding an adult with DD in crisis.

   Through technical assistance and consultation, DD behavioral health experts will transfer their knowledge to CSC MRT professionals. They will provide information to first responders about engaging adults with a DD in crises. DD behavioral health experts will also provide appropriate referrals for additional supports offered by the DD service system.

2. Service Strategy 2: Provision of on-call, DD behavioral health experts available to provide on demand technical assistance, consultation, and interventions to increase the capacity of both CSC 3-day Crisis Diversion Facility and the CSC 14-day Crisis Diversion Interim Services Program. This will help meet the crisis stabilization needs of adults with a DD.

   DD behavioral health experts' services will add to CSC's current stabilization, evaluation, assessment, mental health, substance use disorder, and intensive case management supports offered to adults in crisis stabilization. DD behavioral health experts will also provide appropriate DD service system referrals and transfer knowledge about navigating the DD service system to CSC case managers.

3. Service Strategy 3: Provision of on-call, DD behavioral health experts available to provide on demand technical assistance, consultation, and interventions to increase the capacity of long-term housing providers that rely on CSC services and serve adults with a DD exiting CSC services. In addition to supporting the behavioral health needs of adults with a DD in long-term housing, DD behavioral health experts will provide appropriate referrals to additional supports in the DD service system for adults with a DD living in long-term housing.

   Long-term housing providers cite a lack of capacity to support adults with a DD in long-term housing as a reason why adults with a DD are returning to crisis services and recycling back into the behavioral health crisis response system shortly after they have been referred to them. In addition to meeting the behavioral health needs of adults with a DD in long-term housing, DD

[2] BHRD was formerly known as the King County Mental Health Chemical Abuse and Dependency Services Division [MHCADSD].

[3] 'First responders' is defined as a person [as a police officer or an Emergency Medical Technician] who is among those responsible for going immediately to the scene of an accident or emergency to provide assistance. http://www.merriam-webster.com/dictionary/first%20responder

behavioral health experts will also be able to provide referrals to additional supports available in the DD service system

This proposal aims to use a targeted, cost-effective and cost-reducing approach, and on-call DD behavioral health experts, to close two gaps in the current service system array. These gaps are: 1) a need for more accurate crisis service system response to behavioral health symptoms of an adult with a DD using the behavioral health system's adult crisis services; and, 2) a need to support long-term housing providers to better manage behavioral health needs of the adults with a DD for whom they provide housing. This proposal will help the system to more appropriately respond to both the behavioral health crises and aftercare crisis needs of these adults in order to increase housing stability and integrated community living, and to reduce repeated use of out of home, behavioral health adult crisis services.

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): others?

☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

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

Please describe the basis for the determination(s).

Prevention and Early Intervention: Keep people healthy by stopping problems before they start and preventing problems from escalating; increased access to person centered, culturally appropriate treatment, education and training services; reduce barriers to services; reduce crisis events; increase housing stability.

Crisis Diversion: Assist people who are in crisis or at risk of crisis get the help they need; decrease length of crisis events, reduce barriers to service.

Recovery and Re-entry: Empower people to become healthy and safely reintegrate into the community after crisis; increase access to culturally appropriate treatment services; increased housing stability.

System Improvements: Strengthen the behavioral health system to become more accessible and deliver on outcomes; improved care coordination; improved quality of care; improved client experience; increased use of evidence based practices and assessment tools, right treatment, at the right time, in the right amount (service on demand); culturally diverse providers.

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

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

The reported rate of mental illness among individuals with developmental disabilities (DD) varies considerably. The ARC[4] asserts that rates of 10 to 40 percent have been reported for people served by community agencies. Much lower rates of 10 to 20 percent have been reported in large population surveys.[5] The primary reason for such high rates is that personality disorders are common. The single most common mental health problem is poor social skills. Conduct and behavioral problems occur for

[4] The ARC, previously known as The Association of Retarded Citizens. http://www.thearc.org/page.aspx?pid=2522.

[5] http://www.thearcww.org/helpline/topic/mental-illness-and-people-with-developmental-disabilities/

about one in five people in the community. The rate for affective disorders is about three to six percent of the general population of people with developmental disabilities. Quintero and Flick indicate a conservatively estimated 33 percent prevalence of mental illness in the population of people with an intellectual and developmental disability (I/DD).[6]

While the last twenty five years have seen significant progress in the treatment of mental illnesses, these advances have been slow to be adapted for use with people with a DD. The perception of the problem of mental illness in people with a DD has affected the delivery of needed services. In the past, emotional disturbances and developmental disabilities were viewed as coexisting and inseparable entities, which were untreatable. Eventually there was a realization that these are distinct needs, served by two distinct service systems.

When someone with a DD presents with behavioral difficulties, it can be challenging to determine the underlying cause of such difficulties. Because of their cognitive and adaptive disabilities, individuals with a DD are less likely to have developed appropriate coping skills for a variety of stressors. Also, many people with a DD have limited verbal skills, so pain and discomfort caused by medical problems may be expressed as physical aggression.[7]

Most mental health professionals use the term 'dual diagnosis' to refer to people who have both a mental illness and a substance use disorder. There is another population also described as dually diagnosed that poses significant challenges to professionals. These people have co-occurring intellectual and developmental disabilities (I/DD), formerly called mental retardation, and a mental illness. Few professionals are trained in this specialty or are aware of how frequently the two conditions coexist. As stated above, a complicating factor is the limited communication skills of many people with an I/DD. This limitation makes it difficult or impossible for them to describe their own experience accurately to the clinician. They may simply not have words to use in explaining their feelings and perceptions. Words are essential tools for mental health clinicians, including those providing crisis response services and long term housing. The possible absence of these tools by someone needing their services creates a system need for specialized DD behavioral health expertise consultation and assistance. This new concept proposes a way to provide the system with this needed specialized expertise.

Without specific training in dual diagnosis, clinicians who are unaware of the possibility of co-occurring conditions fail to ask the appropriate clinical questions, and unwittingly create circumstances in which these individuals are either untreated, undertreated, or perhaps more concerning, treated with ineffective or inappropriate methods. This new concept proposes to correct this system deficiency, which at its origin begins with the lack of training in this type of dual diagnosis in the curricula of standard clinical mental health/counseling/social work graduate programs and medical schools. When a clinician sees someone with these two dual diagnoses, there is often a tendency to recognize only the developmental delay and attribute any odd behaviors to that condition. This leads to a phenomenon

[6] Quintero, Maria PhD, Flick, Sarah, MD, *Co-Occurring Mental Illness and Developmental Disabilities,* **Social Work Today**, Vol. 10 No. 5 P.6, September/October 2010 Issue.
http://www.socialworktoday.com/archive/092310p6.shtml

[7] Tang, Betty MD, FRCPC, Byrne, Caron MD, Friedlander, Robin MBChB, FRCPS, McKibbin, Douglas, MD, FRCPC, Riley, Mark BMBS, MRPsych, MPhil, FRCPC, Thibeault, Amy MD, FRCPC, *The other dual diagnosis: Developmental disability and mental health disorders,* **BCMJ-British Columbia Medical Journal,** Vol. 50, No. 6, July-August 2008, page(s) 319-324. http://www.bcmj.org/article/other-dual-diagnosis-developmental-disability-and-mental-health-disorders

known as overshadowing, in which a clinician does not see the possibility of a mental illness as the cause of behaviors for which the person is being referred,[8] or uses mental health responses for what are at their origin DD behavioral management issues.

King County adults with a DD face multiple challenges in accessing community services and supports designed to effectively intervene and stabilize them when in crisis. Adults in crisis with a DD may experience behavioral issues that appear to first responders and community safety net providers as symptoms of a mental illness. This may lead to ineffective referrals to services and supports designed to serve adults with mental health issues.

By the time an adult in crisis with a DD is referred to the Crisis Solutions Center (CSC), their behavioral health has often deteriorated to a state that challenges the mental health skills of CSC professionals in providing an effective intervention. This can contribute to the rapid recycling of an adult with a DD through the crisis response system, while also putting that adult at greater risk of homelessness and/or involvement with the criminal justice system.

CSC staff indicate adults with a DD recycle through the crisis response system at a much higher rate than other populations they serve. CSC staff attribute this rapid recycling to the limited capacity of the current crisis system to effectively address the behavioral health needs of adults in crisis with a DD. The experience shared by CSC staff coincides with KCDDD's experience that the behavioral health issues presented by adults in crisis with a DD are best met by behavioral health experts who have experience in implementing DD specific behavioral health interventions. The three collaborative service strategies proposed in this new concept have been identified by KCDDD and CSC staff as ways to enhance services and supports to address the needs of King County adults in crisis with a DD.

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

This new concept proposes to provide real-time, on-call, on demand availability of DD behavioral health experts to King County's Crisis Stabilization Center (CSC) Mobile Response Team (MRT), CSC Crisis Diversion Facility, CSC Crisis Diversion Interim Services Program and long term housing providers.

Availability of DD behavioral health experts will:

1. Through technical assistance and consultation, transfer their knowledge to MRT professionals;
2. Provide first responders with information about engaging adults in crisis with a DD;
3. Through technical assistance, consultation and interventions, increase the capacity of both the CSC Crisis Diversion Facility and the CSC Crisis Diversion Interim Services Program to meet the crisis stabilization needs of adults with a DD;
4. Through technical assistance, consultation and interventions, increase the capacity of long-term housing providers to better serve adults exiting CSC services.
5. Provide appropriate referrals for additional supports offered by the DD service system, and transfer knowledge about navigating the DD service system to MRT staff, first responders, CSC Crisis Diversion Facility staff, CSC Crisis Diversion Interim Services Program staff, and long term housing providers.

[8] Silka, V.R., Hauser, M.J. (1997). *Psychiatric assessment of the person with mental retardation*, **Psychiatric Annals**, 27(3).

This new concept is a cost effective proposal that reduces siloed services and expertise and maximizes the possibility of an on demand, 'best fit' approach to service provision. It also addresses system gaps by increasing the expertise of both the adult mental health crisis system services and long term housing services staff in most effectively responding to the behavioral health needs of adults with a DD, as well as most skillfully accessing additional available DD service system supports for these individuals.

This new concept highlights the need for collaborative service strategies to increase appropriate services and behavioral supports for adults in crisis with a DD. It asserts that funding these enhanced system supports will reduce these adults' repetitive involvement in use of the crisis response system resources. It is also possible the King County 'Familiar Faces'[9] work includes some adults with a DD in crisis who may find themselves as a repeat 'user' of criminal justice resources as a consequence of their behavioral health needs being inaccurately or insufficiently met when they are in need.

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 responses to questions A.1. and B.1. above include relevant evidence that this approach will address the identified need. Most mental health professionals and physical health care providers are not trained in the dual diagnosis of intellectual developmental disability and mental health disorder. They also lack experience working with individuals that have this combined disorder presentation. This lack of training results in inaccurate and/or inappropriate responses to adults in crisis with a DD and can result in unstable housing, homelessness, repeated criminal justice system involvement, unnecessary human suffering, an increase in mental health and/or substance use disorder symptom severity, and repeated use of King County's adult mental health/behavioral health crisis resources.

This dual diagnosis is also not a specialization of long term housing providers who enable people with a DD to live in an integrated manner in the community, support their ongoing employment, and assist with general life skills development and maintenance. There has been a long term trend to support people with a DD successfully living as valued and integrated members of the community rather than warehousing them in institutions. Accurately responding to the crisis needs of adults with a DD and ensuring the consistent implementation of behavioral management strategies, where needed, strengthens and supports this trend. Implementing this new concept supports this goal for people with a DD.

King County is interested in providing services in the most effective and cost efficient manner possible. Hiring DD behavioral health specialists as contract staff to provide on-call, on demand, specialized consultation, technical assistance, intervention, and referral expertise is an administratively elegant approach to decreasing systemic gaps in workforce training and better meeting DD adult population needs that would otherwise result in poor or mismatched service provision and a repetitive use of County adult mental health crisis resources. Both of these outcomes are costly and inefficient. Implementing this new concept will also increase the skills of the adult crisis response service system and the long term housing system staff.

[9] http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coordination.aspx

While the fact of siloed services is often decried, this new concept proposes a practical way to share expertise from one system (DD) and apply it in another system (MH/BH). This new concept proposes a practical solution to practical problems that curtail the likelihood of some of the worst system outcomes such as an increase in human suffering, use of high cost services (sometimes repeatedly), ongoing untreated mental health and substance use disorders, and services that don't achieve their intended ends.

4. **Please specify whether 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.**

It is a best practice to pool multiple system resources, skills, and abilities to serve people who cross over multiple systems' eligibility boundaries in the most efficient, effective and direct manner. This is using the idea of 'best practice' from the perspective of business administration, in this case public administration. The system gaps identified by this new concept result in poor customer service, repeated use of costly resources, a lack of both accurate problem identification and response, and the possibility of housing instability or homelessness.

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?**

The following outcomes could be measured and evaluated to gauge the success of the three proposed service collaboration strategies:

- Increased utilization of appropriate services, supports, and stabilization for adults with a DD in crisis;
- Right treatment, at the right time, in the right amount (service on demand) in the form of DD behavioral health technical assistance, consultation and interventions within the crisis response service system and the long term housing service system;
- Reduction in use of jail for crisis services;
- Decreased barriers to service; and
- Increased housing stability.

C. Populations, Geography, and Collaborations & Partnerships

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

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☒ **Families**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**

☐ **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.

See detailed answers to this in other sections.

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

This new concept proposes services that would be county-wide.

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.**

Essential collaborations and partnerships include the DD service system, the behavioral health (BH) service system, with a special focus on the adult crisis response services, the housing and homelessness service systems, all law and fire departments' first responders, and all King County jurisdictions with Crisis Intervention Teams (CIT)[10]. It would also be valuable to explore including training by DD behavioral health specialists in the Crisis Intervention Team training for King County law enforcement officers. It might also be valuable for the DD behavioral health specialists to attend the CIT training to enable stronger partnerships with first responders.

The proposed DD behavioral health specialists will also be in a unique position to provide DCHS and KCDDD with real time feedback on needed services for this population as well as an evaluation of whether services are meeting the intended goals and outcomes for adults in crisis with a DD diagnosis.

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?**

Changes in State and Federal legislation, new legislative initiatives, and related funding decisions for both have significant impact on the service systems depending on this funding. All service systems that are intended to collaborate in this proposal to remedy a significant service system gap are affected by these decisions. For example, the public mental health and substance use disorder systems have

[10] Crisis Intervention Teams promote and support collaborative efforts to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illness, their families and communities and also to reduce the stigma of mental illness. http://www.citinternational.org/

endured years of budget cuts, coupled with unfunded, increased statutory requirements; the public developmental disability system has had to contend with a huge wait list for services[11], reduced state general funding for Medicaid based waiver programs. As a result, there has been an accompanying need to reduce services by modifying eligibility requirements, as well as conflicting federal and state legislative policy agendas for people with a developmental disability. Likewise, law enforcement jurisdictions have at times been funded for increased community policing initiatives and then seen funding retreat entirely or be moved to other initiatives such as responding to terrorism. Fire districts that house Emergency Medical Technicians are often underfunded and in some instances rely on an all-volunteer force. All of these systems have been affected by the recent Great Recession with regard to funds available from municipal, county, state, and/or federal sources.

It is unknown if the intended integration of behavioral health with physical health care as of April 1, 2020 in Washington State will result in improved customer health outcomes and increased cross healthcare system collaborations, or if it will continue to result in cutting available money for health care needs and generally curtailing healthcare system resources.

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 unknown if the status of being an on-call, contracted worker will appeal to those with the needed DD behavioral health technical expertise. Possible concerns include: sufficient hours; desire for part time work; willingness to be available on-call; adequate administrative support.

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?**

If those with the needed DD behavioral health expertise wish more stable employment and/or a reliable schedule or benefits, it is feasible that they may choose to leave the proposed part-time, on-call employment for full time employment in either the behavioral health or developmental disability services systems. The best service provision always occurs when there is stability in a trained and able workforce. Instability in the proposed DD behavioral health specialists to serve the adult mental health crisis and housing service systems would be an unintended consequence of the proposed model.

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?**

This has been touched on briefly in the response to question B. 3. above. This new concept proposes a practical solution to practical problems that curtail the likelihood of some of the worst system outcomes, such as an increase in human suffering, use of high cost services, sometimes repeatedly, untreated mental health and substance use disorders, an increase in mental health and/or substance use symptoms, housing instability, homelessness, and services that don't achieve their intended ends.

[11] The statewide DDA waitlist has been at approximately 15,000 for many years. http://arcwa.org/resources/NPS_page.pdf. The Washington State Developmental Disabilities Administration [DDA] is working to reduce and eliminate the waitlist. https://www.dshs.wa.gov/dda

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 two alternatives would be for either or both KCDDD and KCBHRD to seek private funds for the proposed new concept system gap 'fix,' or to seek a legislative requirement for such services, accompanied by adequate appropriations.

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?**

While people with developmental disabilities can be assumed to be included in "community" in the county initiatives of Accountable Communities of Health, Behavioral Health Organization Development, Best Starts for Kids, Committee to End Homelessness, Equity and Social Justice, Health and Human Services Transformation Plan, Community-Level Transformation Plan Strategy: Communities of Opportunity, Physical and Behavioral Health Integration, Recidivism, Reduction and Reentry Strategic Planning, and the Veterans/Human Services Levy, it is likely this new concept is the first time this system gap has been identified in any formal county planning process beyond the focus of KCDDD. Beneficial questions to add to the planning of all these county initiatives might be: how will this affect and how does this meet the needs of adults with a DD living in our community?

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

This new concept proposes an informed and strengths-based response to the crisis needs of adults with a DD. It presumes the ability of people with a DD to gain skills and successfully accommodate personal challenges including traumatic experiences with the help of skilled professionals and needed support services. The services would include a DD behavioral health specialist who provides technical assistance, consultation, and interventions with the mental health crisis and long term housing systems and the competent use of multiple system resources. It recognizes the need for systems to provide individualized responses to crisis needs of adults with a DD that incorporate previously successful behavioral management techniques and create new behavioral health interventions, which can be sustained by multiple service system partners.

People with a DD are among the most vulnerable in the community; often the victims of sexual assault, public emotional humiliation and/or physical violence. A few statistics related to sexual assault of people with developmental disabilities follow to underscore both prevalence and significant service issues. Among adults who are developmentally disabled, as many as 83 percent of females and 32 percent of males are victims of sexual assault.[12] Forty percent of people with developmental disabilities who are

[12] Johnson, I., Sigler, R., 2000. "Forced Sexual Intercourse Among Intimates", Journal of Interpersonal Violence. 15 (1).

victims of sexual violence will experience ten or more abusive incidents.[13] Only three percent of sexual abuse cases involving people with developmental disabilities are ever reported.[14] Thirty three percent of abusers are friends or acquaintances, 33 percent are natural or foster family members, and 25 percent are caregivers or service providers.[15]

A trauma informed service lens is essential for effective and successful crisis responses for adults with a DD in crisis. In part this includes assuming these adults have experienced high levels of trauma and that a trauma-informed approach is categorically necessary.

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

Adults with a DD are a marginalized community. They are often unseen and generally not conscientiously included in thoughts about community needs and general community planning. If investigated, it is likely possible to verify this assertion by exploring the notes of the MIDD community conversations and all other community and stakeholder inclusion activities for county initiatives mentioned in E.1. Were adults with a developmental disability directly supported and encouraged to share their thoughts on their needs for the various county planning and funding opportunities?

This new concept conscientiously includes them, responds to their specific needs, and provides an integrated service system response. Increasing successful, targeted service responses and workforce skill and ability development to meet the needs of a marginalized community is an example of implementing equity and social justice work.

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.)**?**

Resources needed include: direct service staff, administrative support, phones, possibly physical space, time allocated for partner cross system training, supplies, travel, printing and phone costs, insurance, staff training.

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

While full implementation is estimated to cost $105,450 per year, the "$100,000 or less" category most closely represents this new concept.

Pilot/small scale implementation would implement service strategy 1, serve 10-12 people per year and is estimated to cost $21,400.00 per year.

Partial implementation would implement service strategies 1 and 2, serve 30-36 people per year and is estimated to cost $69,450.00 per year.

[13] Valenti-Heim, D., Schwartz, L. 1995. The Sexual Abuse Interview for Those with Developmental Disabilities.
[14] Ibid.
[15] Sobsey, D. (1988) "Sexual Offenses and Disabled Victims: Research and Practical Implication." Visa Vis, Vol. 6 NoA.

Full implementation would implement all three service strategies, serve 20-24 people per year and is estimated to cost $105,450 per year.

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

There are no known revenue sources other than MIDD that could or currently fund this work. The DD system doesn't have a crisis system. The MH system does include required crisis services for all residents regardless of health care or payment.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

It is unknown if there are any current county contracts with DD behavioral health specialists or with DD or MH/BH community services that could be expanded to meet the needs of this proposed new concept. This could eliminate the need for an RFP. It would be important to explore the best way of seeking the DD behavioral health specialists needed.

It would be necessary to determine what part of county government is the best fit for administering and monitoring these activities. A discussion between KCBHRD and KCDDD is advised to discuss and resolve these issues. It might also be valuable for these divisions to jointly agree on the definition of the credentials, experience, background, etc. needed to be a DD behavioral health specialist for the purposes of implementing these crisis-related and housing service supports. There would need to be discussions with the adult mental health/behavioral health crisis service system to determine the best way of including the services proposed by this new concept and training crisis and housing staff in key concepts and approaches.

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?

#98 Working Title of Concept: Developmental Disabilities and Crisis Response System Collaboration

Name of Person Submitting Concept: Denise Rothleutner, Director
Organization(s), if any: King County Developmental Disabilities Division
Phone: 206-263-8988
Email: denise.rothleutner@kingcounty.gov
Mailing Address: 401 5th Avenue, Suite 520, Seattle, WA 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 paper describes a Developmental Disabilities and crisis response system collaboration between the King County Developmental Disabilities Division (KCDDD) and the crisis response system in King County. The objective of the Collaboration is to create system improvements that lead to better behavioral health, social, and justice outcomes for adults in crisis with a developmental disability (DD).

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.

Adults with a DD face multiple challenges in accessing community services and supports designed to effectively intervene and stabilize them when in crisis. Adults in crisis with a DD may experience behavioral health issues that appear to first responders and community safety net providers as symptoms of a mental illness. This may lead to ineffective referrals to services and supports designed to serve adults with mental health issues.

By the time that an adult in crisis with a DD is referred to the Crisis Solutions Center (CSC), their behavioral health has often deteriorated to a state that the mental health skills of CSC professionals are challenged in providing an effective intervention. This can contribute to the rapid recycling of an adult with a DD through the crisis response system, and also puts that adult at greater risk of homelessness and/or engaging the criminal justice system.

This concept paper highlights collaborative service strategies to increase appropriate services and behavioral supports for adults in crisis with a DD. This will reduce their future involvement in the crisis response system.

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

During a crisis event, CSC staff indicated that adults with a DD recycle through the crisis response system at a rate much higher than other populations they serve. They attribute this rapid recycling to the limited capacity of the current system to effectively address the behavioral health needs of adults in crisis with a DD. This supports KCDDD's experience, that the behavioral health issues presented by adults in crisis with a DD, are best met by behavioral health experts who have experience in implementing DD specific behavioral health interventions.

KCDDD and CSC staff identified the following collaborative service strategies as ways to enhance services and supports to address the needs of adults in crisis with a DD:

Service Strategy 1. The provision of on-call, DD behavioral health experts available to provide real-time technical assistance, consultation, and intervention services that increase the capacity of the CSC Mobile Response Team (MRT) in engaging adults in crisis with a DD. On call DD behavioral health experts will provide a surge capacity to the CSC MRT that is currently not available, when they respond to a first responders call regarding an adult with DD in crisis.

Through technical assistance and consultation, DD behavioral health experts will transfer their knowledge to CSC MRT professionals. They will provide information about engaging adults with DD in crisis, to first responders. DD behavioral health experts will also provide appropriate referrals for additional supports offered by the DD system.

Service Strategy 2. The provision of on-call, DD behavioral health experts available to provide on demand technical assistance, consultation, and interventions to increase the capacity of both CSC 3-day Crisis Diversion Facility, and the CSC 14-day Crisis Diversion Interim Services Program. This will help to meet the crisis stabilization needs of adults with a DD.

DD behavioral health experts' services will add to CSC's current stabilization, evaluation, assessment, mental health, chemical dependency and intensive case management supports offered to adults in crisis

stabilization. DD behavioral health experts will also provide appropriate DD referrals and transfer knowledge about navigating the DD system to CSC case managers.

Service Strategy 3. The provision of on-call, DD behavioral health experts available to provide on demand technical assistance, consultation, and interventions to increase the capacity of the long-term housing providers that partner with CSC to serve adults exiting CSC services. In addition to supporting the behavioral health needs of DD adults in long-term housing, DD behavioral health experts will provide appropriate referrals to additional supports in the DD system for adults with DD living in long-term housing.

Long-term housing providers cite a lack of capacity to support adults with a DD in long-term housing, as a reason why adults with a DD are returning to crisis and recycling back into the crisis response system shortly after they have been referred to them. In addition to meeting the behavioral health needs of adults with a DD in long-term housing, experts will also be able to provide appropriate referrals to additional supports in the DD system.

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

Adults experiencing a crisis with a DD will benefit most from Collaboration service strategies, by receiving appropriate and effective behavioral health interventions. Crisis response and stabilization system staff and housing providers, will benefit from increased capacity to effectively serve and stabilize adults in crisis with a DD. The County would benefit from reduced costs associated with fewer adults recycling through the crisis response system, and the prevention of these adults from becoming at risk of engaging the criminal justice system or being homeless.

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.

The following outcomes could be measured and evaluated to gauge the success of Collaboration services strategies:

- increased utilization of appropriate services, supports and stabilization for adults with a DD in crisis
- right treatment, at the right time, in the right amount (service on demand) in the form of DD specific behavioral health
  technical assistance, consultation and interventions within the crisis response system
- reduction in the use of jail for crisis services
- decreased barriers to service
- increased housing stability

It is not known if current data on these outcomes are collected in the crisis response system for adults with DD.

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 the 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 Collaboration concept aligns well with the MIDD II Objective by strengthening the ability of the crisis response system to address the needs of adults in crisis with DD. Strong crisis response systems contribute to improved behavioral health, social and justice outcomes, at the individual program and community level.

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.

Organizations necessary to the success of the Collaboration concept include the following stakeholders in the crisis response and stabilization system: first responders and other crisis system referral agencies, CSC mental health and substance abuse professionals and programming, DD behavioral health experts, KCDDD, and County departments supporting the MIDD's crisis response system.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation: includes service strategy 1. $ 21,400 per year, serving 10-12 people per year

Partial Implementation: includes service strategies 1 and 2. $ 69,450 per year, serving 30-36 people per year

Full Implementation: includes service strategies 1, 2 and 3. $ 105,450 per year, serving 20-24 people per year