King County

Department of
Community and Human Services

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IMPLEMENTATION PLAN
2012 – 2017 Veterans and Human Services Levy:
Activity 2.5 A: Forensic Assertive Community Treatment Program (FACT) / Intensive Care Management Team

1. Goal

Prevent and reduce homelessness.

2. Strategy

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of Ending Homelessness.

3. Activity 2.5 Criminal Justice Initiatives Forensic Assertive Community Treatment (FACT) Program revised to: *Diversion and Reentry Services, Intensive Care Management Team*

The activity described below is one of two activities funded under Activity 2.5 Criminal Justice Initiatives. Two names changes have occurred since the implementation plan was first written. The Mental Health Chemical Abuse and Dependency Services Division (MHCADSD) name was changed to Behavioral Health and Recover Division (BHRD). In May 2014, the division's Criminal Justice Initiatives section's name was changed to Diversion and Reentry Services.

DECEMBER 2015 MODEL CHANGE: *From FACT to Intensive Care Management Team*

Background

BHRD Diversion and Reentry Services team has reviewed the FACT program model and current service array. A literature review was conducted to determine current best practices for serving individuals involved in the criminal justice system who experience both severe and persistent mental illness and homelessness. Service models that combine intensive case management with supportive housing have demonstrated promise. A revised program design is needed that incorporates the following lessons learned and frameworks:

A. FACT Evaluation

A randomized study done on FACT participants from 2008-2011 showed a statistically significant reduction in combined jail and prison booking and incarceration days in the first year of the program (45% reduction). The study also showed a 38% reduction for Year One in the number of days institutionalized. However, subsequent years show no statistical change and after the initial declines FACT participants are still averaging two to three months per year in institutions. Throughout 2014, 44% of FACT clients were homeless and

by the end of the second quarter of 2015, 48% of the individuals served by FACT were homeless. These findings have resulted in a desire to modify the approach in serving this population.

B. Fidelity to the Assertive Community Treatment (ACT) Model

In 2013, the Washington Institute for Mental Health Research and Training (WIMHRT) conducted a review of the FACT program, and found several aspects aligned the FACT team with fidelity to the evidence-based ACT model. However, the recommendations included increasing proficiency in and integration of evidence-based practices, including Integrated Dual Diagnosis Treatment, Motivational Interviewing, Supported Employment and Assertive Engagement and Outreach. The reviewers encouraged the team to increase consumer self-determination and community-based services, and to utilize the specialists on the team by having them conduct individual meetings and groups related to their specialty areas of interest. Another review conducted in 2015 found continued difficulty in adhering to the ACT model.

C. Familiar Faces (FFs) Initiative

As part of the King County Health and Human Services Transformation Plan, one strategy called the Familiar Faces initiative, is working to promote systems coordination for individuals who are high utilizers of the jail (defined as having been booked four or more times in a twelve-month period) and who also have a mental health and/or substance use condition. Being similar to the FACT population, the Familiar Faces initiative may offer important learning that can be leveraged to better serve the FACT population.

Because of the Affordable Care Act under the Obama administration, new opportunities for the community to work together to achieve the Triple Aim of better health, better care, and lower costs for this population have appeared. These changes include expanded Medicaid coverage, the statewide move towards integration of the mental health, chemical dependency, and physical health systems, and the emerging Accountable Communities of Health and system delivery reform efforts.

Familiar Faces Data: Succeeding in matching data across systems gave a much more comprehensive picture of this high utilizer population including the following:

- High utilizers are disproportionally people of color
- In 2014 there were 1,252 down from 1,273 high utilizers in 2013
- 94% of all people with 4 or more jail bookings have a behavioral health indicator.
- 93% had at least one acute medical condition (average 8.7 conditions); 51% had at least one chronic health condition (average 1.8 conditions)
- More than 50% were homeless
- The most serious offense was non-compliance (41%) (Failure to appear for court, supervision violations, etc.)
- About 50% of those aged 24 and under have had contact with the juvenile justice system

Familiar Faces Current State Mapping: Using Lean management tools, the Familiar Faces Design Team (a large cross-sector team from multiple community-based and governmental organizations) spent approximately five months between October 2014 and February 2015 developing an understanding of the current state of the systems serving the Familiar Faces

or high utilizer population. In early March 2015, the team completed the *Current State Map* for the Familiar Faces population. Key themes that emerged included:

- Currently it's not a system, it's more a collection of uncoordinated services
- The current "system" is program centric, not people centric
- Funding stream requirements drive the current system
- There are philosophical differences across various organizations in the system
- Need to stop "brick and mortar thinking" that services need to be facility-based, and explore more virtual and mobile options

To improve health and social outcomes for this population, it became clear this new effort needed to work across program sectors to partner in a better way, and put the people at the center of decisions about funding, policy and programs.

Summary

Given the results of the FACT evaluation, difficulty in adhering to the FACT model along with what was learned through the Familiar Faces work, including its vision to place the individual at the center of a care team to meet specific needs of the individual, it is appropriate to modify the FACT activity. With revisions it will be possible to reduce the number of individuals with mental health or substance use issues who currently cycle through the jails.

4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

Service Needs:

As indicated above, local data shows that 94% individuals who are booked into the King County Jail four or more times in a 12-month period, have a behavioral health issue. Of these, approximately 20% have a severe and persistent mental illness, and 90% of these individuals, (or higher) also have co-occurring substance use disorders.

Homelessness Linked to Jail

Among individuals enrolled in the King County's mental health system, those who are experiencing homelessness are four times as likely to be jailed, than those with housing. Among the Familiar Faces study, over 50% of both the 2013 and 2014 cohorts are experiencing homelessness, which is conservative data, given underreporting to the data source Homeless Management Information System (HMIS).

A Criminal Justice Response to a Health and Human Services Issue

Many individuals with complex social and health issues regularly interact with the King County Jail system, in part due to an inability to effectively engage with fragmented health and human services systems and inappropriate use of a criminal justice response to a health and human services/public health issue. A more robust health and human services system for these individuals is paramount to avoid criminalizing this problem that fills the courts and jails with individuals who need access to housing, treatment resources, and life opportunities (employment, supportive relationships, connection to the community and family).

Ending the Cycle of Homelessness and Criminal Justice Involvement through Supportive Housing

The Corporation for Supportive Housing's (a national housing advocacy, policy and best practice organization) Returning Home Initiative demonstrated the effectiveness of pairing

supportive housing with systems change to break the cycle of criminal justice involvement for thousands of people nationally. Lessons learned included:

- In-reach and immediate connection to housing is critically important.
- Coordination with the court system and probation/parole is critical to maintaining a strong connection with clients even if they are re-arrested or re-incarcerated.
- Robust services are necessary to keep people housed.
- Accurate and comprehensive assessment of clients prior to release is important to match the right intervention to the right population.

Additionally, incarceration often results in loss of housing and publicly-funded benefit entitlements and Medicaid-funded healthcare coverage (i.e. Apple Health), separation from treatment, and a criminal history that disqualifies individuals for future housing. Public services, hospital emergency departments, jails and psychiatric hospitals are inundated with individuals in crisis. Many clients are frequent users who have complex and chronic needs that cannot be met effectively or efficiently in these high-cost settings. Frequent users are often involved in several systems of care—behavioral health, social services, criminal justice, and housing—as well as in the health care system. Repeated visits to jails, emergency rooms, and hospitals result in inflated expenses, often absorbed by public systems, which drive up costs for everyone.

Populations to be served:

The activity will serve individuals with four or more bookings in a King County Jail and a behavioral health condition, who need an intensive level of service and support. The flexible care management team described below will work closely with the Regional Mental Health Court / Regional Veterans Court (RMHC/RVC) teams to ensure compliance with the conditions of probation and address root causes and individual behaviors that lead to contact with the criminal justice system/jail bookings. Support will be provided to sustain client's housing and help them engage with other life-affirming activities, such as employment, education, behavioral health treatment, primary care, addressing basic needs and other community and recovery supports.

Promotion of Equity and Social Justice:

The Equity and Social Justice Ordinance requires King County to consider the impacts of its policies and activities on its efforts to achieve fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency. The King County Equity Impact Review Tool available online at: http://www.kingcounty.gov/exec/equity/toolsandresources.aspx provides a list of the determinants of equity that may be affected by your activity. Evaluate your activity's impact by responding to the following questions:

- *Will your activity have an impact on equity?*

  Based on current Familiar Faces data (see Tables 1 and 2 below), vast inequity related to the race of high utilizers as compared to King County census data, is identified. Whites are less likely to have multiple bookings. In addition, this population is somewhat more likely to be male and non-white than the overall King County jail population, which is new data demonstrating that the more often you are booked into jail, the more likely you are to be a person of color.

Table 1: Race of Familiar Faces as compared to Jail and King County census data

	2013		2014		Total			
Race	**#**	**%**	**#**	**%**	**#**	**%**	2013 unduplicated persons in jail*	KC adult population (census)
White	603	47.4%	679	54.2%	1,282	50.8%	63.7%	69.6%
Black	544	42.7%	456	36.4%	1,000	39.6%	26.6%	6.1%
Native	51	4.0%	51	4.1%	102	4.0%	2.6%	0.8%
Asian	70	5.5%	59	4.7%	129	5.1%	6.3%	16.8%
Other/U	5	0.4%	7	0.6%	12	0.5%	0.6%	2.3%
	1,273	100.0%	1,252	100.0%	2,525	100.0%		

Table 2: Age breakdown of Familiar Faces

	2013		2014		Total		
Age	**#**	**%**	**#**	**%**	**#**	**%**	2013 unduplicated persons in jail
18-24	273	21.4%	260	20.8%	533	21.1%	22.2%
25-34	456	35.8%	468	37.4%	924	36.6%	34.2%
35-44	299	23.5%	264	21.1%	563	22.3%	21.7%
45-54	188	14.8%	210	16.8%	398	15.8%	15.5%
55-64	54	4.2%	47	3.8%	101	4.0%	5.2%
65+	3	0.2%	3	0.2%	6	0.2%	0.8%
Total	1,273	100.0%	1,252	100.0%	2,525	100.0%	99.6%

This Intensive Care Management Team will be serving the high utilizers and the King County RMHC/RVC cohort, both of which are disproportionality populations of color. The agency providing services under this revised plan will have a staff plan, training plan and institutional commitment to racial justice and embed anti-oppressive practices in service delivery. All services will be culturally informed and culturally responsive to the individual. BHRD Diversion and Reentry staff will work closely with the treatment provider to assist with Equity and Social Justice related staff and organizational leadership training, racial equity toolkits, cultural responsive practices and anti-oppressive practices. BHRD staff will engage with the King County Office for Equity and Social Justice, when necessary, to address structural barriers.

Disability justice is another key ESJ issue that needs to be addressed in order to promote equity and best serve individuals in this program. Stigma and discrimination related to mental health disability is still quite present in our dominant culture. BHRD works to promote recovery and reduce stigma, but much work still needs to be done, especially with regards to staff training on how institutions provide behavioral health services. In addition, criminal justice, housing and primary care are other systems that can stigmatize, and criminalize disability.

- *What population groups are likely to be affected by the proposal? How will communities of color, low-income communities or limited English proficiency communities be impacted?*

  Individuals living in extreme poverty who are homeless and have untreated behavioral health and primary care medical issues are coming through our mental health courts/veterans courts and jails at unprecedented rates. Often, when these individuals come into contact with law enforcement they are taken to jail in lieu of addressing the root cause of the problem. This program will provide and promote access to treatment, housing, jobs, support, healing and recovery and access to a community of people who care and value them as people. At its core, this revised program will address equity and social justice and appropriate access to justice allowing individuals to not be criminalized and families be torn apart, for their social services needs/access needs, but rather be assisted to meet and fulfill those needs.

- *What actions will be taken to enhance likely positive impacts on these communities and mitigate possible negative impacts?*

  BHRD Diversion and Reentry staff will work closely with partners and the agency to promote harm reduction to avoid criminalizing behavioral health issues. Harm reduction training will enhance positive impacts and is critical as substance use tends to be a large driver of criminalization. Promoting equity and social justice in meaningful political ways to address the criminalization of behavioral health issues (further impacted by race and class) will also enhance the positive impacts along with having active and open conversations about race. Consulting as needed with the Advisory Group of former Familiar Faces may also be helpful.

5. Activity Description

Levy funds will be braided with other fund sources available to support the Intensive Care Management Team. The team will serve up to 60 Veterans or other individuals experiencing homelessness, at any given time, after program ramp-up.

The care team will accommodate the level of care and specific needs of each individual and use a trauma informed approach and motivational interviewing methods along with other evidence-based approaches. Under this revised model, the Intensive Care Management Team services will include:

- Permanent supportive housing to stabilize and support housing tenure, which includes a limited amount of sponsor-based housing vouchers provided by the Seattle Housing Authority and units procured through a community housing provider. Also, staff on the care management team will have housing expertise and housing case management skills.
- Community-based services with staff that integrate mental health and substance use disorder treatment with primary health care and employment training into a single, comprehensive flexible care management team that supports the reentry process and coordinates with the jurisdiction when the individual is court-involved.
- High staff to client ratios no larger than 1:15 to assure frequent contact and availability.
- Nontraditional hours, face-to-face crisis response and housing preservation services for participants and landlords, as well as the availability of respite housing for crisis periods.
- Range of housing models to accommodate and support individual stabilization and recovery.

- Specific graduation parameters to ensure individuals are continually re-assessed and supported towards recovery and reentry goals.

The new Intensive Care Management Team will not replicate the Assertive Community Treatment (ACT) model but will include a number of evidence-based, best-practices, or promising practices. These practices are grounded in research, produce meaningful outcomes, can be replicated and often have fidelity scales or tools to measure adherence to the model. They will include the following:

- Motivational Interviewing
- Permanent Supportive Housing
- Assertive Outreach
- Trauma-informed care and Trauma-focused interventions
- Intensive Case Management
- Assess-Plan-Identify-Coordinate (APIC) Model of jail reentry support and planning
- Illness Management and Recovery (IMR)

Other program elements may include the following additional practices:

- Diversion Support
- Integrated care management
- Flexible care management

The evidence based practices, best practices and promising practices that will be used by the Intensive Care Management Team are described in more detail below.

A. Motivational Interviewing (Evidence-based practice)

Motivational interventions focus on respecting and promoting client choice. It is a client centered approach for eliciting behavior change by helping clients to explore and resolve ambivalence. [1] The wraparound support team works together to plan engagement strategies and is creative in their attempts to meet people "where they are at" to ready them for change.

B. Permanent Supportive Housing from a *Housing First approach* (Best/promising practice)

Housing First is an approach that centers on providing individuals experiencing homelessness with housing as soon as possible and regardless of whether they are involved in any other services such as substance abuse or mental health treatment. Once housed, other services can be provided as needed, however, under this approach, housing cannot be removed due to lack of utilization of services offered.[2] The program will also use a Housing First approach to engage and rapidly house frequent users of institutions or who are experiencing homelessness.

C. Assertive Outreach/Engagement (Best practice)

Motivational interventions that respect and promote client choice are key to assertive engagement. The wraparound support system works together to plan engagement strategies, and clinical judgement is used to determine when these assertive engagement

[1] Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334. Cited from http://www.motivationalinterview.net/clinical/whatismi.html

[2] http://www.endhomelessness.org/page/-/files/1425_file_WhatisHousingFirst_logo.pdf

techniques need to be applied and to what degree. When motivational interventions have not worked, other alternatives may be needed in the on-going planning process for assertive outreach and engagement.[3] Ongoing assessment of the individual's need and the corresponding level of care will be done at regular intervals.

D. Trauma Informed Care (Evidence-based practice)

Research suggests up to 50% of people with a severe mental illness have a rate of three or more adverse childhood experiences (including abuse, neglect, and witnessing violence)[4]. These traumatic experiences can be dehumanizing, shocking or terrifying, and often include a perceived loss of safety

Trauma-informed services are based on an understanding of the vulnerabilities or "triggers" of trauma survivors, so that these services and programs can be more supportive and avoid re-traumatization. This includes understanding the client's need to be respected, informed, and hopeful regarding their own recovery as well as understanding the relationship between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety.

Intensive Care Management Team services will be trauma-informed, recognizing the impact of these experiences on a person. Trauma-informed services will offer choice whenever possible, respect the dignity of the person, and support individuals in moving from "criminal" to community "citizen", as well as from "victim" to "person".

E. Intensive Case Management[5] (Evidence-based practice)

Intensive Case Management (ICM) will be used to provide the wraparound services of this project. The ICM model was designed for persons with severe mental illness who are either high service users or not using mental health services at all. The ICM model operates on a "full support" philosophy and uses a multidisciplinary team approach. It involves assertive outreach, assessment of need, negotiation and coordination of care. It combines the principles of case management with a low staff-to-consumer ratio[6]. The ICM team integrates services and coordinates with the courts, law enforcement, community services, housing providers, probation and/or the Department of Corrections as appropriate. The team encourages family involvement, where possible, and provides 24-hour crisis services. Active ICM caseloads are limited to 15 persons per case manager.

F. The Assess, Plan, Identify, Coordinate (APIC) Model of jail reentry.

The APIC Model—Assess, Plan, Identify and Coordinate—describes elements of re-entry planning associated with successful reintegration back into the community for people with mental illnesses or other special needs who are being discharged from jails. The model is particularly important for breaking the cycle of repeated homelessness and incarceration.

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[3] *TMACT Protocol for Assertive Engagement & Consumer Self-Determination & Independence.* Cited from TEAGE, G., Monroe-Devita, M (2008, May) *Enhancing Measurements of ACT Fidelity: The Next Generation* as presented at the 24th Annual Assertive Community Treatment Association Conference, Indianapolis, Indiana, May 14-17, 2008.

[4] Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. *Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders.* Psychiatric Services. 2008 (59)"1018-1026

[5] Addy, J., Mundil, K., Parker, T., Talbott, P. (2008). *Intensive Case Management for Behavioral Health Jail Diversion: The Lancaster County, Nebraska Approach.* American Jails. January/February 2008

[6] Myer, Piper S., Ph.D. and Morrissey, Joseph P., Ph.D. (2007). *A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas.* Psychiatric Services. American Psychiatric Association: 58:121-127, January 2007.

G. Illness Management and Recovery (IMR)[7]

IMR is a set of specific evidence-based practices for teaching people with severe mental illness to manage their condition in collaboration with providers and other key supports, in order to achieve key personal recovery goals. Some IMR strategies include:

Peer Support[8] Peer support services are provided by trained staff who are in recovery from mental illness and have past involvement with the criminal justice system. Peer specialists will collaborate to link clients to community resources and assist in obtaining public entitlements, transportation to appointments, housing, and education and/or employment assistance.

Wellness Recovery Action Plan (WRAP) is a self-management and structured recovery system designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist persons in achieving their own life goals. Peer Specialists are trained in assisting with these plans.

6. Funds Available

The 2012 Service Improvement Plan identified the following allocations for this activity.

	2012	2013	2014	2015	2016	2017
Veterans Levy	$ 63,000	$ 63,000	$ 63,000	$ 63,000	$ 63,000	$ 63,000
Human Services Levy	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000
Total	$ 205,000	$ 205,000	$ 205,000	$ 205,000	$ 205,000	$ 205,000

A total of $205,000 in Levy funding is available annually to implement this activity.

7. Service Partnerships

The systems that are involved /partnering with King County Diversion and Reentry Services listed below have committed to be involved with the project:

- King County Regional Mental Health Court/Regional Veterans Court
- King County Department of Juvenile and Adult Detention
- King County Prosecutors Office
- City of Seattle Municipal Court including Mental Health and Veterans Treatment Courts
- Seattle Police Department Crisis Triage
- King County Health and Human Services Transformation and the Familiar Faces Initiative
- King County Housing Authority
- Seattle Housing Authority
- Public Defender Association – Law Enforcement Assisted Diversion (LEAD)

Additionally, the All Home (formerly the Committee to End Homelessness in King County) prioritized homeless individuals who are the most frequent users of jails and psychiatric

[7] Mueser, K., MacKain, S. The National GAINS Center for Systemic Change for Justice-involved People with Mental Illness. (2005). *Illness management and recovery*. Concord, NH. Retrieved from www.naco.org.
[8] Davidson, L., Ph.D., Rowe, M., Ph.D. (2008). *Peer Support within Criminal Justice Settings: The Role of the Forensic Peer Specialists.* Delmar, NY: CMHS National GAINS Center, May 2008.

hospitals as a key population for intervention. Recognizing the overlap of the two high utilizer populations groups, All Home sought to create combined diversion/discharge intervention strategies. A significant number of the people and systems committed to the All Home are partnering on the implementation of this Levy activity.

8. Performance Measures

The following performance measures and targets were identified by the Levy's Evaluation Team. Performance will be evaluated annually and targets will be adjusted accordingly as needed for the following year.

Performance Indicators	Target(s)	Data Source
Total clients engaged in services.	30 (Year 1) 60 (Year 2)	Report Card – Services
Average monthly number of clients in permanent housing	80%	Report Card – Services
No more than 5% of clients exited to institutions or homelessness	Less than 5%	Report Card – Services
At program exit, 80% of clients are in permanent housing	80% or more	Report Card - Services