

MIDD Briefing Paper

ES 7b BP 38 Expand Youth Crisis Services and Enhancements

Existing MIDD Program/Strategy Review x MIDD I Strategy Number 7b (Attach MIDD I pages)
New Concept x (Attach New Concept Form)

Type of category: Existing Program/Strategy EXPANSION

SUMMARY: Existing MIDD strategy 7b supports countywide crisis response system for King County youth up to age 18 who are currently a mental health crisis. These services are provided to children, youth, and families where the functioning of the child and/or the family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. This program is named the “Children’s Crisis Outreach and Response System” and is known as CCORS. MIDD funds also added a CCORS focus on services for children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement.

This briefing paper also includes a new concept proposed as an enhancement to the current CCORS services. The new concept aims to reduce the length of crisis events and increase family follow through with safety planning recommendations and treatment by reducing the average time it takes for CCORS to get to the scene of the crisis, thereby increasing CCORS’s ability to carry out in-person crisis response in tandem with law enforcement.

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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?**

Existing MIDD strategy 7b supports countywide crisis response system for King County youth up to age 18 who are currently a mental health crisis. These services are provided to children, youth, and families where the functioning of the child and/or the family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. This program is named the “Children’s Crisis Outreach and Response System” and is known as CCORS. MIDD funds also added a CCORS focus on services for children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement.

The CCORS program was funded to: 1) reduce the number of youth with mental illness and substance use disorders using costly interventions such as jail, emergency rooms, and hospitals; and 2) divert these youth from initial or further justice system involvement.

CCORS offers short term, community-based and family centered services, with the goal of crisis prevention and placement stabilization. Services are available 24 hours a day, seven days a week, 365 days a year. The CCORS program utilizes strength-based, individualized approaches via teams that include Crisis Intervention Specialists (Mental Health Professionals), Family Advocates, and Parent Partners. Teams meet the referred youth and families in the home and community locations. CCORS partners with families, as well as other professionals and systems, and uses short-term, evidence-based, crisis intervention strategies.

CCORS aims to create a single, integrated, county-wide, comprehensive system of crisis outreach response, stabilization intervention, family reunification, and transition to community supports for children and youth; and to ensure the safety of children/youth and their families and/or caregivers who are facing crisis situations. The CCORS program has three main components: 1) Crisis Outreach Services and Non-Emergent Outreach (NEO); 2) Intensive Stabilization Services (ISS); and, 3) Crisis Stabilization Beds (CSBs) also known as Hospital Diversion Beds. CCORS also provides community education and technical assistance, consultation to and coordination with community partners, such as those serving child, youth and families, schools, law enforcement, mental health and substance use disorder providers, and hospitals.

CCORS’ Crisis Emergent and Non-Emergent Outreach services are available to children and youth in King County who meet the crisis services eligibility in the King County Regional Support Network’s (RSN)¹ Policies and Procedures Manual and are not currently receiving services through an RSN contracted mental health agency. This includes youth who are Medicaid eligible but have not yet been connected to mental health services and those who are not Medicaid eligible, including both those with no insurance and those with private insurance. Emergent Crisis Response consists of: 1) crisis telephone response

¹ King County’s RSN will become King County’s Behavioral Health Organization (BHO) on April 1, 2016.

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available 24 hours a day, seven days a week that includes immediate access to a mental health professional, as well as: 2) an outreach team that, at a minimum, consists of a Children's Mental Health Specialist and a Family Advocate who are trained in crisis management.

Crisis Outreach services provide rapid face-to-face response at the community site of the escalating behavior. Teams develop crisis safety plans with family and youth input. Teams also provide crisis outreach to children/youth not engaged with an RSN-contracted mental health agency that have been referred for inpatient hospitalization. Teams provide client access to Crisis Stabilization Beds when needed as an alternative to hospitalization or placement disruption, and provide referrals for voluntary hospitalization or coordination with the Designated Mental Health Professionals (DMHPs) for involuntary hospitalization when needed, while keeping youth in the least restrictive option available that is clinically appropriate.

Intensive Stabilization Services (ISS) is an intensive service lasting up to 90 days that provides families and the child/youth with immediate crisis stabilization. They build on the family's and child/youth's strengths and provide creative and flexible solutions focused on teaching and modeling parenting and problem-solving skills, developing skills necessary to manage behavior within the home/community environment and to prevent out-of-home placement. ISS is accessed via screening and referral by either a King County RSN or Division of Children and Family Services (DCFS) gatekeeper. ISS serves families currently served by either RSN contracted outpatient mental health providers or state Child Welfare² services where functioning of the child and/or family is severely impacted due to significant emotional or behavioral problems, in cases where the client is not served via DCFS's Behavioral Rehabilitation Services (BRS) and the client's living situation and/or safe maintenance in the community is at risk. A variation of this stabilization service is available to those not enrolled in the public mental health system services provided by King County who are determined to need and agree to stabilization services upon initial crisis outreach services. They are available for up to eight weeks.

Crisis Stabilization Beds (CSB) are designed for CCORS clients who would likely be hospitalized or experience another out of home placement without the use of a CSB, or are enrolled in RSN contracted mental health services and are in need of a CSB for hospital diversion.

CCORS provides:

- 1) Prompt referral and linkage to mental health, child serving, and other appropriate providers, including outpatient mental health and/or substance use disorder services, if eligible;
- 2) Psychiatric evaluation and medication management services when clinically indicated and not available through other resources;
- 3) Community-based, in-home stabilization services available 24/7 to the child/youth and family, including teaching and coaching the parent(s)/caregiver(s) and the child/youth to develop skills and strategies to manage the crisis behavior;
- 4) In-home stabilization services at the level of urgency, intensity, and frequency necessary to result in rapid stabilization of the child/youth in the home environment;
- 5) Stabilization services as needed for up to eight weeks for those not enrolled in RSN services and up to 90 days for those enrolled in RSN services.
- 6) Partnering with the child/youth and family to develop an Action Plan that identifies the priority needs of the family, detailing specific, concrete action steps to stabilize those needs;

² Children's Administration of the Washington State Department of Social and Health Services. DCFS is a Division of the Children's Administration.

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- 7) A discharge summary that includes, at a minimum, a description of the initial crisis behavior, the priority needs, action steps that were implemented to meet those needs, and recommendations for the ongoing treatment provider after discharge from CCORS;
- 8) Copies of the discharge summary to the family, the referral source, and the ongoing treatment provider after discharge from CCORS; and
- 9) Coordinated care with new or existing community providers, including, but not limited to, other treatment providers, DCFS social workers and school staff.

This briefing paper also includes a new concept proposed as an enhancement to the current CCORS services. The new concept aims to reduce the length of crisis events and increase family follow through with safety planning recommendations and treatment by reducing the average time it takes for CCORS to get to the scene of the crisis, thereby increasing CCORS's ability to carry out in-person crisis response in tandem with law enforcement. It builds on the information about the value of law enforcement based Crisis Intervention Teams³ being able to de-escalate crises and reduce criminal justice involvement of those with mental health issues. This strategy enhancement proposes a quicker CCORS response time to crisis calls from law enforcement officers who are at the community site of the youth/family crisis in order to enable crisis triage while law enforcement is still on the scene. It is proposed this quicker response will increase family follow-up with mental health treatment resources law enforcement personnel refer them to.

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):

- | | |
|--|--|
| <input checked="" type="checkbox"/> Crisis Diversion | <input checked="" type="checkbox"/> Prevention and Early Intervention |
| <input checked="" type="checkbox"/> Recovery and Re-entry | <input checked="" type="checkbox"/> System Improvements |

Please describe the basis for the determination(s).

Crisis Diversion: assist people who are in crisis or at risk of crisis get the help they need; increased access to person centered, culturally appropriate outpatient treatment on demand; reduction in use of detention, jail, emergency departments and inpatient mental health services; decreased length of crisis events.

Prevention and Early Intervention: keep people healthy by preventing problems from escalating; increased availability of behavioral health information in non-traditional settings; reduce risk factors for substance use and mental health disorders; increased access to primary care services; reduced barriers to service.

Recovery and Reentry: empower people to become healthy and safely reintegrate into the community after crisis; increased application of recovery and resiliency principles in services provided, reduction in detention, jail, emergency department and inpatient hospitalization utilization; reduced barriers to services; increased availability of peer services.

System Improvements: strengthen the behavioral health system to become more accessible; increased geographic availability of services; increased use of evidence based practices and assessment tools; improved care coordination; improved quality of care; improved client experience; recovery oriented system of care; Provide the right treatment, at the right time, in the right amount (service on demand).

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

³ See <http://citinternational.org/> for becoming acquainted with the general concept of Crisis Intervention Teams [CIT]. See <http://www.seattle.gov/police/work/CIT.htm> for information about the Seattle Police Department's CIT.

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- 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.**

Regional Support Networks (RSNs)⁴ are required to provide mental health crisis response services for all people in the geographic boundaries of the RSN.⁵ King County has chosen to use a layered approach to providing those crisis response services. While the Crisis Clinic is used to centralize initial phone crisis response, triage calls to expert outreach response, and authorize hospitalization, specialized crisis-focused community-based outreach programs are needed to meet the most intense crisis needs of community residents. Providing mental health services to children, youth and families is an area of mental health specialization, best provided by or under the supervision of Children's Mental Health Specialists.⁶ Washington State has recognized the importance of specialized attention to children, youth and families in documents such as *Washington State Children's Behavioral Health Principles*.⁷

King County wishes to operate services in the most efficient and effective manner possible. The most efficient and effective administrative approach to meeting the mental health crisis needs of King County children, youth and families is to create and maintain a program that can provide an integrated comprehensive, person and family centered, recovery-oriented, strengths based, community-based continuum of crisis outreach, crisis stabilization, and intensive in-home evidence based services to children, youth, and families. King County has developed such a program that significantly exceeds its performance targets and maintains a high level of staff continuity and engagement in providing specialized crisis services to a population with many particular needs. It is most cost effective to maintain a program that works to meet required community crisis needs.

A huge system gap and significant additional costs would occur if the funding for King County's Children's Crisis Outreach and Response System was not maintained. The legal requirement to provide crisis services would remain without an approach to meet the requirement. Additionally, any different type of approach would have significant start up time requirements that include, but are not limited to, additional county staff time, community and system stakeholder engagement, and needs assessments to determine what alternative approach was desired to meet the needs and requirements. Those alternative approaches would then need to be examined in the context of all demands on the behavioral health system budget in order to evaluate the fiscal feasibility of proposed alternatives. During such a reinvention process, the county would need to continue to provide a full continuum of crisis services.

Children and youth experiencing acute crises because of their emotional and/or behavioral problems may inappropriately enter the most restrictive and costly settings, including inpatient hospitalization, juvenile detention, foster care and, and eventually, the Children's Long-term Inpatient Program (CLIP) or Juvenile Rehabilitation Administration institutions. Youth who become involved in the child welfare and

⁴ RSNs will become Behavioral Health Organizations as of 4/1/2016. The same state requirement to provide crisis services for all residing in the geographic boundaries of the BHO will continue.

⁵ <http://apps.leg.wa.gov/RCW/default.aspx?cite=71.05>

⁶ <http://apps.leg.wa.gov/WAC/default.aspx?cite=388-865-0150>

⁷ <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WA%20State%20Children%27s%20BH%20Principles.pdf>

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juvenile justice systems because of their emotional or behavioral problems face many barriers later in life, such as difficulty with: successful matriculation through the educational system; achieving and maintaining steady, gainful employment in which they are able to use their developed strengths and abilities and independently support themselves and a family; and retaining safe stable housing. These are some examples of the many detrimental consequences to both individual county residents and families, as well as the county budget, in both the short and long term if an expert, comprehensive continuum of mental health crisis response for children, youth and families does not exist.

King County holds the value that children and youth are better served when they remain in their homes and/or communities. Immediate crisis outreach and stabilization can help to de-escalate the current crisis, stabilize and maintain the current placement, and provide the family with tools and skills to prevent future crises. Crisis outreach can prevent inappropriate utilization of costly out-of-home services and support the least amount of disruption to the child, youth and their family when a crisis occurs.

The new concept enhancement being proposed suggests there is a need to increase the effectiveness of the crisis response and family follow through on treatment and safety recommendations made by Crisis Intervention Team (CIT) trained law enforcement personnel. This new concept asserts that on-site, tandem de-escalation of community based mental health crises with both CIT law enforcement and CCORS personnel present will meet these goals, ensuring connection to and services from needed treatment providers. King County MIDD funds currently support Crisis Intervention Team (CIT) training, for law enforcement officers including a daylong training focused on youth.

The following CCORS data is the basis for asserting the need for the proposed service enhancement of a quicker arrival at the site of a crisis when law enforcement is involved.

- In 2014, 40 percent of the 1,038 families receiving a CCORS crisis outreach were engaged in violence to others or property. There were 464 unduplicated referrals in this group and an unduplicated client count of 427 youth. Of these 184 also presented with suicidal ideation and/or attempts.
- Law enforcement (LE) involvement was indicated by either the initial presenting problem or case note content for 180, or 42 percent of these youth. It is possible there was more LE involvement, as only portions of case records were reviewed to determine this approximate statement of need.
- After responding to the crisis in a residential setting and advising the family to call CCORS via the Crisis Clinic, law enforcement officers often must depart for other urgent calls.
- In debriefing these crisis intervention events, officers and crisis workers agree that effectiveness, family follow through and long term stabilization would likely have been increased if law enforcement and mobile crisis staff had been able to work together, in person as a team.

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

Response to this question, how the CCORS program addresses King County's need and legal requirement to provide a continuum of mental health crisis response services, in this case for children, youth and families has been described in some detail above in response to question A. 1.

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The CCORS program is a child, youth, and family focused concentrated and comprehensive approach to providing a seamless continuum of crisis outreach, crisis stabilization, and intensive in-home services response to King County youth and families. It has been in operation and run by the YMCA of Greater Seattle's Family Services and Mental Health in the Metrocenter Y Branch since 2005; it expanded in 2007 and again in 2011 when it began receiving MIDD funding in Year 4⁸ of MIDD I. CCORS' primary function for MIDD purposes is to divert children and youth from inpatient hospitalization and prevent out of home placements, while supporting the maintenance of children and youth in their homes or current living arrangements.

The King County crisis system for children and youth prior to MIDD funding had proven to be effective, but its capacity was insufficient; there were gaps in services for certain populations. MIDD I funding was used to expand capacity to serve additional King County youth and families, particularly those youth involved in the justice system whose placement is at risk. It also added in-home Behavioral Support Specialists (BSS) to the CCORS in-home stabilization services. BSS staff assist families in implementing behavioral support programs by providing teaching, modeling, and coaching of strengths-based, positive behavioral management strategies. They have flexible schedules to ensure availability to go into the home on a frequent basis, daily if needed, to implement specific behavioral interventions, i.e. 7-9 am every morning or multiple mornings a week to support a parent/child/youth implementing a new morning routine/behavioral program or 6-9pm daily to implement a bedtime program, until the family and/or child/youth are able to successfully utilize the skills on their own. This is one example of the many ways the CCORS program design responds in an individualized manner to youth and family needs. Another is employing Parent Partners who also have children with significant emotional and behavioral issues. Most people, including parents, can more easily learn from and integrate information from someone who has 'walked a mile in their shoes'.

The CCORS program is supported by blended funding. MIDD funding in 2015 provided approximately 17 percent of total program costs. It is also supported by King County RSN Medicaid and Federal Block Grant funds and Children's Administration funding. The CCORS operational design includes a monthly CCORS Operations Meeting of the Y's Clinical Director, all CCORS Supervisors and staff from the two funders, King County's Behavioral Health and Recovery Division (BHRD) and the Washington State Department of Social and Health Services, Children's Administration (CA), Region 2 Division of Children and Family Services (DCFS). The meeting is facilitated by King County's Children's Mental Health Planner. Quarterly the other two key parts of the County's crisis services, the Crisis Clinic and the Crisis and Commitment Services, join this operations meeting to insure coordination of all key parties and the planned ability to discuss and resolve any issues that involve any or all of the parties. This thoughtful construction of coordinated administrative support for the CCORS program ensures the program maintains responsiveness to current needs and demands and is able to identify and implement any needed modifications and/or process improvements. Additionally, BHRD and CA-Region 2 DCFS staff that are members of the CCORS Operations Meeting are also members of King County's Uniting for Youth (UfY) Executive Committee, which has representatives from all child, youth and family serving systems in King County. This is another avenue to hear of crisis response needs, concerns and successes as well as explore and/or share CCORS program content that may be relevant to or of interest to other UfY members.

The new concept enhancement proposes CCORS will arrive at a community crisis location involving law enforcement officers within 30-60 minutes of receiving the referral in cases where quicker response is

⁸ Year 4 of MIDD I was 2011-2012.

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needed. The current CCORS crisis response time expected is face-to-face contact within two hours of receiving the referral.

The new concept asserts a minimum response time of 30-45 minutes is recommended for cases that are screened as having emergent acuity, and as having law enforcement involvement. The response time requested by law enforcement ranges from 15 to 45 minutes and is highly individualized, depending on family situation and community demands on the officer's time. The CCORS response time would ideally coincide with the length of time officers have available to stay in the home. Anecdotal evidence gleaned from CCORS experience indicates law enforcement is present in the home for a range of time from 15-60 minutes.⁹

Jurisdictions indicating a need for expedited CCORS in-person crisis response in tandem with law enforcement include: Seattle Police Department's Crisis Intervention Team, and Renton, Kent, Federal Way, Auburn, Bellevue and Burien Police Departments. Officers from the King County Sheriff's Department have expressed a desire for more tandem work at the Crisis Intervention Training, which CCORS conducts monthly at the Policy Academy, for all King County law enforcement departments.

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.

MIDD I expanded CCORS capacity of community- based outreach and stabilization, including in-home behavioral specialist services lasting up to 90 days, by an additional 300 children, youth and families served each year and added marketing/communication plan development¹⁰.

In MIDD Year 4 (2011-12), the first year of MIDD funding, CCORS served 951 unique individuals, achieving 317 percent of their target. In Year 5 they served 959, reaching 320 percent of their target. In Year 6, they served 1,030, achieving 343 percent of their target. Every year the demand for their services is increasing. This data is for the crisis outreach and stabilization for those on Medicaid not currently connected with mental health outpatient services and those not on Medicaid, which includes those with no insurance and those with private insurance.

In addition to the above services, CCORS also provides Intensive Stabilization Services both for those whose Medicaid funded mental health outpatient services are insufficient to adequately respond to an acute crisis; and those in extreme crisis served by the child welfare system whose family/caregivers/foster homes need assistance with management of the child's/youth's acute emotional and/or behavioral needs. Children, youth and their families who are involved with Child Protection, Child Welfare, or Family Reconciliation Services can all be referred to CCORS-ISS. With ISS services, children involved with DCFS are able to remain in their family's home, maintain placements, improve their level of functioning, and decrease disruptions. Families not involved with DCFS are also able to avoid child welfare involvement.

⁹ This information supplied by the proposer of this new concept/program enhancement.

¹⁰ MIDD Performance Target Changes Matrix.

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CCORS-ISS data for 2012:

- 128 enrolled in ISS services and 140 discharged during the year.
- 59 clients (42 percent) were between ages 6 – 12, 72 (51 percent) were between the ages of 13 and 17, six were between zero and five years, and three were 18 years of age or older by the time of discharge.
- Approximately 64 percent of youth served were male.
- 89 percent were covered by Medicaid at the time of CCORS enrollment.
- Approximately 45 percent of youth served by CCORS-ISS were involved with DCFS, regardless of referral source.
- 88 percent were successfully stabilized in their current living situation.
- 86 percent of those expressing the need for out-of-home placement were diverted from child welfare involvement.
- 91 percent of youth referred for hospitalization were successfully diverted from inpatient psychiatric care.

CCORS-ISS data for 2013:

- 141 enrolled in ISS services and 164 discharged during the year.
- 74 clients (46 percent) were between ages 6 – 12, 72 (44 percent) were between the ages of 13 and 17, thirteen were between zero and five years, and three were 18 years of age or older by the time of discharge.
- Approximately 66 percent of youth served were male.
- 84 percent were covered by Medicaid at the time of CCORS enrollment.
- Approximately 48 percent of youth served by CCORS-ISS were involved with DCFS, regardless of referral source.
- 88 percent were successfully stabilized in their current living situation.
- 85 percent of those expressing the need for out-of-home placement were diverted from child welfare involvement.
- 93 percent of youth referred for hospitalization were successfully diverted from inpatient psychiatric care.

CCORS-ISS data for 2014:

- 134 enrolled in ISS services and 190 discharged during the year.
- 82 clients (43 percent) were between ages 6 – 12, 102 (54 percent) were between the ages of 13 and 17, six were between zero and five years, and none were 18 years of age or older by the time of discharge.
- Approximately 52 percent of youth served were male.
- 83 percent were covered by Medicaid at the time of CCORS enrollment.
- Approximately 52 percent of youth served by CCORS-ISS were involved with DCFS, regardless of referral source.
- 89 percent were successfully stabilized in their current living situation.
- 76 percent of those expressing the need for out-of-home placement were diverted from child welfare involvement.
- 77 percent of youth referred for hospitalization were successfully diverted from inpatient psychiatric care.

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The public mental health system run by King County's Behavioral Health and Recovery Division serves those children, youth and families with the most severe, persistent and significant mental health issues and needs. The fact that those served in this system are at the highest level of need on the continuum of mental health needs in the general population of children and youth heightens the significance of the service response and achievements evidenced by the above CCORS data. The need and request for these services increases every year. MIDD funding is an essential component in the blended funding model supporting the CCORS program services.

The new concept enhancement focuses on a subset of the population presenting in crisis due to the child's/youth's highly disruptive or aggressive behavior, with special focus on those with law enforcement linked referral to CCORS. Looking at the 199 law enforcement linked referrals to CCORS in 2014, there were virtually no arrests made. It is believed the police and CCORS working collaboratively with families were able to de-escalate the crisis, help the youth, parents, guardians and natural supports develop their own effective safety and wraparound crisis prevention plan, including de-escalation skills. CCORS also knows that many families who are advised by law enforcement to call CCORS and other community resources at the time of the crisis do not follow through after the officer leaves the home. This proposal proposes to test the hypothesis that both receiving and responding to a referral more quickly will increase the number of families who follow through with accessing treatment and reduce the use of crisis services, emergency departments and detention for crisis needs.

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

The existing strategy incorporates existing evidence based crisis response practices and implements system of care and recovery principles and approaches. These have been guiding systemic approaches to services for children, youth and families for almost thirty years.¹¹

The new concept enhancement is proposed as a pilot to test a hypothesis.

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?

There are innumerable outcomes the County will be able to see as a result of continued investment in the CCORS program services. A few possible outcomes follow. From a global overview ('the big picture'), the County will see a continuation of children and youth experiencing a mental health crisis being diverted from the more expensive and disruptive services of inpatient hospitalization, detention, jails, hospital emergency departments, child welfare dependency and/or out of home placements. Children, youth, and families will continue to receive face-to-face, in-home and community-based crisis response that is individualized to their specific needs and increases their skills and abilities to respond to and de-escalate crises. Youth and families will receive help to successfully navigate other service systems with

¹¹ <http://www.samhsa.gov/specific-populations/age-gender-based>,
<http://www.kingcounty.gov/healthservices/MentalHealth/Recovery/KnowledgeIsPower/ChildrenYouth.aspx>,
<http://www.kingcounty.gov/healthservices/MentalHealth/Recovery/10FundCompRecovery.aspx> and
<http://store.samhsa.gov/term/Systems-of-Care>.

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which they are involved. It would be possible to determine what percent of the total receiving services were able to manage all future mental health crises with one crisis response and/or stabilization service experience. More children, youth, and families will be connected with outpatient mental health and/or substance use services after crisis outreach response, stabilization, and linkage with ongoing treatment providers. Children, youth, and families will experience emergency services that are responsive to their needs and available when they need them.

The data collected from programs and services funded by the MIDD is massive. Multiple client demographics, service, and outcome data across multiple variables is collected from the CCORS program, existing strategy 7b. All of this data is available to evaluate both longitudinally and correlated with mental health outpatient data and other King County human, community, health, juvenile and criminal justice, housing/homeless, educational and employment services data. The CCORS-ISS data shared above are but a few of the potential outcomes that can be gleaned from available data. Other data points relate to whether youth are in school, length of time needed for service provision, cross system collaboration, effect of improved service protocols, marketing efforts, etc.

The new concept enhancement outcomes would need to be established as part of the MIDD concept funding development. It might be initially explored as a pilot and in selected geographical parts of King County. A pilot approach would test the veracity of the hypothesis that quicker joint CCORS/Law Enforcement crisis response at the residential site of the crisis will increase family follow through with referrals and active participation in CCORS crisis and stabilization services. Another possibility is to choose two law enforcement departments: one with significant CIT¹² training by frontline officers, and another with few or no officers with CIT training, to evaluate the benefit of the proposed program enhancement.

C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD

Strategy/Program: (Select all that apply):

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

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<http://webcache.googleusercontent.com/search?q=cache:Yeet5AxeVAgJ:www.citinternational.org/CITINT/PDF/CITResearchBibliographyofPublishedReportsAugust2015.pdf+&cd=1&hl=en&ct=clnk&gl=us>

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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.

Transition age youth, adults and older adults may be parents and/or caregivers of children and youth experiencing a mental health crisis and therefore involved in receiving services from this existing strategy, as well as the youth themselves.

- 2. Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection:**
County-wide

The existing CCORS strategy is offered countywide.

The new concept is proposed as a countywide enhancement. Since implementation would be testing a hypothesis of how to better engage families of youth who present with violence to others and/or property, it might best be initially explored as a pilot with one or more law enforcement departments.

- 3. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

The existing CCORS strategy requires ongoing collaborations and partnerships with the mental health and substance use disorder provider networks, the Crisis Clinic, hospitals, Crisis and Commitment Services' Designated Mental Health Professionals, Region 2 Division of Child and Family Services, juvenile justice, law enforcement agencies, developmental disability services, schools and all other stakeholders who work with children and youth.

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?**

There are multiple drivers and factors which may impact the need for CCORS services. They include: 1) the integration of the mental health and substance use disorder service systems into a behavioral health system as of April 1, 2016; 2) the integration of behavioral health services and primary (physical) health care as of April 1, 2020; 3) current and potential future lawsuits and related settlements that have a children's crisis services component; 4) legislative changes/reductions in state general fund support for mental health services/behavioral health services; 5) legislative changes in statutory requirements and/or funding of Behavioral Health Organizations; Managed Care Organizations providing Apple Health Medicaid funded services; health services to children and youth who are dependents of the State through the Child Welfare system; and/or private insurance providers; 6) federal changes in the Affordable Care Act benefit package requirements; and, 7) changes to federally funded healthcare for veterans and/or their family members covered under these health systems. Another factor might be the comparability of the children and family crisis services in adjoining RSNs/BHOs. It isn't unknown for people to move to geographic locations where better health services are offered.

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A possible driver for the new concept might be reduced support by law enforcement departments for Crisis Intervention Training for their officers, with an increase in requests for the type of enhancement being proposed as a substitute for directly training their officers.

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?

The existing concept funds an important portion of the central necessary component of the County's crisis response system for children, youth, and families in King County experiencing a mental health crisis. It would be a significant crisis if these services were not adequately funded. As the need and request for these services has increased every year they have been available, a potential barrier would be inadequate funding to meet the increasing need.

A potential barrier for implementing the proposed new concept enhancement might be other concepts proposed for MIDD funding, whether they are existing strategies or new concepts, being evaluated as of greater value or urgency. Another barrier might be increased costs for existing strategies that are determined to need continuation and/or expansion.

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?

Given the high quality of CCORS services, it is possible families might move to King County if one of their children is in need of intensive mental health crisis intervention that is part of an integrated, comprehensive, person and family centered, recovery-oriented, strengths based, community-based continuum of crisis outreach, crisis stabilization, and in-home services.

An unintended consequence of the new concept being implemented is that families may call law enforcement when they haven't in the past, in order to get a quicker crisis response from CCORS. This would put an added strain on law enforcement resources. Another unintended consequence of implementing the new concept enhancement is that those families who directly request CCORS might get a delayed response.

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?

CCORS program services are very successful in reducing immediate use of more costly services such as inpatient hospitalization, detention, jail, hospital emergency department, child welfare, out of home placements, juvenile justice administration. Not sufficiently funding implementation of CCORS' existing services would likely increase short and long term costs to the county, youth, and families. It is also likely more youth with significant emotional and behavioral needs would have their health needs go untreated, increasing negative trajectories for their lives that can be measured in outcomes such as unsuccessful matriculation through educational systems, increased mental health and substance use disorder symptoms, the inability to find and maintain gainful employment, homelessness, involvement in criminal activities, and incarceration in juvenile or adult criminal justice institutions.

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A possible unintended consequence of not funding the proposed program enhancement may be that this population needs a different type of crisis response than currently exists and an opportunity to develop a more collaborative crisis response with law enforcement would be lost.

- 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?**

There are no alternative approaches to fully funding CCORS. The program currently requires blended funding from four sources, including MIDD. These four budgets are challenged every year at federal and/or state levels.

Private grant funding is the only alternative funding for the proposed new concept enhancement.

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?**

The existing strategy is an essential component of the behavioral health continuum of care. It is a requirement of mental health service provision. It will be important to coordinate with the All Home service system needs, the Youth Action Plan, the Vets and Human Services Levy and Best Start for Kids. The CCORS approach detailed in questions A.1 and B.2. above utilizes some of the conceptual framework of Best Start for Kids by providing needed services at the intensity needed to support children, youth, and families, and to hopefully foster the most positive culturally consistent life path for all King County children, youth, and families.

The new concept is an example of innovation in system collaborations to reduce long term costs, to improve service response, and increase use of lower cost, community based services.

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

This has been answered earlier for the existing concept. The whole CCORS program model is based on the principles of recovery, resiliency, and trauma-informed care.

The new concept aims to most efficiently and quickly respond to youth presenting violent behavior to increase child, youth, and family engagement in crisis and ongoing treatment supports.

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

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The services provided through this existing concept are available to all King County children, youth and families in need of community based crisis response and stabilization. This is an equitable service as it is individualized, with youth and family participation intrinsic to the de-escalation of crises.

With regard to the new concept, people of color, including youth, experience a disproportionate impact of the criminal justice system. Youth presenting with violent behaviors who were seen by CCORS crisis response staff were almost universally not charged, arrested or detained. This new concept proposes to increase family engagement in community based mental health crisis and outpatient behavioral health treatment, and to reduce the adverse impact of criminal justice system involvement on community members of color.

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.)?

Staff, physical space, utilities, printing and transportation costs, staff training, phone and computer resources, and insurance are included in general operating resource needs.

2. Estimated ANNUAL COST. \$501,000-\$1.5 million Provide unit or other specific costs if known.

For the existing strategy, the MIDD portion of current year funding is just under \$500,000. This estimate of annual cost is based on the likelihood of steadily increasing program costs due to both increasing service need and general operating costs.

It is estimated the cost per person served through the new concept enhancement is \$525.41. It is estimated that pilot, small scale implementation would serve 302 family members, for a total cost of \$158,412.50. Partial implementation would serve 452 family members, at a total cost of \$237,618.75. Full implementation would serve 603 family members, at a total cost of \$316,825.00. Funds would primarily be used for additional staff needed to reduce response times.

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

There are currently three other funding sources that are blended with MIDD funding to provide CCORS services countywide: King County RSN Medicaid and Federal Block Grant funds, and Children's Administration funding. MIDD currently funds approximately 17 percent of CCORS total program service costs.

4. TIME to implementation: Currently underway

- 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?**

The existing strategy is currently administered by the YMCA of Greater Seattle. Services are currently being provided. Contract extension and review of contract terms are needed to facilitate ongoing service provision. Since this is a continuation and an expansion of an existing program with a contracted provider, an RFP is not required.

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The new concept enhancement will need some development work and definition of scope, depending on the amount of funding provided.

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?

Strategy Title: Expand Services for Youth in Crisis

Strategy No: #7b – Expanded Crisis Outreach and Stabilization for Children and Youth

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals

1. Program/Service Description

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

Children and youth experiencing acute crises because of their emotional and/or behavioral problems may inappropriately enter the most restrictive and costly settings, including inpatient hospitalization, juvenile detention, foster care, and eventually, the Children's Long-term Inpatient Programs (CLIP) or Juvenile Rehabilitation Administration institutions. Youth who become involved in the child welfare and juvenile justice systems because of their emotional or behavioral problems face many barriers later in life related to education, employment, and housing.

◇ B. *Reason for Inclusion of the Strategy*

King County holds the value that children and youth are better served when they remain within their home and community. Research suggests that immediate crisis outreach and stabilization can help to de-escalate the current crisis, stabilize and maintain the current placement, and provide the family with tools and skills to prevent future crises. Crisis outreach can prevent inappropriate utilization of costly out-of-home services. The current King County crisis system for children and youth has proven to be effective, but current capacity is insufficient; there are gaps in services for certain populations.

◇ C. *Service Components/Design*

The current Children's Crisis Outreach Response System (CCORS) offers a continuum of crisis outreach, crisis stabilization, and intensive in-home services to children, youth, and families in King County. MIDD funding will expand capacity to serve additional youth and families, particularly those youth involved in the justice system whose placement is at risk. Funding will support a comprehensive needs assessment and planning process with the goal of enhancing the continuum of children's crisis services, incorporating elements of national best practice models (i.e., short-term crisis beds, reception center). The planning process will be coordinated with the planning for related MIDD strategies (especially Reception Center (7a), and Crisis Intervention Training for first responders (10a)).

◇ D. *Target Population*

Children and youth age 3-17 who are currently in King County and who are experiencing a mental health crisis. This includes children, youth, and families where the functioning of the

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child and/or family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. The program will also target children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement.

◇ E. *Program Goal*

King County children's crisis response system will have sufficient capacity and a range of available services to fully address the needs of the target population.

◇ F. *Outputs/Outcomes*

1. Serve an additional 300 children, youth and families each year.
2. Conduct needs assessment, in conjunction with strategy 7a to determine additional capacity and resource needed to develop the full continuum of crisis options within the CCORS program
3. Increased # of youth in King County receiving crisis stabilization within the home environment
4. Maintain current living placement for youth served
5. Reduced admissions to hospital emergency rooms and inpatient psychiatric units
6. Decreased admissions and detention days in juvenile detention facilities
7. Decreased requests for placement in child welfare system

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sep – Dec 2008	Stakeholder work group will conduct needs assessment, evaluate alternatives and recommend model for expansion (budget for needs assessment in strategy 7a)	
	Total Funds 2008	\$
Jan – Dec 2009	<ul style="list-style-type: none"> Development of expanded model Contract amendment and/or RFP as needed; services begin Training and technical assistance is provided 	\$1,000,000
	Total Funds 2009	\$1,000,000
2010 and beyond	<ul style="list-style-type: none"> Comprehensive continuum of crisis interventions available to children and youth; Ongoing training and technical assistance and quality improvement process. 	\$1,000,000
Ongoing Annual	Total Funds	\$1,000,000

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

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

The YMCA of Greater Seattle administers the current CCORS program. The planning process will help determine the need to expand provider capacity.

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

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Dates:	Activity:
Jan – Dec 2009	Implement expanded crisis services, providing orientation and training to providers and stakeholders, depending upon final model
2010 and ongoing	Continuous assessment of staff development needs; ongoing training and technical assistance is offered

◇ C. *Partnership/Linkages*

Ongoing partnerships with the mental health provider network, the Crisis Clinic, hospitals and Crisis and Commitment/Designated Mental Health Professionals. Region IV Division of Child and Family Services is a funding partner in the current CCORS program. As an expanded model is evaluated and implemented, MHCADS will collaborate with juvenile justice, law enforcement agencies and other stakeholders who work with children and youth in crisis.

4. Implementation/Timelines

◇ A. *Project Planning and Overall Implementation Timeline*

Needs assessment and stakeholder planning process -- final recommendations completed by December 2008

Amend current contract as needed, expanding current interventions, and/or develop RFP as needed for new components in the continuum of crisis services – January -July 2009

Program phase-in until operating at full capacity (depending upon model) -- September 2009 - January 2010

Program evaluation and modifications as needed -- ongoing

◇ B. *Procurement of Providers*

Since this is an expansion of an existing program with a contracted provider, an RFP is not required. See overall timeline above.

◇ C. *Contracting of Services*

See overall timeline above.

◇ D. *Services Start Dates(s)*

To be determined through needs assessment and stakeholder planning process.
Target date range for service enhancements: September 2009-January 2010.

#38

Working Title of Concept: Enhancing evidence informed treatment, diversion access and law enforcement linkages for youth and children in crisis with disruptive and aggressive behaviors

Name of Person Submitting Concept: Rose Quinby

Organization(s), if any: YMCA of Greater Seattle with collaborating partners

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Mailing Address: 2100 24th Ave. S. Suite 260; Seattle, WA 98144

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.

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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 builds on the successful Children's Crisis Outreach and Response System (CCORS) program, partially funded by MIDD Initiative #7B implemented in close partnership with King County Mental Health, Chemical Abuse and Dependency Division Services (MHCADS). We begin with a brief introductory review of the purpose of CCORS and the status of the MIDD outcomes CCORS has successfully addressed. CCORS is a mobile, on-demand, 24/7, family-centered crisis response system serving children and youth up to age 18 who are experiencing a mental health and/or substance use related crisis and their families. The purpose of CCORS is to safely divert unnecessary and costly child psychiatric hospitalization and divert children and youth with mental health and/or substance abuse issues from initial or further juvenile justice involvement. CCORS meets with families face to face in homes, schools, hospital emergency departments and other community settings. Following the initial outreach, CCORS stabilization services are by design very intensive with an average length of service of 21-30 days, and intensity of 2-3 meetings per week of 1-2 hours in duration. In 2014, 1,116 youth and their families were served through in-person crisis response designed to help children and youth stay safely in their homes, increasing wellness and recovery. CCORS is managed and delivered by the YMCA of Greater Seattle's Family Services and Mental Health in the Metrocenter Y Branch. Thanks to the support of the MIDD Oversight Committee, the King County Council, and King County MHCADS, and effective partnerships with King County families, law enforcement, the Crisis Clinic, and mental health and substance abuse treatment providers, CCORS has demonstrated outstanding effectiveness related to the following three Policy Goals adopted by the MIDD Oversight Committee and the King County Council:

1. Safely reduced unneeded child and youth psychiatric hospitalization. Sixty nine percent of hospitalizations were safely diverted at the ER in 2014 (250 children or youth). Most returned safely to their family or a relative. **2. Safely reduced initial and repeated justice system involvement among youth and children with mental illness or chemical dependency.** In 2014, 464 unduplicated children or youth were referred to CCORS for homicidal ideation, violent/aggressive behavior, or property destruction. An estimated 603 youth and family members in total were served. Of these youth, 40% or 189 presented with suicidal ideation or attempt. Law enforcement was involved in 199 or 43% of these referrals. In reading the case notes of our frontline crisis workers, it can logically be assumed that these youth were at extremely high risk of arrest and entry or re-entry into the juvenile justice system, yet just 3% of these children or youth who completed CCORS crisis intervention and stabilization services, spent time in detention. **3. Increased access to person centered, culturally appropriate, outpatient treatment on demand.** All children and youth referred to CCORS for crisis services are not connected with mental health services when they first call. Sixty two percent of these youth do engage with counseling following CCORS crisis services, as measured by attendance at appointments with a licensed provider agency. In 32% of the families, counseling was recommended however declined by the youth and/or family.

Building on the success of CCORS, we propose a pilot project to enhance services for children and youth in crisis because of disruptive, violent behavior, or property destruction. This will respond to the following two MIDD II Policy Goals: **1. Further enhance access to person centered, culturally appropriate outpatient treatment on demand.** **2. Increase access to evidence-based and evidence-informed juvenile justice diversion options that prevent entry or re-entry into the juvenile justice system.** We propose to reach these two MIDD policy goals by achieving the following two MIDD II outcomes:

****1. Reduce the length of crisis events and family follow through with safety planning recommendations and treatment by reducing the average time it takes to get to the scene, thereby increasing our ability to carry out in-person crisis response in tandem with law enforcement.** Experience shows that if trained crisis

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responders can arrive at the home, school or community setting and address the crisis in a crossover fashion for a brief time with law enforcement, the crisis is likely to be of shorter duration, and the family is more likely to follow through with the recommended crisis prevention and safety planning options. Provided this concept is selected for Phase II, we will work quickly with family representatives, King County MHCADS specialists, law enforcement, Crisis Clinic and community partners to develop a pilot differential response method for reducing the average response time it takes to reach the crisis scene, for families with aggressive and disruptive youth. The goal is to carry out crisis prevention and safety planning with enhanced immediacy, and with the presence of law enforcement, if appropriate. Any differential response must retain the current system of centralized Crisis Clinic data collection related to crisis response and community needs. **2. Remove family-specific barriers to child and youth engagement with evidence based or evidence informed diversion programs, and outpatient treatment. To do this, we will enhance the use of brief alternative family placement options to help alleviate family crisis and increase access to evidence-based and evidence-informed alternative diversion programs. The use of crisis stabilization beds in licensed, therapeutic foster homes as an effective brief respite for youth and families in crisis is not yet well understood by community referents and stakeholders. CCORS already has three Crisis Stabilization Beds retained for families in crisis, in YMCA licensed therapeutic foster homes. In 2014 the average length of stay for children and youth was 3.6 days. In collaboration with the State DSHS Children's Administration, children and youth in crisis who are placed do not enter into the state's child welfare system. We will enhance family, law enforcement and staff understanding of when and how to give children, youth and families a brief respite in the midst of a heated crisis involving youth with disruptive behaviors, thereby giving more families access to the respite they need. In addition, we will reduce initial entry and re-entry into the juvenile justice system by increasing linkage with evidence-based and informed alternative and diversion programs such as the King County Superior Court's evidence-based Parent Youth Connections Seminar (called Coordination of Services when evaluated as an evidence-based practice by WSIPP), and evidence-informed STEP UP and Project 180, for youth and their parents, as appropriate. Currently, youth enter these programs only through the doorway of Diversion, the Prosecutors Office or the courts, with very limited referrals directly from the community. We will work with schools, law enforcement, King County Superior Court and the Prosecutors Office to expand capacity and program development so that these effective programs can accept direct community referrals, before the youth enters the system, e.g. from schools, natural supports, families, CCORS, law enforcement and other helping professionals. Existing structured curriculum will be tailored to fit this population, as needed.

Most officers now receive routine, MIDD-funded Crisis Intervention Training featuring skills training by CCORS and other agencies, and understand that many youth with disruptive behavior are challenged by significant mental health, substance abuse, or co-occurring disorders, and need to be engaged in evidenced informed, community-based treatment or diversion programs. As a result, instead of detaining or arresting a youth, they try whenever possible to use the less restrictive option of referring to CCORS, other community resources, and/or their own internal, mental health staff. Having the ability to directly refer to the Parent Youth Connections Seminar and STEP UP, and Project 180 programs will increase the array of evidence-based and evidence-informed options available to reinforce the family's ability to sustain the family safety and crisis prevention plan, after CCORS and law enforcement involvement ends.

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.

In 2014, 464 of the 1,166 King County families (40%) receiving a CCORS crisis outreach called because of a child or youth's violent or aggressive behavior or property destruction. Law enforcement was involved in the referral to CCORS in 195 (42%) of these families. After responding to the crisis in a residential setting and advising a family to call CCORS via the Crisis Clinic, law enforcement officers often must depart for other, urgent calls. In debriefing these crisis intervention events, officers and crisis workers agree that effectiveness, family follow through, and long term stabilization would likely have been increased if law

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enforcement and mobile crisis staff had been able to work together, in person as a team, and if brief, family respite placement had been available.

Evidence based and evidence informed diversion programs are in place in the community that are known to improve youth's ability to cope with and gain support for positive ways of expressing emotions of frustration, anger, and rage, enhance communication with connected adults and parents and attain a high quality of life. This in turn reduces entry or re-entry into the juvenile justice system. Referral to these programs is usually limited to youth who've been arrested, or those who've formally entered into the juvenile justice system. There is a need for direct referral to these very effective programs from CCORS, schools, law enforcement, families and other community sources, before the youth or child advances to formal system involvement.

3. How would your concept address the need?

Please be specific.

Our pilot will focus on a subset of the population presenting in crisis due to highly disruptive or aggressive youth/ child behavior, with special focus on those with a by law enforcement-linked referral to CCORS. Looking more closely at the 199 law enforcement-linked referrals to CCORS in 2014, we find that virtually no arrests were made, as the police, and CCORS Crisis Intervention team (delivered by the YMCA), working hand in hand with the families, were able to de-escalate the crisis, and help the youth, parents, guardians, and natural supports develop their own effective safety and wraparound crisis prevention plan, including de-escalation skills. We also know that many families who are advised by law enforcement to call CCORS and other community resources at the time of the crisis do not follow through after the officer leaves their home. Increasing the speed with which the CCORS crisis team receives the referral, and arrives at the scene will increase the number of families who follow through with accessing treatment, and reduce the use of crisis services, emergency departments, and detention for crisis needs. As described in question one, a more immediate in person tandem response will be designed quickly with key law enforcement, King County, the Crisis Clinic, and other partners. Short term respite for families in crisis is available through YMCA licensed therapeutic foster homes, yet the benefit of such a planned placement without entry into the child welfare system is not well understood by potential referents. There is often a stigma attached to the idea of one's child staying with a new family, and hence, the relief that could be provided is unseen. Certified, trained foster and regular peer parent partners who've had their own children go through similar crisis will participate in initial and follow up crisis meetings to help educate family members about how respite care may help them. These staff will also educate and inform law enforcement and other community partners. Finally, we will open up referral pipelines for families struggling with youth disruptive behavior to existing evidence-based and evidence-informed diversion and pre-diversion programs such as King County Superior Court's Step Up and Parent Youth Connections Seminars, and the King County Prosecutor's Office Project 180.

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

Approximately 464 King County youth up to age 18 who present a danger to themselves and others by reason of destructive or aggressive behavior, primarily in home or school will benefit. Approximately 139 additional family members of these youth will also benefit by participating in enhanced services to keep the youth safe, prevent future crisis, and enhance family communication, stability and unity. Key law enforcement agencies partnering for this pilot will benefit by reduced time spent on family crisis response and reduced volume of police repeat response to frequent users of crisis stabilization services. All King County law enforcement agencies either have been, or will be invited to participate in this pilot.

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.

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1. Program/ Individual MIDD Outcome: Increase access to and use of person centered, culturally appropriate treatment, education, and training services by youth in crisis who present with destructive or aggressive behavior. **Current measure for treatment linkage possible through King County MHCADS system: measure actual engagement with treatment for Medicaid-eligible youth by looking at youth & family attendance at initial and subsequent counseling appointments at licensed mental health & substance abuse treatment agencies. **Current measure for safe, child psychiatric hospitalization diversion consists of CCORS staff meeting the family at the ER where the stated intent was to have the youth or child enter the hospital, and recording in the electronic health record whether or not the requested voluntary or an involuntary hospitalization occurred or not. Goal: An 8% increase for safe, psychiatric hospital diversion for youth with aggressive or disruptive behaviors. 1.2. Process Measures expected to lead to Outcomes: **Current measure of response time for Crisis Team to reach the scene. Goal: decreased response time from baseline. **Add measure of tandem response with police: yes or no. **Current measure: number of families making use of Crisis Stabilization Homes for respite monthly. Goal: increase number of families accessing respite. 2. Program/ Individual MIDD Outcome: Increased youth/ family access to evidence-based or evidence-informed diversion programs. **New measure: Add measure for youth engagement with these programs by securing release from family at time of CCORS intervention and contacting program to check on family or youth attendance.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

- ☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

This concept focuses on those King County children and youth in crisis who are challenged by aggressive behavior or disruptive behavior. Such behavior is a high risk factor for adult mental illness, substance addiction and incarceration. With the increased access to and engagement with the evidence-based and evidence-informed prevention, early intervention, and diversion opportunities described in this concept, children, youth and families will improve their quality of life, experiencing wellness and recovery by foregoing costly and disruptive incarceration and hospitalization. Without it, they face a much higher probability than the general population of adult incarceration or prolonged/ repeated psychiatric hospitalization.

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.

Community and government planning partners will include law enforcement leaders and line officers, youth and families impacted by crisis due to child or youth mental illness or substance abuse/dependency, key leaders at the King County Superior Court and Prosecutor's Office, community mental health agencies - including those specializing in culturally relevant youth & family services and wraparound service delivery, key leaders from the King County Mental Health, Chemical Abuse and Dependency Services Department and the Crisis Clinic, and other interested and informed parties.

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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: \$ 146,931 per year, serving 81 people per year

Partial Implementation: \$ 244,885 per year, serving 302 people per year

Full Implementation: \$ 489,770 per year, serving 603 people per year