Connections Health Solutions

Crisis System Final Assessment
Report Prepared for:

North Central Washington Region

Prepared by:

Chris A. Carson, MD | Co-Founder & Chief Strategy Officer
Mackenzie Barta | Senior Business Development Associate
Nick Margiotta | Crisis System Engineer and Former Police Officer

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Executive Summary

Connections Health Solutions (Connections) performed a Sequential Intercept Model (SIM) exercise, inclusive of three days of stakeholder visits and a one day SIM mapping workshop, to gain a multi-stakeholder, multi-county perspective on the gaps in the current behavioral health crisis continuum in the North Central Region in Washington. The North Central Region is diverse, with each county having unique needs. However, consistent across all counties are clearly dedicated behavioral health providers and community organizations committed to the individuals they serve. ***The North Central Region has made great strides in the planning of their crisis system in line with the Washington State vision, particularly with the development of mobile crisis teams which were non-existent just five years ago.***

This report endeavors to provide objective suggestions to build on the regional achievements to date with an eye towards continuous improvement. There is strength and innovation present within the community and this report aims to emphasize the successes, while recommending areas for further development.

While there is a strong provider base, the SIM exercise identified that one of the biggest challenges facing the region is fragmentation of the network. Linkages between providers and community organizations are often informal, creating a system that can be challenging for patients and first responders to navigate, resulting in:

- Individuals are not consistently getting the care they need, right when they need it. This can lead to escalation in their condition and poor outcomes.
- Emergency departments (EDs) and jails remain the de facto treatment facilities for many in crisis–with neither equipped to do the job.

These issues are exacerbated by the fact that there remains a critical gap in the current continuum of care: a crisis stabilization center. Individuals with higher acuity needs have the greatest struggle finding care, with many sent out of the region. The SIM mapping workshop underscored this gap, with most participants across Chelan, Douglas, Grant, and Okanogan counties voting for a *crisis stabilization center* as the top priority for regional action planning.

This report details an array of potential next steps to improve the existing crisis system–some that can be implemented now. However, this report also takes steps to recommend a crisis stabilization center that can address the need for high acuity care and system fragmentation. A regional crisis stabilization center could operate on a model of local access points connected to a central hub.

The local access points are community-based entry points that function today as gateways to the crisis system. These include EDs, local providers, Federally Qualified Health Centers (FQHCs), and many others. In the future state, these access points would be able to access the hub for psychiatric consultation and transfer higher acuity cases to the hub.

The hub would serve as the convener of the crisis system, ensuring that individuals in crisis have a seamless experience. The hub would also serve as the convergence of multiple systems—substance use, mental health, jail, EDs—ensuring that there is an entity accountable for supporting individuals in crisis across all. The hub would treat and coordinate care for multi-system involved individuals, complex cases, and individuals of all acuities to ensure that they do not fall through the cracks. In short, the hub would serve both as a crisis stabilization center and an enabler to support crisis care at each of the local access points.

The work of developing a robust crisis continuum is never done. Consumer-centered continuous quality improvement is the hallmark of any great system of care. The Regional Diversion Workgroup has made great strides to improve access to care in the North Central Region. This report intends to provide a helpful input into the workgroup's vision for a collaborative, coordinated regional system of care that fits within the unique cultures and communities in Chelan, Douglas, Grant, and Okanogan counties.

However, it is important to acknowledge inherent limitations in the SIM exercise and report. While numerous key stakeholders participated in the visits, SIM mapping workshop, or both, 988 and the regional crisis line were not represented. Further, crisis system data was not analyzed as part of the scope of the exercise. As such, the report reflects the perspectives of the stakeholders that participated and may not represent the entire crisis system of care or the perspectives of all stakeholders.

Introduction and Overview of Engagement

In 2020, the North Central Washington Region—inclusive of Chelan, Douglas, Grant, and Okanogan counties—created a Regional Diversion Workgroup comprised of representatives from diverse stakeholder groups including funders, service providers, law enforcement, corrections, courts, and others. Over the past three years, the workgroup has convened monthly to strategize around the behavioral health crisis system and identify opportunities to divert individuals with mental health and substance use disorder from the criminal justice system into treatment. ***Through the workgroup, the region has achieved incredible cross-functional buy-in and established strong cross-county collaboration to improve the behavioral health crisis system.***

The workgroup has identified some of the key challenges facing the community, including the prevalence of individuals with mental health and substance use disorders. They've also identified gaps that exist in the crisis continuum, limitations in available services, and a lack of standardization across counties. Connections was contracted to work with the North Central Region to help assess the regional behavioral health crisis system, including identifying the core components of the existing continuum and how they are functioning, uncovering unmet needs and gaps, and recommending strategies to improve and build upon the crisis system. In the fall of 2023, Connections conducted three days of on-the-ground stakeholder visits in all four counties and facilitated a one day in-person, partial SIM mapping workshop for a broad group of participants from the North Central Region.

Stakeholder Visits

Background and Purpose

Connections spent three days in Chelan and Douglas, Okanogan, and Grant counties conducting in-person stakeholder visits with over 35 organizations, groups, or departments within the behavioral health crisis continuum including providers, law enforcement, hospitals, community non-profits, jails, courts, Emergency Medical Services (EMS), and others. Connections toured facilities and met with stakeholders in each of the region's largest population centers—Wenatchee and East Wenatchee, Omak, Moses Lake, and Ephrata—to develop a deeper understanding of both the region as a whole and the unique nuances of each community. Chelan and Douglas counties were grouped together due to their shared metropolitan area (Wenatchee and East Wenatchee) which collectively contains most services for both counties including the jail. Okanogan County and Grant County were visited separately.

The goal of the stakeholder visits was to begin to understand the current state of the behavioral health crisis system to serve as a foundation for the subsequent SIM mapping workshop. It is important to listen to the individual experiences of the community stakeholders using, providing, and interacting with the crisis system to understand how they perceive their role within the broader system as well as what they see as its strengths and weaknesses.

The North Central Region is an incredibly expansive and diverse region with dispersed population centers. ***The three days of stakeholder visits not only illuminated the region's large geographical area, but also the vast diversity in geography, culture, available services, and service delivery practices between each of the counties.*** Further, the visits emphasized the strength of the existing network, while also highlighting gaps in the system. The following pages detail the key themes that emerged from each day of stakeholder visits.

Day 1: Chelan and Douglas Counties

Stakeholders

- American Behavioral Health Systems (ABHS) Parkside
- CAFÉ
- Cascade Medical
- Catholic Charities
- Chelan County Regional Justice Center
- Chelan County Sheriff's Office
- Chelan County Superior Court
- Columbia Valley Community Health (CVCH)
- Confluence Health
- Douglas County Sheriff's Office
- East Wenatchee Police Department
- RiverCom
- The Behavioral Health Unit (BHU)
- The Center for Alcohol and Drug Treatment
- Thriving Together North Central Washington (NCW)
- Wenatchee Police Department

Key Themes

- **Existing organizations are doing great work to help individuals in behavioral health crisis.**
    - There are a variety of organizations and programs providing services across Chelan and Douglas counties, including ABHS Parkside, the Behavioral Health Unit (BHU) at the Chelan County Sheriff's Office, CAFÉ (and their Recovery Navigator Program), Catholic Charities, The Center for Alcohol and Drug Treatment, and Columbia Valley Community Health (CVHC).
    - Each of them is doing great work and providing quality care to the individuals they serve.
- **However, their efforts are often fragmented.**
    - Accessing and navigating the system of care can be difficult and often relies heavily on interpersonal relationships and knowing "who to text." While there are strong relationships between existing providers and community-based organizations, there isn't a formal system for collaboration, and for those in need of services it can be difficult to know how to begin seeking treatment.
    - There are several organizations that provide some level of co-response including Catholic Charities, the BHU, and CAFÉ. Without a formal system for dispatch, response, and referral, law enforcement often ends up calling the personal cell phone of whoever they may know at one of these organizations to respond.
    - Mental health and substance use disorder treatment is largely bifurcated and it is not uncommon for one individual to receive services through multiple different organizations. There is often a lack of coordination, information sharing, and warm hand-off between organizations working with the same individual.
- **For many, the jail serves as the de facto regional behavioral health facility.**

    - The Chelan County Regional Justice Center has a very high number of inmates suffering with behavioral health issues. Law enforcement reports this is due to the lack of resources for readily available treatment, leaving jail as the only option in many circumstances.
        - ~ 75% of inmates are on an antipsychotic medication
        - ~ 80% of inmates test positive for fentanyl
    - The jail routinely has individuals detoxing in holding cells upon intake (which usually takes three to 10 days) before being able to enter the general population. This inhibits law enforcement's ability to arrest and book other individuals, some of whom have more serious charges.
    - At the same time, law enforcement interacts with many "familiar faces" who have mental health or substance use disorder and frequently commit low level crimes (such as criminal trespass). Eventually, law enforcement often ends up arresting them because there is no other alternative.
- **Many people are unable to access behavioral health treatment without going through a less than ideal—and often restrictive—pathway.**
    - It is difficult to access acute treatment for mental health or substance use disorder without being arrested, going to the ED, or both. The region lacks an unequivocal "front door" to the behavioral health crisis system where anyone can access treatment, anytime.
- **There are insufficient inpatient behavioral health services dedicated to the region.**
    - Behavioral health beds are limited to ABHS Parkside, The Center for Alcohol and Drug Treatment's residential substance use disorder unit, and Confluence's "MU1"[1]. Existing beds are often difficult to access.
    - ABHS Parkside offers comprehensive voluntary and involuntary inpatient services, including crisis stabilization, evaluation and treatment, and secure withdrawal management and stabilization. However, it accepts statewide referrals and doesn't allow for law enforcement drop-offs, limiting regional access and capacity. Walk-ins are redirected to the ED for evaluation.
    - Due to the lack of resources in the community, individuals often must travel great distances, usually to Seattle or Spokane, to receive further care—and transportation is a challenge. CAFÉ, one of the few organizations that offers transportation, has transported ~ 70 individuals out of the North Central Region in the past 18 months for treatment.

Day 2: Okanogan County

Stakeholders

- Advance NW
- LifeLine Ambulance
- Mid-Valley Clinic
- Mid-Valley Hospital
- North Valley Hospital
- Okanogan Behavioral Healthcare (OBHC)

[1] Recent news articles suggest that Confluence Health will be closing "MU1" in March 2024.

- Okanogan County Community Action Council (OCCAC)
- Okanogan County Prosecutor's Office
- Okanogan County Sheriff's Office
- Omak Police Department
- Omak School District
- Oroville School District
- Room One
- Three Rivers Hospital

Key Themes

- **Community non-profit organizations are doing exceptional work to fill critical gaps in the crisis continuum.**
    - Room One in the Methow Valley is a “rural one stop shop” that has been around for 25 years. Anyone can walk in and receive help with mental health or social determinants of health (SDOH) needs, including accessing food and shelter. Room One also has a peer support program.
    - Advance NW provides peer support for people who have been discharged from inpatient psychiatric or substance use disorder treatment. They also have a Recovery Navigator Program and offer recovery coaching in the jail.
    - The Okanogan County Community Action Council helps low-income and/or people experiencing homelessness with housing assistance. They offer hotel vouchers and have housing case managers that provide wraparound services.
    - Other organizations, including Foundation for Youth Resiliency & Engagement (FYRE) and the Support Center, provide services to fill gaps in Okanogan County.
- **Organizations are implementing creative and innovative solutions to address the behavioral health crisis in the community.**
    - LifeLine Ambulance acts as a key player in the behavioral health system, providing 85-90% of all behavioral health transports in Okanogan County and frequently taking individuals to Seattle or Spokane for inpatient treatment. LifeLine is at the front lines of the behavioral health crisis, with most of their calls (80%) being for mental health or substance use disorder.
    - North Valley Hospital recently implemented a pilot program with a mental health professional embedded in the ED to supplement OBHC’s work. Prior to this, they had no dedicated behavioral health staff. Since beginning the program, OBHC has already noted a positive impact.
    - The Omak Police Department’s dedicated behavioral health worker (through their CORE Program) goes through police reports to identify “familiar faces.” They provide case management, try to refer them to OBHC for services, and connect them to other community resources.
    - Room One has a co-located mental health therapist from OBHC on site to support efforts to keep individuals in the community and not have to travel outside of the Methow Valley for services.
    - OBHC operates a supportive housing program, called the Shove House, to combat regional housing challenges and provide a safe living environment for individuals receiving services with them.

- **The county's vast geography and rural landscape pose unique barriers to both providing and accessing behavioral health services.**
    - Okanogan County has a population of about 43,000 spread over land the size of both Connecticut and Rhode Island combined. Pockets of the county are isolated and hard to access (such as the Methow Valley, which is surrounded by mountains on three sides), and a large portion is home to the Colville Reservation (which is made up of 12 tribes).
    - There is multi-generational poverty, homelessness, and increasing income disparities. People are moving into the region from Seattle to work remotely, raising property values and making it increasingly more difficult to afford the cost of living. This is compounded by a lack of low barrier shelters.
    - Most services are concentrated in Omak, however, transportation is a barrier for many people due to cost, distance, or other geographic factors (weather, road closures, etc.). Telehealth is not widely available as a solution. People are often transported by EMS to Seattle for inpatient treatment, posing safety risks and using significant time and resources.
    - All three hospitals are small, critical access hospitals that lack the infrastructure, resources, and workforce to deal with individuals in behavioral health crisis. Three Rivers Hospital has only one nurse on staff in the ED at night. Mid-Valley Hospital has over 30 travelers and 50 open positions. Doctors and nurses generally lack the tools and experience to treat behavioral health.
    - The schools are experiencing increasing problems with mental health and substance use and feel they do not have the resources to be able to intervene. One superintendent described his frustration in accessing care, saying "we are better than this."
- **Mobile crisis is generally not functioning as a reliable resource in the community.**
    - OBHC is funded to operate two mobile crisis teams for eight hours per weekday.
    - However, due to staffing challenges and the size of the region, it is logistically difficult to provide mobile crisis services in the community. In practice, the majority of mobile crisis responses currently occur in the ED.
    - Law enforcement and first responders report that mobile crisis often doesn't show up or is significantly delayed in responding in the field, leaving them to handle most crises on their own.
    - The Omak Police Department created the CORE Program, a co-responder program with a dedicated behavioral health worker, in part to fill the gap in mobile crisis response and other behavioral health providers in the community.

Day 3: Grant County

Stakeholders

- Grant County District Court (Community Court)
- Grant County Prosecutor's Office
- Grant County Sheriff's Office
- Moses Lake Police Department
- Renew
- Samaritan Hospital

Key Themes

- **There is strong collaboration in the community, particularly between Renew and Samaritan Hospital.**
    - Most individuals experiencing a behavioral health crisis in Grant County end up at Samaritan Hospital. Despite the lack of dedicated internal behavioral health staff, Samaritan is relatively equipped to deal with individuals in crisis due to their strong relationship with Renew.
    - If an individual comes in with behavioral health needs, Samaritan conducts medical clearance and then contacts Renew. Renew assesses the need and deploys the appropriate staff to the ED to evaluate the individual and connect to further care.
    - Renew also recently implemented a pilot program with Samaritan where they send recovery coaches into the ED to support individuals with substance use specific needs.
- **Crisis staff are deployed efficiently and effectively.**
    - Renew has a diverse crisis team comprised of designated crisis responders (DCRs), crisis intervention specialists, peers, and recovery coaches. Renew also has a co-located DCR in the Moses Lake Police Department to co-respond to individuals with behavioral health needs.
    - Renew's licensed mental health professional receives referrals from law enforcement, hospitals, and community members through an on-call phone and then triages appropriately. They act as the team lead deploying crisis staff as needed and are also able to perform the DCR function of assessing for involuntary treatment.
    - To combat workforce constraints, the mental health professional's role is not solely to do Involuntary Treatment Act (ITA) assessments as the DCR, but also to lead the team and respond as part of the mobile crisis team when needed.
    - Since implementing this structure, the number of DCR contacts has decreased but not the number of ITA commitments, indicating that team resources are being utilized more efficiently and effectively.
    - Renew also provides seven- and 30-day follow-ups with those who are evaluated for the ITA and not committed, even if they aren't eligible for ongoing services.
- **There is a lack of coordination with the regional crisis line[2]. This was emphasized in Grant County but is an issue across the region and felt nationwide due to the rollout of 988.**
    - When law enforcement calls the regional crisis line for assistance with someone experiencing a crisis, they are often told the crisis line will follow-up. In most cases, they are offered no immediate help and are left to deal with the crisis on their own. Law enforcement is then faced with the decision to either arrest the individual or leave them in the field (and potentially respond to them again in a few hours).
    - Instead of utilizing the crisis line, law enforcement has started calling Renew directly for assistance with behavioral health crises. Once contacted, Renew may

[2] Stakeholder discussions did not illuminate whether this was the regional crisis line, 988, or another local line.

call the individual's cell phone while they're still with law enforcement and try to resolve the crisis in the field or get them a follow-up appointment for the next day. There is strong collaboration between Renew and law enforcement in Grant County.
    - When providers call the crisis line, they may wait on hold or not receive a call back. When an individual from Grant County calls the crisis line, there is often a lack of communication, coordination, and follow-up for referral or connection to community resources from the crisis line to local providers.
- **Re-entry into the community—both from jail and from inpatient treatment—is a challenge.**
    - One of the biggest challenges is connecting people to behavioral health services upon release from jail, especially due to the suspension of Medicaid benefits. Renew is able to set up services for individuals 30 days prior to their release, however it is not always known exactly when the release will happen. As a result, people often re-enter the community without being connected to services and they end up cycling through the jail.
    - Similarly, it seems that people often have success in inpatient treatment (usually outside of the region) but struggle once they enter back into the community largely due to a lack of stable shelter or housing. The individuals able to maintain stability in the community usually have housing, which is limited in Grant County.

Sequential Intercept Model Mapping

Background and Purpose

The North Central Region participated in a day-long Sequential Intercept Model (SIM) mapping workshop, designed to identify resources and gaps within the community with the goal of increasing the ability to divert individuals with behavioral health needs away from the criminal justice system into treatment, when appropriate. The workshop was lightly focused on Intercept 0 (Community Services), with a heavier focus on Intercept 1 (Law Enforcement) and the start of Intercept 2 (Initial Detention/Initial Court Hearings).

The SIM was developed in the early 2000s as a conceptual model to inform community-based responses to the involvement of people with mental health and substance use disorders in the criminal justice system by Mark Munetz, MD and Patricia A. Griffin, PhD, along with Henry J. Steadman, PhD, of Policy Research Associates, Inc. (PRA). With funding from the National Institute of Mental Health, PRA developed the linear version of the SIM as an applied strategic planning tool to improve cross-system collaborations to reduce involvement of people with mental health and substance use disorders in the justice system. The SIM helps communities identify resources and gaps in services at each intercept and develop local strategic action plans. The mapping process brings together leaders, agencies, and different systems to work together to identify strategies to divert people with mental health and substance use disorders away from the justice system into treatment.

Ideally, the SIM process is part of a structured approach from a macro or system level, and not merely just focused on ad-hoc interventions or services in a vacuum. The SIM is most effective when used as a community strategic planning tool to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use,

law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experiences, family members, and many others.[3]

Participants

Building on the foundation of collaboration and partnership developed through the Regional Diversion Workgroup, more than 20 individuals participated in the workshop. ***Convening four counties for a regional SIM mapping exercise is a challenging endeavor and remains a testament to the significant work already done in the region.*** Participants represented varying constituencies (i.e., funders, providers, law enforcement, corrections, courts, advocacy, etc.) from across all four counties, including:

- Carelon
- Catholic Charities
- Chelan County Commissioners
- Chelan County Regional Justice Center
- Chelan County Regional Justice Center Nursing Staff
- Chelan County Superior Court
- Chelan-Douglas Health District
- Douglas County Commissioners
- Douglas County Sheriff's Office
- Grant County Jail
- LifeLine Ambulance
- North Central Region Behavioral Health Advocate
- Okanogan County Commissioners
- Okanogan County Sheriff's Office
- Renew
- The Center for Alcohol and Drug Treatment
- Thriving Together NCW

The workshop was designed to not only develop a map illustrating how individuals with behavioral health needs encounter and flow through the criminal justice system, but also to bring together key local stakeholders to increase cross-system collaboration, discuss best-practice approaches from across the nation, and identify potential opportunities and priorities for change. This encompasses a review of best-practice crisis services models that are in keeping with The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care-Best Practice Toolkit and National Council's Roadmap to the Ideal Crisis System, including a robust community-based crisis system that incorporates an interconnected array of essential elements and operates under a "no wrong door" philosophy. The following pages detail the results of the SIM mapping workshop.

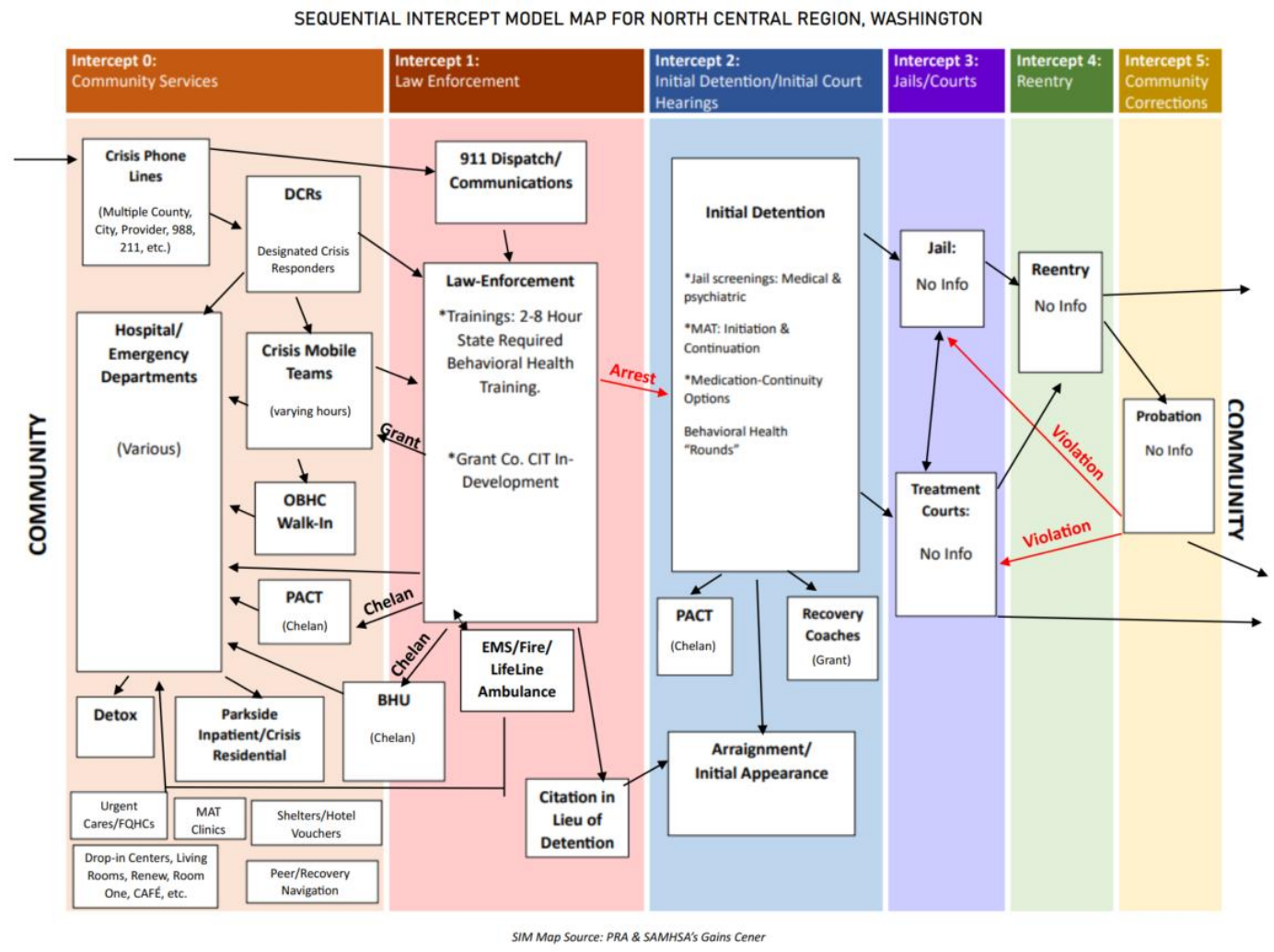
SIM Map

The North Central Region SIM map is an outcome of the workshop and discussion. It depicts how workshop participants perceive that individuals with mental health and substance use

[3] Excerpts from Policy Research Associates (PRA) SIM webpage

disorders move through Intercepts 0, 1, and 2, but may not include all existing resources or reflect what happens in practice.

Figure 1. The North Central Region SIM Map



Intercept 0: Community Services

Overview

Typically, services at Intercept 0 provide opportunities to divert people into crisis care or treatment, without requiring police involvement or the use of 911. Ideally, services are available to support pre-diversion and are accessible to the community. To the degree they are available, community behavioral health resources help prevent the need for law enforcement involvement as well as reduce the burden on EDs and inpatient hospitals. While there are significant variations across the nation related to community-based crisis services, the ideal continuum, especially considering 988-related initiatives, includes three key elements:

- Regional Crisis Call Center

- Mobile Crisis Teams
- Crisis Stabilization Centers

In essence, an ideal system offers the community *Someone to Call, Someone to Respond, and Someplace to Go.*

Resources

The North Central Region has many strong resources already in place across Intercept 0. While there was not full uniformity or agreement across the four counties, participants generally identified the existence of the following services in the North Central Region:

- **Crisis Lines:** Washington has a centralized crisis line related to 988. Despite this, challenges remain in using it effectively and there are still other crisis lines functioning in the region as well. These crisis lines have varying hours of operations, processes, and abilities. They are operated by Crisis Connections, OBHC, Catholic Charities, and a variety of others. Some (but not all) can dispatch mobile crisis teams. Participants generally had limited information on specific crisis lines and providers.
- **Mobile Crisis:** While there has been great progress in the development of mobile crisis over the past five years, there currently are differences between counties in the existence and functioning of mobile crisis teams. Some counties have both youth specific and adult specific teams, while others have teams that serve all ages. Specific mobile crisis teams and other co-response programs include:
    - Catholic Charities Youth Mobile Crisis: serves Chelan and Douglas counties, operates weekdays from 8 a.m. to 5 p.m.
    - Catholic Charities Adult Mobile Crisis: serves Chelan and Douglas counties, operating hours unknown to law enforcement
    - Chelan County Sheriff's Office Behavioral Health Unit (BHU): serves Chelan and Douglas counties, functions as "co-responder crisis units," does not operate 24/7 but there is discussion to align coverage with Catholic Charities
    - Renew Adult Mobile Crisis: serves Grant County, available 24/7, leverages the use of the DCR
    - Renew Youth Mobile Crisis: serves Grant County, available from 7 a.m. to midnight
    - OBHC Mobile Crisis: serves Okanogan County, in process of development and when staffed can respond weekdays from 8 a.m. to 5 p.m.
    - Omak Police Department CORE Program: serves the City of Omak, provides co-response and case management to "familiar faces"
    - DCRs: available on-call 24/7 to assess for involuntary treatment in all counties
- **Crisis Stabilization Facilities:** Currently there are no facilities that serve as a "front door" for community crisis stabilization, however there are a variety of services that provide some level of walk-in services:
    - EDs are the primary facilities available during a crisis, but they lack dedicated behavioral health staff and resources. North Valley Hospital, located in Tonasket, recently launched a pilot program to embed a mental health professional in the ED during specific hours. While DCRs can operate in the community, they

primarily respond to EDs to complete assessments since that is the primary facility option.
    - American Behavioral Health Systems (ABHS) Parkside operates an inpatient "crisis" facility, for voluntary and involuntary individuals, however they currently do not accept direct admits. Rather, they require individuals to obtain medical clearance and be evaluated by a DCR in the ED prior to admission. Although located in Wenatchee, Parkside serves the entire state and does not prioritize access for residents of the North Central Region. (Previously they operated a model that would allow walk-ins or law enforcement drop-offs).
    - Medical urgent cares and FQHCs offer some opportunities to walk in, but these services are not specifically geared for individuals experiencing a behavioral health crisis. Columbia Valley Community Health (CVCH) has designated walk-in hours, however, individuals need to know the specific times to take advantage of them.
    - OBHC, Renew, and Catholic Charities allow for crisis walk-ins during business hours.
    - There are "drop-in centers" in several counties, such as Room One and CAFÉ. While not designed to resolve complex crises, they do offer a place for individuals who are voluntary and not acute or agitated to engage with staff and/or peers during daytime hours. The Okanogan County Community Action Council provides support services and case management focused more on SDOH needs than behavioral health crisis services.
- **Other**
    - LifeLine Ambulance is a good resource that responds to and transports a large number of individuals with behavioral health needs in all four counties.
    - There are several homeless shelters, however, few (if any) are low barrier. They are typically not accessible for walk-ins or individuals experiencing a crisis. All counties have access to hotel vouchers.
    - Law enforcement carries Narcan. Naloxone is widely available throughout the community (including in vending machines).
    - Catholic Charities operates a Program for Assertive Community Treatment (PACT) Team that can respond 24/7. Wraparound with Intensive Services (WISE) is available for youth and families and is designed to provide 24/7 services for individuals enrolled in the program. Both are available only for individuals enrolled in the programs, for which there are high thresholds, and not for general community members in crisis.
    - FYRE in Okanogan County provides drop-in services for youth, typically focused on addressing SDOH and providing health and wellness resources (i.e., Narcan, sex education, etc.).
    - All counties have Recovery Navigator Programs or coaches (peer support) that can assist individuals in care coordination and transportation.
    - There are MAT and other outpatient clinics, however, appointments are typically required (no "walk-in crisis" access).
    - There are various NAMI training initiatives, primarily focused on schools.

<u>Gaps</u>

- **Crisis Lines**: While there are multiple crisis lines across the North Central Region (988, regional, county, and agency specific lines), the lack of centralization creates a fractured, rather than centralized, "front-door" to the crisis system. The rollout of 988 has created similar challenges across Washington State and nationwide. As 988 continues to evolve and grow, having multiple "competing" crisis lines is likely to continue to dilute the system benefits of a centralized call center. This is especially problematic because an effective crisis line can resolve many crisis situations without further involvement from mobile teams. The best-practice role of a regional crisis call center is to serve as a single point-of-contact to dispatch mobile crisis teams in a defined region. Although crisis call center providers did not attend the SIM mapping workshop and may have been able to provide additional insight, it is clear there is considerable confusion across the community. As a result, stakeholders are essentially using one-off and informal processes, rather than a broader, systemic approach to access crisis services. Further, there is a lack of coordination between the crisis line and local providers.[4] Specifically, the crisis line doesn't communicate with local providers about calls they are able to resolve. A formalized feedback loop between the crisis lines and local providers is important to ensure no one falls through the cracks.
- **Mobile Crisis:** While there are a variety of iterations related to mobile crisis teams across the four counties and some are still in the "development" stage, in general there is a lack of consistency, even within the same regions. Most teams are not available 24/7 and there is not a centralized dispatching process in individual counties or the region as a whole. There is significant confusion about how to activate a team as well as varying expectations and inconsistent delivery of mobile crisis responses (i.e., teams do not necessarily respond when activated without further triage, there are unclear expectations on response times, etc.). Staffing seems to be an issue in all of the counties and while DCRs are available across the entire region they do not fill or support a mobile crisis team function in most counties (except Grant). In line with state guidelines, DCRs primarily perform an "assessment" role, rather than a crisis intervention or community stabilization role, responding telephonically or to hospitals and other facilities with limited in-community or home response. This is challenging given significant staffing constraints in the region and, while aligned with Washington State regulations, effectively creates parallel services in an already challenging workforce environment. There is further confusion and barriers regarding workforce for mobile crisis teams that may impact adequately staffing 24/7, since the state expectation is that mobile teams must include a clinician to respond in-person to the community. Combined, these challenges adversely impact the ability of mobile crisis teams to achieve their full potential across the North Central Region and negatively impact law enforcement's ability to divert individuals they encounter.
- **Crisis Stabilization Center/Detox Center:** Currently, there are no crisis stabilization facilities in the region that operate as "no wrong door." There are also no detox centers since The Center for Alcohol and Drug Treatment had to close their unit due to funding gaps. Several of the facility-based solutions (ex. ABHS Parkside) have become challenging to directly access during a crisis (i.e., requiring medical clearance, DCR

[4] Workshop participants were largely unable to articulate which crisis line they were referring to as a point of the discussion.

referrals, not 24/7, etc.). This effectively results in the ED and law enforcement (jail) becoming the de facto solution for many, when less restrictive and cost-effective options would be more appropriate. This is further exacerbated since not all hospitals have sufficient behavioral health beds or staff available. When individuals do seek immediate help, providers often arrange transport out of the region for care. These out-of-county placements require long-distance transportation that frequently doesn't exist, except by law enforcement, EMS, or some local organizations or providers (on a limited basis).

- **Housing:** Limiting housing, group homes, and shelter solutions exist for those with behavioral health needs, especially substance use disorder. While there are a number of shelters across the four counties, few (if any) are low barrier, effectively preventing the vast majority of individuals who may be experiencing a crisis or who come in contact with law-enforcement from having a least-restrictive shelter option available.
- **Transportation:** Due to the large geographic distances involved, access to the resources or facilities that do exist is often not possible. This is further exacerbated by the limited existence of crisis transportation options, other than law enforcement or EMS.
- **Workforce and Cross-Partner Collaboration:** As in most communities across the nation, there is a limited pool of licensed level staff available, especially to do crisis work, often after hours in the community. In addition, while there appears to be strong collaboration and relationships at the "executive level" across the region, there is a need for greater collaboration and partnership at the ground-level between providers, key stakeholders, and governmental partners.
- **PACT/ACT/FACT Services:** Chelan and Douglas Counties report having a PACT Team available, however, the other counties do not as the state controls the rollout of PACT Teams. In addition, there is not a formal process to ensure PACT members are readily identified (i.e., by a centralized call center) so that PACT can respond when an enrolled member is in crisis.
- **Community Awareness:** While there are various gaps in the regional crisis system, there are also a variety of services and resources that are in place (i.e., some providers offer walk-in hours), however, there is not a common understanding or coordinated approach to leveraging them.

Intercept 1: Law-Enforcement/First Responders

Overview

Law enforcement and other first responders disproportionally encounter individuals experiencing behavioral health crises, especially when there are limited community-based crisis services available. When someone doesn't have a clear route to access care in the community, law enforcement is frequently called to help. Once law enforcement is involved, the likelihood of the jail becoming the crisis receiving center escalates dramatically. *Robust and accessible* community-based behavioral health crisis systems (Intercept 0) can help reduce the reliance on law enforcement, however, there will always be a need for law enforcement to have the ability to divert individuals into treatment in lieu of being arrested, when appropriate.

Typically, Intercept 1 incorporates three key areas: 1) CIT training and dispatcher training, 2) the ability for law enforcement to seamlessly access "no wrong door" crisis services, and 3) 911 diversion initiatives (i.e., transfers to 988). In an ideal situation, most individuals can avoid law

enforcement involvement through a robust community crisis system (Intercept 0). However, in situations where law enforcement does encounter individuals in crisis, they must be prepared to identify that behavioral health issues are present, be trained in de-escalation techniques, and be able to divert individuals through rapid "hand-offs" to accessible "no wrong door" community behavioral health crisis services.

Resources

While there are some differences across the four counties, in general the participants identified the following existing resources:

- Most counties are providing two to eight hours of Mental Health Awareness training (as required by the State of Washington).
- Chelan and Douglas Counties have access to the BHU and are also able to activate mobile crisis teams from Catholic Charities during limited hours.
- Grant County is in the process of developing and providing a 40-hour CIT training. Okanogan County is also interested in training officers.
- Chelan and Douglas counties have weekly meetings with the BHU and Catholic Charities and have pathways to utilize the PACT Team and recovery navigators.
- Grant County has access to mobile crisis teams and recovery navigators through Renew.
- The Sheriff's offices have the flexibility to divert individuals, typically based on officer or deputy discretion. They can also cite and release in lieu of booking.

Gaps

- 40-hour Crisis Intervention Team programs currently do not exist and few (if any) officers across the region have attended this training. Grant County is in the process of developing a 40-hour class in 2024. The other counties are not currently planning on sending officers and/or do not feel they have sufficient staffing to send officers to a 40-hour training.
- Dispatchers do not appear to be receiving behavioral health specific training on awareness, identification, and de-escalation.
- There is minimal interest or effort in diverting calls coming into 911 to 988.
- While mobile crisis teams exist across the region, the lack of consistency, access, and awareness of them results in underutilization by law enforcement. This is further exacerbated by the lack of a regional call center that serves as a centralized dispatching center for mobile crisis teams. Flows and processes are not codified nor clear and vary based on time of day as well as individuals involved (i.e., rotating list of mobile crisis team staff numbers, which changes daily, and officers must call if they wish to request a mobile team). In most of the counties, teams are not available 24/7 and do not provide expedited responses to law enforcement (responses can range from several hours to days). This is compounded by the lack of clear expectations and standards for consistent, rapid response and hand-off which greatly limits utilization of the community's behavioral health crisis mobile teams. As a result, law enforcement has created their own BHU to increase access to crisis responses.

- There are limited crisis stabilization centers or solutions (other than EDs) for law enforcement to seamlessly hand off individuals. This is further complicated by the geography of the region and lack of crisis transportation options other than first responders.
- While officers can divert individuals at their discretion and/or utilize citations in lieu of detention, there is no official guidance or policy to support or encourage diversion, when appropriate.
- There is limited utilization of community paramedicine.
- There are limited working relationships between law enforcement and behavioral health service providers. For example, there is a lack of "customer service" and data sharing by community behavioral health crisis service providers (mobile teams, crisis lines), including the monitoring of key metrics such as response rate, response time, and law enforcement release times.
- There is a lack of education and awareness in the community around state legislation regarding law-enforcement responses and realistic expectations.

Intercept 2: Initial Detention/Initial Court Hearings

Overview

Intercept 2 involves efforts to divert individuals to community-based treatment options during the jail intake or booking and initial hearing process. While Intercept 1 attempts pre-jail diversion, for a variety of reasons, this will not always be possible. Some individuals with behavioral health needs will be booked into jail, and Intercept 2 offers an opportunity to identify individuals who may have behavioral health needs and seeks to divert or minimize time in jail during the initial phase of the criminal justice system. This involves opportunities both by corrections and correctional health staff as well as court staff (pre-trial, judge, prosecutor/defense attorney, etc.). Typically, Intercept 2 involves four key areas, including: 1) brief screening and identification tools, 2) deferred prosecution and release to services, 3) linkages to jail-based services, and 4) data matching and coordination.

Resources

Chelan and Douglas counties have implemented numerous processes and, in general, there was agreement amongst participants that there are considerable efforts occurring across the North Central Region. Participants from Chelan and Douglas counties specifically identified the following processes:

- Pre-intake screening incorporating behavioral health related questions (from both law enforcement and jail intake). In addition, county correction and mental health staff conduct walk-throughs to identify individuals displaying potential behavioral health needs while incarcerated.
- Facilitated rounds for individuals with identified behavioral health needs through a weekly Recovery Integration Group meeting that includes representatives from corrections, correctional health, and community providers.
- Adjusted time window for releases from jail to facilitate discharge to services, including modified releases to recovery coaches for warm handoffs.
- Four hours of psychiatric oversight weekly provided by Catholic Charities.

- Processes for providing and continuing medications while individuals are incarcerated.
- Advocacy in court by correctional health clinicians for incarcerated individuals with behavioral health needs.
- Attempting to hire a dedicated employee to work on benefit coordination and transition to community providers in the jail. (Grant County utilizes recovery coaches in the jail to identify individuals who are eligible for services prior to release).
- Ability to maintain and initiate MAT as well as offer Naloxone upon release.
- Ability to share jail roster with MCOs for review.

Gaps

- **Risk Assessments:** While most of the jails conduct pre-booking screening, they are largely focused on health (physical or mental health risks) and do not focus on criminal recidivism risk assessments via a brief screening tool. Thus, the screening tools are useful to identify potential needs that correctional staff need to be aware of, however, do not include a Risk-Need-Responsivity (RNR) lens related to identifying individuals who would be appropriate and benefit from expedited early release efforts.
- **Codified Processes and Communication Between Jail and Initial Hearing Stages:** Currently informal communication and collaboration occurs, however, there is not a codified system to share jail initial observations and findings with the initial court hearing process. In addition, the court system typically relies on factors related to criminal offense, warrant, failure to appear history and violence, but does not incorporate behavioral health/RNR assessment. Jail mental health staff tends to participate and share information with the court during later stages (i.e., in mental health or problem-solving court), but there is not a formal process to coordinate during the preliminary hearing stage, which could expedite early release and diversion.
- **Codified Pre-Trial Diversion Programs or Options and Early or Conditional Release and Release to Services:** There was widespread agreement that the lack of viable and readily accessible community-based treatment services is a large barrier to expedited releases during the initial hearing stages. It was reported that there are no forensic-based residential treatment facilities in the community and very limited access to timely outpatient intakes and services. Courts are hesitant to release individuals early without having a viable treatment option for them.
- **Behavioral Health Staff:** In general, there is a lack of on-site behavioral health staff working in the jail. While this varies somewhat from county to county, there was wide agreement that more in-person behavioral health resources are needed in the jail via additional employees or collaboration with community providers.
- **Citations in Lieu of Arrest:** While law enforcement can provide citations in lieu of arrest, there currently is no official system or program designed to encourage this process for low-level crimes.
- **Data:** While several counties offer or provide their jail booking roster, there is not an official or codified process between the jails, community providers, and MCOs to review and coordinate care for individuals actively engaged in services. In addition, while some staff informally know who is on a PACT team, there is no official data sharing to systemize these processes. Increased awareness of inmates who are currently affiliated with community providers could increase the likelihood and ability to expedite release to

services or deferred prosecution opportunities. This would avoid waiting for individuals to eventually enter into more official mental health or problem-solving courts when released from jail.

Gaps, Prioritization, and Action Planning

Gaps

Towards the end of the SIM mapping workshop, participants identified and agreed upon a list of priorities. Below is list of 14 priorities that the SIM group identified via consensus:

1. Crisis line – fractured/not coordinated
2. Mobile crisis team access, performance, and law enforcement access to mobile teams
3. Crisis stabilization center
4. Crisis detox/sobering solutions
5. Low barrier shelter/housing solutions
6. Crisis transportation
7. Workforce and cross-partner collaboration
8. Community awareness
9. CIT training
10. Dispatch training
11. Community paramedicine
12. Data, info, and performance metric sharing
13. Early/conditional release
14. Release to services

Prioritization of Gaps

Participants were then asked to vote for their top three priorities. These votes were tabulated by total number and by county (Chelan and Douglas, Grant, and Okanogan). The top three priorities were selected for a brief discussion for action planning:

- Chelan and Douglas Counties
    1. Crisis stabilization center
    2. Crisis detox/sobering solutions
    3. Mobile crisis team access
- Grant County
    1. Crisis stabilization center
    2. Crisis detox/sobering solutions
    3. CIT training
- Okanogan County
    1. Crisis stabilization center
    2. Mobile crisis team access
    3. CIT training
- Combined North Central Region
    1. Crisis stabilization center
    2. Crisis detox/sobering solutions
    3. Mobile crisis team access

Action Planning

Since the SIM mapping workshop was only one day and four counties participated, there was not sufficient time to do full strategic planning on key priorities. However, each county had the opportunity to participate in a facilitated discussion around action planning for each of the identified priorities. Additionally, since there are several potential crossovers and synergies between the counties and across the entire North Central Region, the group had a brief discussion about potential opportunities for region-wide collaboration and solutions related to the crisis stabilization center, crisis detox/sobering solutions, mobile crisis team access, and CIT training. Below is what the SIM group discussed:

Priority 1: Crisis Stabilization Center

- Objective: Explore the opportunity to develop a crisis stabilization center that can serve as the “no wrong door” facility for community walk-ins and law enforcement drop-offs.
- Considerations and Key Actions:
    - Define catchment area (one county, several, or all the North Central Region)
    - Explore possible site location and opportunities to leverage existing facilities, buildings, or providers (i.e., Parkside, etc.)
    - Identify funding streams for both capital and ongoing operations/sustainability
    - Develop service model (i.e., voluntary, involuntary, both, detox capable, etc.)
    - Establish community buy-in efforts
    - Identify potential providers with the capacity to operate
- Timeline: Start immediately, goal of completion within two years

Priority 2: Crisis Detox/Sobering Solutions

- Objective: Explore the opportunity to develop a crisis detox center that can serve as a no wrong door solution for the community and law enforcement.
- Considerations and Key Actions:
    - Explore if The Center for Alcohol and Drug Treatment can reinstate accepting walk-in crisis detox admissions (from community and law-enforcement)
    - Define the catchment area (one county, several, or all the North Central Region)
    - Understand if stand-alone crisis detox is needed or if it can be incorporated into crisis stabilization center (i.e., regulations, capacity, etc.)
    - Identify possible site location and opportunities to leverage existing facilities, buildings, or providers (i.e., The Center for Alcohol and Drug Treatment, etc.)
    - Identify funding streams for both capital and ongoing operations/sustainability
    - Develop service model
    - Establish community buy-in efforts
    - Identify potential providers with the capacity to operate
- Timeline: Start immediately, goal of completion within two years

Priority 3: Mobile Crisis Team Access

- Objective: Explore the opportunity to develop or evolve existing resources into effective mobile crisis teams that are readily available to the community and law enforcement.
- Considerations and Key Actions:

  - Identify current status of mobile crisis teams in each region
  - Define the catchment area (i.e., are there opportunities for or efficiencies in cross-county collaboration, dispatching structure, etc.).
  - Develop streamlined processes for community and law-enforcement to request mobile crisis response
  - Investigate potential solutions for workforce gaps and shortages
  - Facilitate collaboration and coordination between the crisis line(s) and mobile crisis teams
  - Facilitate collaboration and coordination between law enforcement and mobile crisis teams
  - Establish community buy-in efforts
- Timeline: Start immediately, goal of completion within one year

Priority 4: Crisis Intervention Team (CIT) Training

- Objective: Explore the opportunity to develop CIT Programs and associated 40-hour training for law enforcement (and related first responders, dispatchers, EMS, probation, etc.)
- Considerations/key actions:
  - Leverage access to the State's CIT Training (CJTC) and explore the development of localized CIT Training
  - Define the catchment area (one county, several, or all the North Central Region)
  - Establish workforce coverage strategies to support the ability to send officers, deputies, correctional staff, and others to 40-hour training
  - Identify local providers, funders, consumers, and advocates to collaborate in developing localized CIT program, associate curriculum, and local crisis resources
  - Explore funding and collaboration opportunities
- Timeline: 2024

Opportunities and Recommendations

Through the efforts of the Regional Diversion Workgroup, the North Central Region is fortunate to have engaged a wide range of community, county, provider, law enforcement, and advocacy organizations who have been working together for many years towards improving the community's behavioral health crisis system and reducing the number of individuals with behavioral health needs in the criminal justice system. ***These foundational efforts are invaluable and have developed not only opportunities for networking and convening, but also productive cross-system collaboration and relationships that are critical to the evolution of the existing system and can address challenges, gaps, and opportunities.*** The stakeholder visits and SIM mapping workshop were extremely valuable. The support and involvement of a wide variety of stakeholders throughout shows the degree to which providers, government, and other institutions are committed to improving the crisis system in the region.

The SIM mapping workshop focused on law enforcement and the justice system in Intercept 1 and Intercept 2. However, any effort to decrease reliance on law enforcement must assume that many people in need are able to access care in Intercept 0 and continue to receive necessary care throughout Intercepts 1 and 2. The SIM process should be part of a structured approach from a system level and should lead to strategic community planning that ensures behavioral health crisis services are available without the necessary involvement of law enforcement. When law enforcement does become involved, Intercepts 1 and 2 should be used to relocate appropriate individuals into the community and decrease reliance on ongoing involvement with the justice system.

There is currently a reliance on law enforcement and EDs for most individuals in behavioral health crisis. Although both are doing their best, neither has the training or tools to effectively perform this function. This has created a situation in which law enforcement is essentially functioning as mobile crisis, and the outcome for many is languishing in the jail or ED for an extended period until care can be arranged, usually out of the region. Behavioral health providers, medical providers, and law enforcement are all working within the existing constraints

and providing good care, but there needs to be a more organized and specific crisis response plan that allows those in need to access behavioral health treatment and be stabilized quickly and effectively.

A community-based crisis system can appropriately manage individuals with all acuities and resolve behavioral health crises quickly. An individual in crisis is often at risk and, as such, responding to help resolve their crisis requires speed and specialized training. An unresolved crisis frequently worsens and the risk to all involved increases. Individuals in crisis are frequently involved in several segments of the system—they may have physical health, mental health, substance use, SDOH, and legal challenges. An effective crisis system must address and be involved with all of these providers and agencies in order to truly resolve an individual's crisis.

The North Central Region is incredibly diverse. The response to an individual in crisis varies across the region and each community has different resources, law enforcement approaches, ED engagement, and community providers. Despite these specific community nuances, there are overall gaps and challenges that a more regional, cooperative, and strategic approach would help resolve.

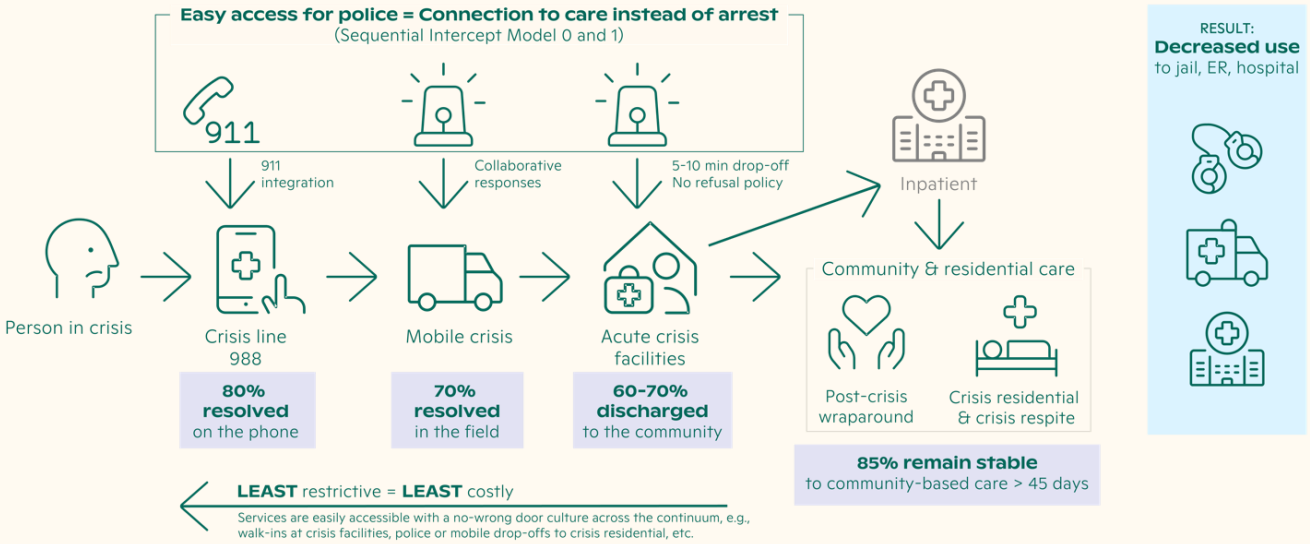
Crisis System Fragmentation

There is a range of crisis services throughout the North Central Region and the counties are committed to improving existing services and increasing opportunities for diversion. However, there are also clear opportunities to expand the crisis system. Critical services are underfunded, and others are absent altogether. The services that do exist are at times challenging for law enforcement and individuals in crisis to navigate due to informal ties linking providers. Relationship-based solutions have been developed over time, and those working in each community know who to call and who might be willing to help. These solutions could be better leveraged with a consistent protocol to access them that can serve the broader community and all members of law enforcement and first responders.

A behavioral health crisis system should function equally well within the ecosystems of law enforcement, the justice system, and the medical system, and should interconnect with all available resources in the community. An individual in crisis frequently has issues that cross several of these systems and no single system can resolve these issues unilaterally. Rather, the crisis system must be able to work closely with all systems while taking responsibility for the individual's care during the crisis. Currently, the responsibility for the individual in acute crisis often lies with either law enforcement, the ED, or both. In many circumstances, neither is staffed nor has the capabilities to truly assess, treat, and resolve the crisis.

In an ideal community-based crisis system, not only are the three core service components present—1) a centralized call center, 2) mobile crisis teams, and 3) crisis stabilization facilities—but these services should work together seamlessly, in essence functioning as a unified crisis system rather than individual services. The crisis system should also take responsibility for the person in crisis in such a way that other parts of the system can rely upon their services.

Figure 2. The Ideal Community-Based Crisis System[5]



The Regional Diversion Workgroup should continue to foster cross-system collaboration to not only add and improve services, but also ensure that these services are working together to increase access to care and reduce law enforcement involvement while maximizing opportunities for cost-savings through the efficient use and collaboration of system resources. Systemizing the crisis continuum and ensuring clear pathways for individuals and law enforcement to access "no-wrong door" care will increase efficiency and opportunities for diversion, foster recovery, and minimize the need for costly or restrictive levels of care such as EDs or inpatient hospitals.

"Someone to Call" – Crisis Call Center

A centralized regional crisis call center (catchment can be defined as city, county, regional, or even statewide) is a critical, foundational component of an effective crisis continuum, even more so with the implementation of 988. This centralized call center should serve as the central entity for assessing and streamlining the dispatch of mobile crisis teams in its catchment area. As previously described, there are current challenges in the regional approach to a crisis call center and a wide array of crisis lines, largely because of changes related to the national and statewide rollout of 988. Each county is experiencing struggles with the current crisis line, and there are efforts underway to improve the situation. However, this is a current barrier, and the region should advocate for and support efforts to resolve it both at the state and local level.

A streamlined, simple pathway to access mobile crisis teams is critical not only for law enforcement but also for broader community access, which supports reducing the need for law

[5] Adapted from: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Psychiatric Services. Epub ahead of print Oct 20, 2021. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000721. (Community stabilization rates are based on FY2019 from the Southern Arizona region and were provided courtesy of Johnnie Gasper at Arizona Complete Health/Centene)

enforcement response in the first place. It also helps to ensure accountability and consistency with expectations, which are critical to ongoing use and success of community crisis services.

"Someone to Respond" – Mobile Crisis Team Access and Performance

Mobile crisis team access was identified as a top priority by all the counties, except for Grant County. As described, there are a variety of resources and gaps related to mobile crisis team services. Best-practice mobile crisis teams are cost-effective crisis solutions designed to respond rapidly to community-based locations via a central dispatch center to promote community stabilization through least-restrictive, person-centered interventions. Primary goals include to:

- Stabilize crises in the field and prevent the need for higher levels of care
- Facilitate transport and warm hand-off to facility-based care when unable to resolve crises in the field
- Reduce the need for law enforcement involvement and support diversion from the criminal justice system when appropriate
- Encourage recovery and connectivity to ongoing timely services to prevent future crises

Effective mobile crisis team models are designed specifically to respond rapidly and directly to individuals experiencing a crisis in the community regardless of age, insurance status, or underlying need. The model seeks to improve community stabilization, while increasing individual and community safety through the delivery of least-restrictive interventions. A critical philosophical element to best-practice mobile crisis teams is that the primary purpose of the intervention is not to merely conduct an evaluation for a higher level of care or involuntary commitment, but rather to stabilize the crisis in the community. Although an evaluation is necessary to achieve community stabilization, it is merely a tool in the process, not the end goal. When possible, the goal of the intervention is community stabilization (i.e., at home, with natural supports, in outpatient clinics, etc.) and when that is not possible, to help connect individuals to least-restrictive facility-based care by directly providing transportation and warm-handoffs.

Key tenets include:

- 24/7 availability
- Inclusion of two-person teams
- Majority of responses to the community occur without the need for a law enforcement co-response
- Centralized streamlined mobile crisis team request and dispatch for community and law enforcement
- Consistent and rapid responses 24/7 across the entire region and expedited and guaranteed responses to law enforcement
- Ability to resolve crisis situations in the field

In addition to discussions and key action steps outlined during the workshop, the North Central Region may wish to consider exploring additional opportunities and options to develop best-practice mobile crisis teams:

- Identify a single call center to serve as a centralized entity for requests and dispatch (each county or group of counties).
- Explore staffing model variations that might be feasible in the region due to workforce shortages, including utilizing bachelor's level clinicians, behavioral health specialists, crisis intervention specialists, or peer support specialists.
- Leverage the role of the licensed mental health professional. Where there are workforce challenges, there may be value in exploring if the licensed mental health professional can be leveraged not only as the agent of the ITA but also as the clinical lead for the crisis team, responding via mobile crisis where needed (similar to Renew's efforts in Grant County). This could potentially create efficiencies by eliminating parallel workforces and may be effective given the nature of the workforce shortages in the North Central Region.
- Maximize efficiency and cost-effectiveness by continuing efforts to align BHU and mobile crisis team responses so combined they can provide the maximum coverage for the community, increasing the ability to provide 24/7 response between both services.
- Convene a meeting with funders, mobile crisis providers, and law enforcement in Okanogan County. Law enforcement has indicated a lack of awareness that mobile crisis teams exist in their community, let alone are available to respond to law enforcement requests. While the mobile crisis program in the county is still in development, through increased communication and collaboration, pilot processes can be implemented to maximize utilization of services, even at the reduced level coverage currently available.
- Expand data sharing capabilities between mobile crisis and law enforcement. Mobile crisis providers should share "customer service" related performance data with law enforcement. Accountability is critical to growing meaningful collaboration and confidence in the value of the service, which is key to increasing utilization by law enforcement. At a minimum, the following data points should be tracked and shared:
    - # of law enforcement requests
    - # of requests responded to immediately
    - Average mobile crisis response time (how quickly mobile crisis arrives on scene after law enforcement request)
    - Average release time of first responders (how quickly mobile crisis releases law enforcement from scene)

"Someplace to Go" – Crisis Stabilization Center

A crisis stabilization center was identified as the top priority by all counties. Crisis stabilization centers fill a critical role as the "someplace to go" in the best-practice crisis continuum. While effective crisis call centers and mobile crisis teams can and should resolve most crises in the field, there will always be individuals with higher acuity needs that require a specialized milieu in which to be evaluated, treated, and ultimately to have their crisis resolved. In the absence of a crisis stabilization center, the burden often falls upon other systems such as the jail or ED, neither of which is equipped to do more than hold someone until they can be admitted elsewhere. It is in the crisis stabilization center that crisis intervention can occur in a safe environment and necessary care coordination and multi-system involvement can be utilized to stabilize and resolve more acute crises. In the absence of such a center, often all that can be

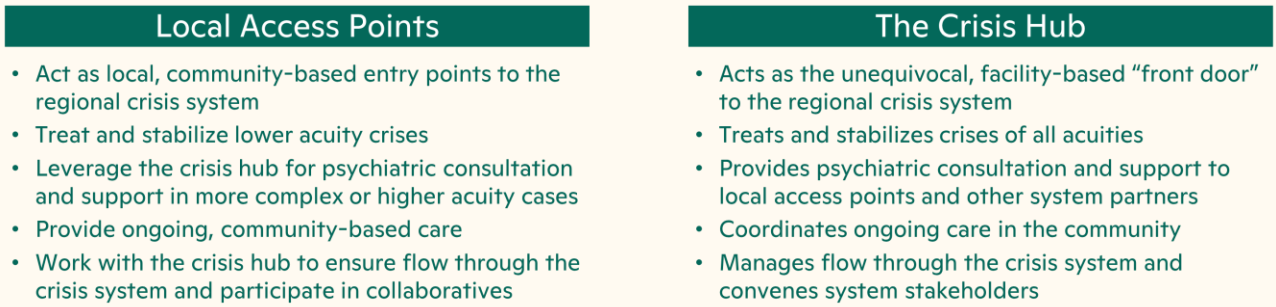
done is attempt to find a hospital bed. Data shows that an effective crisis stabilization center can resolve even the most acute crises without requiring hospital admission.

The North Central Region currently lacks a dedicated place for individuals in crisis to go that is not the ED or jail. Each county and community has developed a pathway for those in crisis, but it frequently demands law enforcement or ED involvement. Some pathways are more effective than others and their efficacy is ultimately dependent on different systems cooperating with each other, the level of which waxes and wanes over time. Addressing this gap would make a significant improvement in the crisis system of the region. However, the population, demographics, and geographic distances involved in North Central Washington create unique challenges to operationalizing a traditional crisis stabilization center model. The Regional Diversion Workgroup could consider a modified approach that may better meet the needs of the region. This approach would maximize the great services already available in each county as well as create a place where individuals could access more acute services when needed.

The Crisis Hub and Local Access Points: A Crisis System of Care

The biggest challenge in creating a regional crisis system and providing more acute crisis services in North Central Washington is the large geography, rural population, and existence of resources that are not evenly distributed throughout. One model to consider is a modified system that leverages local crisis access points throughout the region and creates a central regional crisis hub that works tightly with them to provide support, consultation, and treatment in more complex and acute cases.

Figure 3. Core Crisis System Components and Functions



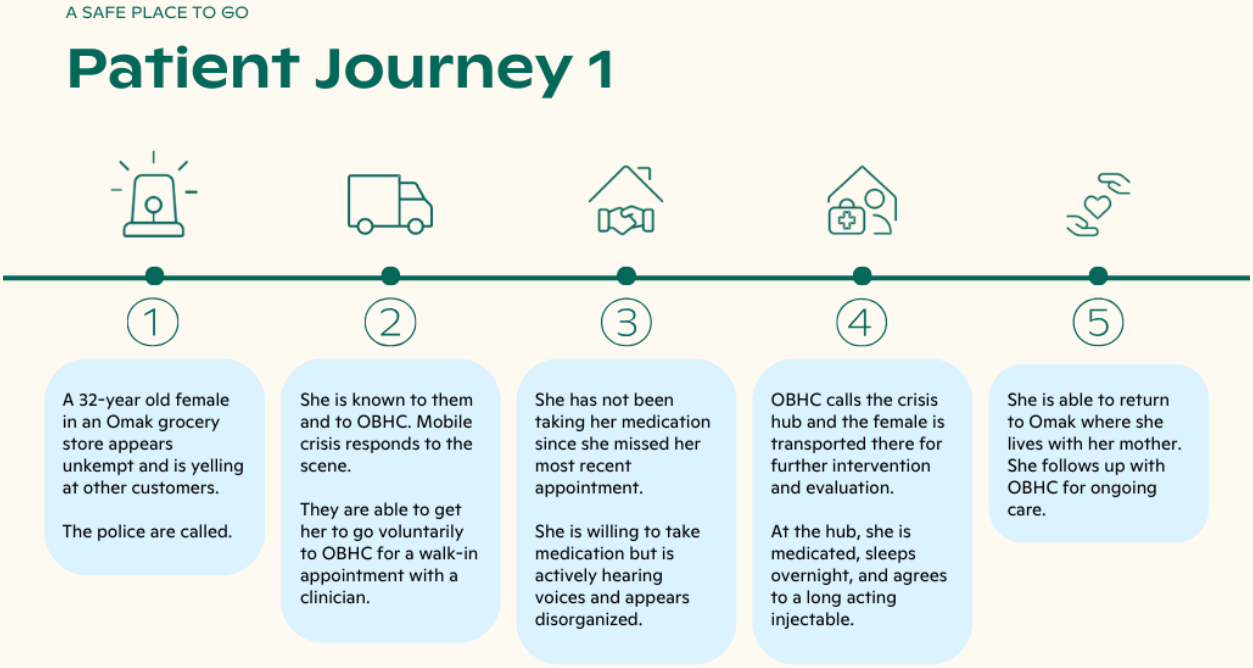
Local, Community-Based Access Points to Care

It is important that community members, first responders, and providers know where to go to immediately access high-acuity crisis care and more intensive services. Given the geographic spread and rural nature of much of the North Central Region, the counties could identify local access points to facilitate connection to crisis care. These access points do not have to be newly created, but rather should leverage the existing network and resources. They should be the logical connections to care in the community, or where people are already encountering services. They should provide immediate access to some level of behavioral health crisis care, although less comprehensive than the regional crisis hub and functioning at a lower level of acuity and need. These local sites should be integrated systemically with the central hub and serve to stabilize and resolve *some* of the crises in the community, while triaging and relying on the hub as needed to stabilize those with higher acuity needs.

Local crisis access points may include the following community resources, amongst others:

- EDs
- Renew, OBHC, Catholic Charities
- FQHCs (such as CVCH)
- Homeless shelters (or other community-based organizations like Room One, CAFÉ, etc.)
- Local jails and law enforcement

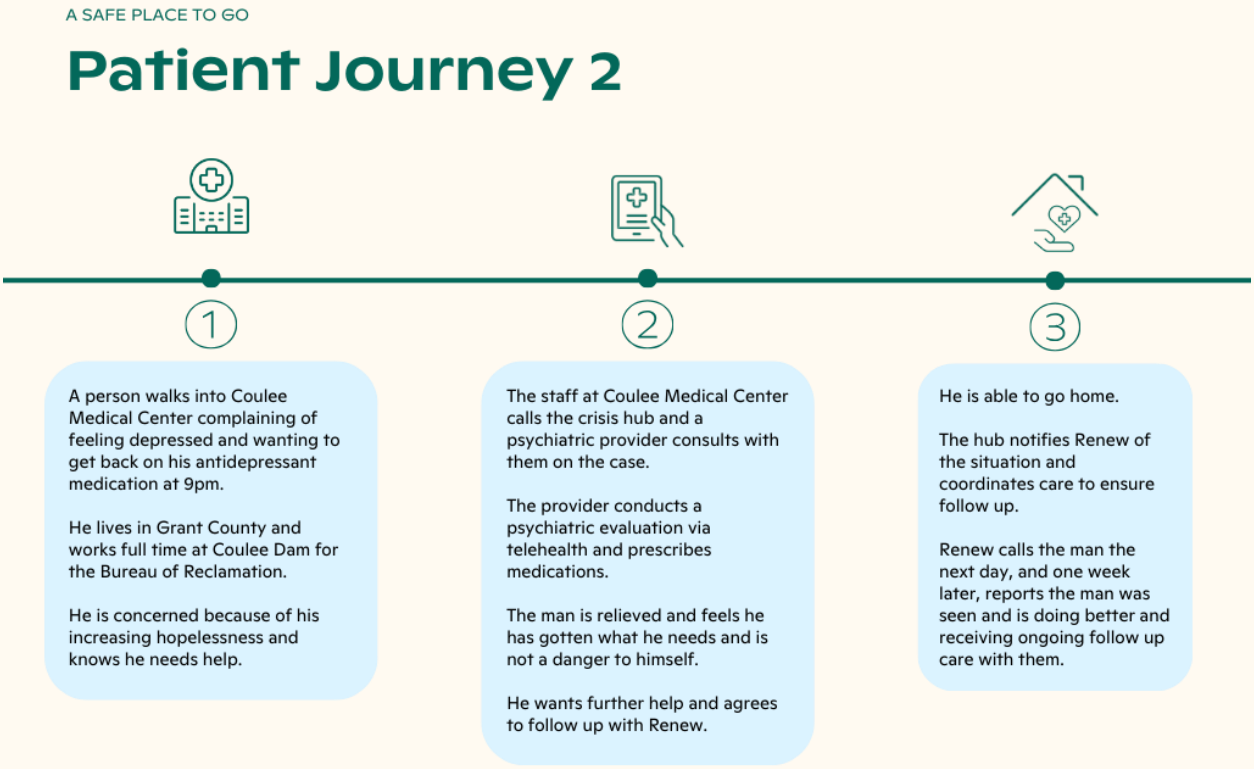
Some access to evaluation and connection with local resources should be available in the community. For example, if a mobile crisis team is unable to resolve a crisis in the field, they should be able to decide whether the individual needs to go to a local access point (in lower complexity or less emergent cases) for ongoing care or whether they need to go to the central crisis hub. The lower complexity level of care is required of some community mental health centers and FQHCs.



The crisis hub should work closely and transparently with the local access points to coordinate care and assist with appropriate triage. The local access points should be able to access the hub for ongoing support, consultation, and guidance in the moment. At any point, clinicians should be able to determine that more intensive interventions are needed and arrange transportation to the hub. Likewise, the hub should work with these sites on discharge and ongoing treatment plans for those in their care.

The crisis hub and the local access points to care should work together to enhance the continuum of care across the region. The level of support the hub offers may vary depending on specific local needs and capabilities but might include embedding a mental health professional or peer in local EDs, community organizations, or outpatient clinics (which is already ongoing in the North Central Region) or providing 24/7 psychiatric consultation services via telehealth.

Likewise, the local access points to care may provide community-based treatment and support, or a place for the hub to refer individuals for ongoing care based on their specific needs.

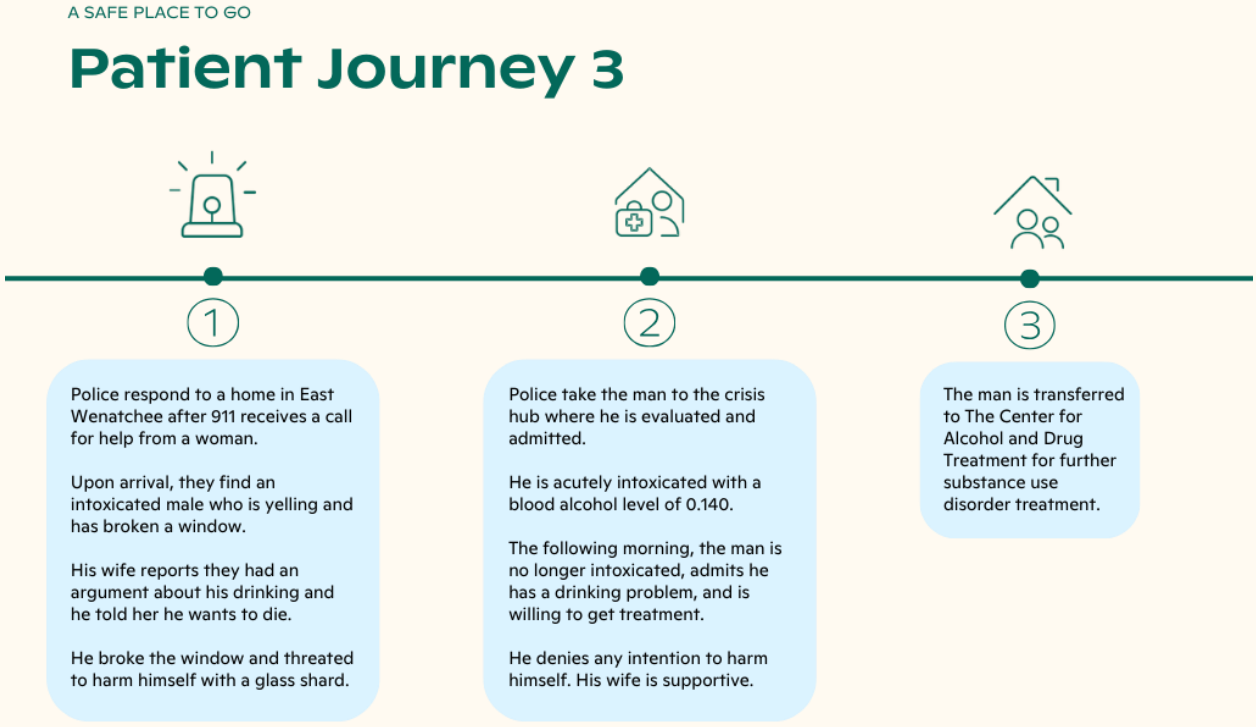


A Regional Behavioral Health Crisis Hub

The North Central Region could establish a regional behavioral health crisis hub in a location accessible to all four counties to supplement the work of the local access points and connect, streamline, and systemize the crisis continuum of care in collaboration with the BH-ASO. This site should:

- Offer a more extensive set of services and be able to accept and treat more complex crisis cases than would be expected of the local access points.
- Have more medical and nursing capabilities to enable the proper treatment of an acute population.
- Provide support and expertise to the local access points via 24/7 telehealth consultation or embedded staff.

Tight coordination between the access points and the hub would allow people to be treated locally when possible, yet have access to a central site that provides higher acuity treatment when needed, still within the North Central Region. The regional hub should be a central, facility-based crisis center that serves as the unequivocal “front door” to the North Central Region’s behavioral health crisis system.



In line with SAMHSA's National Guidelines for Behavioral Health Crisis Care, at a minimum, the regional behavioral health crisis center should:

- Provide 24/7 immediate access to behavioral health care
- Accept everyone, regardless of acuity or insurance status
- Serve individuals with mental health, substance use disorder, or co-occurring disorders
- Allow for anyone to walk in at any time
- Provide a place for law enforcement and other first responders to drop people off
- Accept and expedite all law enforcement and first responder drop-offs
- Not require prior authorization, referral, DCR evaluation, or medical clearance

The crisis center should provide a behavioral health specific treatment milieu that is able to accept people with acute behavioral health challenges, whether voluntary or involuntary, and provide evaluation, treatment, and stabilization. Through immediate intervention and care, the center should be able to stabilize and discharge many individuals back to community-based treatment without requiring a higher level of care. It should significantly decrease the demand on regional EDs and provide law enforcement with an option besides jail when appropriate. The crisis center should take responsibility for the individual in crisis and work across various systems to resolve the complicated factors leading to it. The crisis center should be able to transfer ongoing care to community-based providers once the crisis is stabilized, helping route individuals to the proper services and navigating the different systems they may be involved with.

Features to consider for the crisis center include:

- An unlocked, outpatient behavioral health urgent care setting to serve walk-ins and lower acuity individuals
- A secure unit to treat and stabilize higher acuity individuals (ex. 23-hour observation recliners)
- An additional unit for short-term stays after initial stabilization (ex. crisis stabilization or respite beds)
- A post-acute care program to provide follow-up and warm hand-off to ongoing community resources
- A separate entrance for law enforcement and first responders to drop people off
- An interdisciplinary workforce, inclusive of behavioral health medical providers, nurses, case managers, behavioral health specialists, and peer support specialists
- The ability to initiate medication-assisted treatment for individuals requiring detox (prior to coordinating for further SUD-focused care)

The regional behavioral health crisis center is ultimately just one component of a broader system of care and cannot function effectively without coordinating with all other pieces of the continuum. This is even more important in a region so vast and rural as North Central Washington, where the regional hub may be several hours away from any given person in crisis. The crisis center hub should have visibility and transparency into every aspect of the system and manage the flow of individuals in crisis to ensure no one falls through the cracks. The hub should support the BH-ASO in tracking system outcomes, driving process improvements, and convening cross-functional stakeholders for regional collaboration. In essence, the crisis hub should coordinate across the continuum of care and work closely with the BH-ASO to ultimately create one single, unified, and effective behavioral health crisis system.

Crisis Transportation

Crisis transportation is a common need across the nation and can be especially vital in rural communities with large distances between available resources and services. Transportation is a critical element in accessing services and increasing opportunities for diversion, while reducing the burden on first responders to address what is fundamentally a public health need. There are currently very limited transportation options if law enforcement encounters someone in crisis or if someone in the community who is voluntary and non-violent wants to access care, which may be two to three hours away. This results in either taking a police officer off the streets for several hours to make the trip or activating a high-cost and unnecessary ambulance transport. Perhaps more likely, this often leads to a missed opportunity to connect the individual to care.

During the SIM mapping workshop, there was discussion that Recovery Navigator Programs and coaches can assist individuals with transportation, however, the current model and associated processes do not appear to provide this transportation rapidly. LifeLine Ambulance provides ambulance services in all four counties and primarily utilizes an Advanced Life Support (ALS) response. They do have access to a van for non-medical crisis transportation, however, there is not currently funding or processes in place to provide the service. As the North Central Region continues to expand available crisis-related resources throughout the region, this gap in transportation will become increasingly more important to address.

The North Central Region may want to explore the potential to partner with LifeLine Ambulance for non-medical, crisis transportation via a van or other non-ambulance vehicle. The counties

could also identify opportunities to collaborate with Recovery Navigator Programs to provide streamlined access to urgent transportation options, even if only during business hours. In addition, if the four counties decide to combine resources and efforts on a regional crisis stabilization center, transportation options will need to be incorporated in some fashion to facilitate transportation options that can take several hours from some of the outlying areas of the region.

Other Opportunities and Recommendations

Crisis Intervention Team (CIT) Training

The lack of CIT was identified as a critical gap during the SIM mapping workshop. CIT's motto is "more than just training" and effectively includes five key "legs":

- Law enforcement training (40-hour advanced training, ideally focused on voluntary students, which is largely taught through community instructors)
- Community collaboration that includes law enforcement, providers, consumers, and families
- A vibrant and accessible crisis system that operates with a "no wrong door" approach
- Behavioral health provider training to increase providers' "cultural competency" to effectively work with law enforcement
- Education for families, consumers, and others

While the primary discussions during the workshop were focused on improving behavioral health services and coordination, which are key elements of a CIT Program, services alone will likely not affect changes in policing practice. Without ensuring officers are appropriately trained and "bought-in" to concepts related to recovery, de-escalation, and diversion, additional services alone will likely not lead to increased diversion. It is critical to ensure that at least a subset of officers and deputies have attended the full 40-hour CIT training to meaningfully support pre-jail diversion activities.

Sharing of Booking Roster

Most of the counties have at least some sort of process for sharing their inmate and booking rosters with community providers and MCOs. A key aspect of expediting diversion opportunities during Intercept 2 and supporting re-entry activities during later intercepts is to determine, as rapidly as possible, if individuals are affiliated with ongoing care or community resources. This creates a two-fold benefit, providing the opportunity for providers and funders to "reach-in" while also affording courts the ability for increased planning and coordination for "release to services" dispositions. The counties may want to outreach to key providers and MCOs to explore opportunities to develop more codified processes and increase identification of members with behavioral health needs. Since non-formal processes already exist, this approach may not require added funding or staffing, but rather improving processes and communications with these key treatment stakeholders.

Formalized Information Sharing Between Jail and Initial Appearance

As described, while informal communication and collaboration occurs, there is not currently a codified system to share jail initial observations and findings during the initial hearing court

process. In addition, courts are hesitant to support early or conditional release and “release to services” solutions due to a lack of viable and readily accessible community-based treatment options. The counties may want to explore opportunities and appropriateness of increased communication and sharing of screening and observations between the jail intake and initial hearing stages. While developing release-to-treatment programs and residential facilities was not selected as a key priority focus at the workshop, if the counties are able to engage existing community providers and funders through codified processes to share and review booking rosters, and if initial hearing courts are made aware of screening and service connections by jail intake staff, the court may be able to increase opportunities for expedited releases through improved communication and coordination until the development of community-based forensic service programs is possible.

Summary

Connections conducted in-person stakeholder visits and a SIM mapping workshop in the North Central Washington Region to help assess the regional behavioral health system and understand how community stakeholders perceive key gaps and resources in Chelan, Douglas, Grant, and Okanogan counties. Each county differs greatly in geography, demographics, available resources, and provision of services, however, existing providers and community organizations are doing incredible work across the region to help the individuals they serve. While there are a variety of services and providers, there is ultimately a lack of collaboration and coordination between them both within individual counties and across the region. Further, the region lacks one central, facility-based “front door” to the crisis system where anyone can walk in or be dropped off by law enforcement and immediately access behavioral health care. The region has many strong components in the behavioral health crisis continuum but ultimately does not have a cohesive, unified, and comprehensive system, and the jail and the ED are the primary sites carrying the burden as a result.

A best-practice and ideal crisis system has three main components that offer the community *Someone to Call, Someone to Respond, and Someplace to Go,* including:

- Regional Crisis Call Center
- Mobile Crisis Teams
- Crisis Stabilization Centers

While the North Central Region has the first two components—a regional crisis call center and mobile crisis teams—there is more work to be done to ensure they are functioning effectively as part of a broader system. There is a lack of coordination and communication between 988/the regional call center and local providers, and several additional crisis lines that complicate and confuse the pathway to telephonic crisis resolution and mobile crisis dispatch. The region should consider working to streamline the crisis call system aligned with any state efforts to enhance the centralized crisis call center and create a simple pathway to access.

There has been great progress in the development of mobile crisis teams in every county, however, the way they function and the coverage they provide differs across the region. Best-practice mobile crisis teams can resolve many crises in the field, reducing the need for more costly and often restrictive levels of care. The region should consider further investing in bolstering their existing mobile crisis teams to ensure 24/7 coverage, response in the community, and ability to stabilize crises in the field

The North Central Region lacks the third and final component to the ideal crisis system: someplace to go. Stakeholders across the region identified and agreed upon the need for a regional behavioral health crisis center that can serve both walk-ins and law enforcement drop-offs from all four counties. Given the vast geography of the region, the region should consider taking a modified approach that leverages local, community-based access points to care and creates a central crisis hub that coordinates and collaborates with them to provide support, consultation, and ongoing treatment in more complex and acute cases.

The North Central Region is well-positioned to improve and build upon the current behavioral health crisis system and increase opportunities to divert individuals with mental health and substance use disorder from the criminal justice system into treatment through their Regional Diversion Workgroup. The state of Washington is in a pivotal moment in which funding for and implementation of evidence-based crisis care models is at the forefront. This past legislative session, the state passed Senate Bill 5120 to create a new 23-hour crisis relief center level of care in line with national best practices. The state also previously passed legislation[6] to require commercial payers to cover crisis services and the Health Care Authority (HCA) has convened a workgroup to explore pathways to sustainable funding for crisis stabilization services, including capacity funding. These efforts and more are creating mechanisms for communities across the state to implement crisis solutions that provide 24/7 access to care for all, regardless of acuity or insurance status, and without requiring medical clearance or referral.

The counties should consider taking advantage of the movement happening at the state level and plug into conversations at the HCA around crisis services funding to ensure the sustainable implementation of a crisis center and other services in the North Central Region. They should also continue to build on the incredible work started by the Regional Diversion Workgroup and the progress made in the planning of the crisis system over the past few years. While building out the ideal crisis system is costly and time intensive, there are several lower cost, lower effort ways the North Central Region can begin improving the existing system of care right now. These include addressing system-wide fragmentation, exploring the creation of crisis transportation solutions, bolstering CIT training, sharing jail booking rosters, and creating more formalized information sharing between jail and initial appearance (as well as across other systems).

Through the formation of the Regional Diversion Workgroup, the region has already established the multi-county and cross-stakeholder buy-in and collaboration that is needed to develop a regional crisis continuum of care. ***The North Central Region ultimately has what it takes to create a best-practice crisis system that could serve as a national model for rural communities across the country.***

[6] Engrossed Second Substitute House Bill 1688