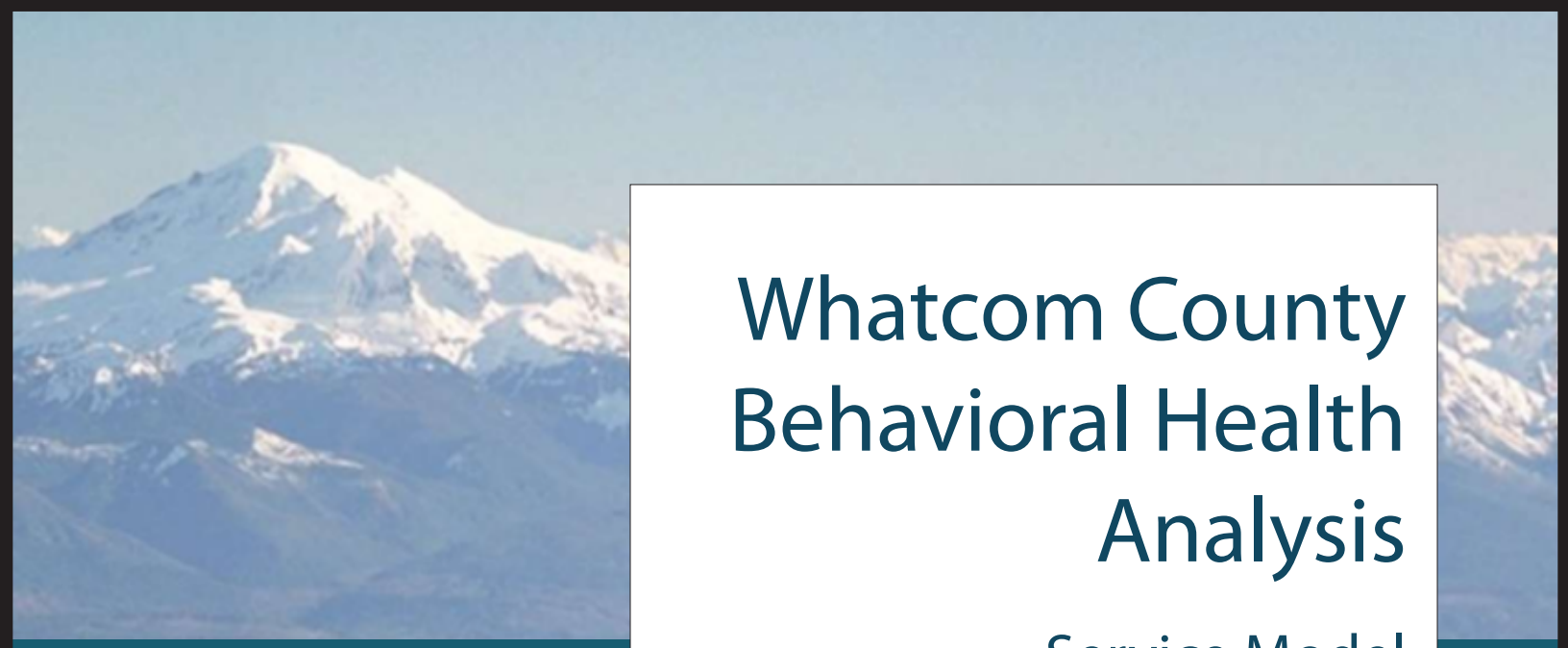

Whatcom County Behavioral Health Analysis

Service Model Recommendations for a Proposed Behavioral Care Center

developed for

WHATCOM COUNTY HEALTH AND COMMUNITY SERVICES

Final Report
March 20, 2026

Prosecutorial Diversion Addendum Pending

stv

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The consultant team would like to sincerely thank the project stakeholders for your contributions to this project. Your thoughtful and sincere dedication to those who require care the most in Whatcom County is clear and is key to this project's success.

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List of Acronyms

ADDD	Automated Drug Dispensing Device
ADP	Average Daily Population
ALOS	Average Length of Stay
APRN	Advanced Practice Registered Nurse
ART	Alternative Response Team
BCC	Behavioral Care Center
BCJDPM	Bexar County Jail Diversion Program Model
BHT	Behavioral Health Technician
CCC	Crisis Care Center
CHP	Correctional Health Partners (Whatcom County Jail health care provider)
COD	Co-Occurring Disorders
CPT	Current Procedural Terminology
CRC	Crisis Relief Center (23-Hour)
CSU	Crisis Stabilization Unit
DCR	Designated Crisis Responder
DOH	Department of Health
DSHS	Department of Social & Health Services
ED	Emergency Department
EMS	Emergency Medical Services
E&T	Evaluation & Treatment
FTE	Full-Time Employee
GRACE	Ground-Level Response and Coordinated Engagement program
IOP	Intensive Outpatient Program
IST	Incompetent to Stand Trial
LCSW	Licensed Clinical Social Worker
LEAD	Law Enforcement Assisted Diversion (also known as “Let Everyone Advance with Dignity”)
LMFT	Licensed Marriage & Family Therapist
LOS	Length of Stay
LPC	Licensed Professional Counselor
LVN	Licensed Vocational Nurse
LWC	Lake Whatcom Center
MAT	Medication-Assisted Treatment
MCOT	Mobile Crisis Outreach Team
MD	Medical Director
MHP	Mental Health Professional
MOUD	Medications for Opioid Use Disorder
NS-BHASO	North Sound Behavioral Health Administrative Services Organization
OFM	Office of Financial Management

PA	Physician's Assistant
PHP	Partial Hospitalization Program
PHS	Pioneer Human Services
PNP	Psychiatric Nurse Practitioner
PUC	Psychiatric Urgent Care
RCW	Revised Code of Washington
RN	Registered Nurse
RTF	Residential Treatment Facility
SIM	Sequential Intercept Model
SRSC	Spokane Regional Stabilization Center
SUD	Substance Use Disorder
TASC	Treatment Alternatives for Safe Communities
WAC	Washington Administrative Code
WCD	Whatcom Community Detox
WCHCS	Whatcom County Health & Community Services

Executive Summary

Purpose of this Report

This purpose of this report is to present the analysis, findings, and recommendations for the delivery of behavioral health and substance use disorder services within a consolidated Behavioral Care Center (BCC) serving Whatcom County residents. The BCC is intended to serve community members who are in behavioral health crisis, are experiencing substance use challenges (or both), and require immediate intervention. Many individuals experiencing such events are also vulnerable to criminal-legal system involvement, and a major goal of the proposed BCC is to serve as a deflection option for first responders, where individuals can be brought for treatment services in lieu of the jail.

Additionally, the BCC's proposed Co-Occurring Disorders (COD) facility is presented as a potentially significant alternative to incarceration through its availability as a placement option for prosecutorial diversion, where an individual can be released from a carceral setting on condition that they participate in and complete an individualized treatment program within the COD facility. Both pre-arrest deflection and post-arrest diversion options are presented in the sections that follow.

Overview of Methods

The study team consists of facility planning professionals with deep experience in projecting the needs for justice and behavioral health services. The principal methods employed for this study include:

- Interviews with client representatives and service providers to establish goals, objectives and needs (see the Introduction for additional detail).
- Visits to and observations of operations at current, related county facilities.
- Review of state-of-the-art facilities nationwide.
- Analysis of demographic and service provision data for current facilities and statistical projections of future needs.

In addition, the team applied its expertise to interpret current and future needs in light of Whatcom County's objectives and resources.

Summary of Findings

Recommended Services

The following are recommended for inclusion in the BCC:

Crisis Relief Center: a 23-hour crisis relief center is a place for immediate support for people suffering mental health or substance use crises.[1] The program is intended to avert psychiatric emergency room visits and involuntary hospitalization by providing voluntary crisis emergency services to adults presenting in distress or severe intoxication.

Principal services include:

- Psychiatric care: the CRC functions as a walk-in clinic for individuals with an urgent mental health need.
- SUD treatment: the CRC will provide services to address substance use crises.
- Minor medical care: the CRC will have the capacity to deliver care for minor, nonlife-threatening treatment for those arriving at the BCC for a mental health and/or substance use challenge.

Co-Occurring Disorders Facility: an inpatient treatment facility that provides an integrated approach to the simultaneous treatment of behavioral health and substance use conditions. A treatment team delivers medication management, behavioral therapies, therapeutic communities, and support groups to improve outcomes, reduce symptoms, and prevent relapse.

Principal services include:

- Comprehensive assessment: comprehensive diagnostics are key to identify all service needs clearly and determine if or how they interact.
- Behavioral therapy: evidence-based, trauma-informed approaches, such as cognitive behavioral therapy (CBT) and contingency management to change thinking and help patients build strong coping skills and manage self-harm.
- Substance Use Treatment: structured care for people who need medical supervision, stabilization, and intensive therapy for substance use disorder.
- Medication management: access to psychiatric medications to manage mental health symptoms and, if needed, medications for withdrawal or addiction treatment.

[1] WAC 246-341-0901, WAC 246-341-1140.

A Psychiatric Urgent Care (PUC) would provide services on a voluntary, walk-in basis to adults who are experiencing a mental health or substance abuse crisis, regardless of ability to pay. The demand for Psychiatric Urgent Care services was analyzed, and it was determined that there is insufficient demand for a standalone facility at this time. PUC functions have, therefore, been included as part of the functions of the CRC with the recommendation that demand be revisited as county population grows over the next 15 to 20 years. Throughout this report, reference to the CRC includes PUC functions.

Capacity Demand/Programming Recommendations

The following bed capacities are recommended:

Table 1: Recommended Bed Capacity

Function	Beds*	Comments
Crisis Relief Center	22	Includes behavioral health crisis, sobering, and PUC clients.
Co-Occurring Disorders Facility	32	Two units of 16 beds.

*"Beds" for the CRC include cots, beds, recliners or any other dedicated seating/lying space for clients.

Deflection and Diversion Opportunities

The recommended facility options reflect the County's strong commitment to reducing the jail population for those who can effectively be deflected or diverted from incarceration and have their problems addressed in the community. The CRC adds an option that will provide the network of outreach teams and first responders with a new type of resource to deflect potential subjects of law enforcement responses away from jail. It provides a one-stop drop-off that both expands community-based behavioral health and substance use disorder resources which can reduce demand on the jail for those who do not pose a risk to the community. The COD facility will provide a new treatment program to support prosecutorial diversion and community need, as well as more ambitious use of diversion and the support of ongoing treatment for those who have been deflected from the legal system at the CRC.

There was specific interest in the impacts of increased prosecutorial diversion on:

- Reducing jail ADP
- Bed demand at the COD facility.

An additional data collection effort is underway by the county at time of publication of this report. Upon receipt and analysis of the data, estimates of jail ADP reduction and COD

facility bed demand based on utilization of this facility for prosecutorial diversion will be included as Attachment B to this report.

Licensure Requirements

Crisis Relief Center: CRCs must meet the requirements outlined for outpatient crisis services in WAC 246-341-0901 and for crisis relief centers in RCW 71.24.916. The Washington Department of Health licenses a Crisis Relief Center as a Behavioral Health Agency.

Co-Occurring Disorders Facility: The COD will be licensed at the Residential Treatment Facility (RTF) level of license. Requirements for this license are outlined in WAC 246-341-0300 and WAC 246-341-1105.

Operational Costs

For both the CRC and the COD facility, staffing costs are based on a salary survey of similar positions in Washington State and Whatcom County. Each position was calculated at the median point of the range of the survey. To estimate total operating costs, a 70% staffing, 30% "other" ratio was utilized.

Table 2: Estimated Operating Costs

Facility Breakdown	Estimated Cost
CRC	
Staffing	$5,154,308.00
Other Operating Costs	$2,208,990.00
CRC TOTAL	**$7,363,298.00**
COD Facility	
Staffing	$3,652,392.00
Other Operating Costs	$1,565,310.00
COD Facility TOTAL	**$5,217,702.00**
Total BCC Estimated Operating Costs: CRC and COD Functions	**$12,581,100.00**

Cost Reimbursements

The consultant team analyzed the impact that payer reimbursements, particularly Medicaid, would have on BCC revenues:

Table 3: BCC Reimbursements Breakdown and Estimate by Payer

Payer	Percent of Adults	Percent Utilization	Percent of Payments	Estimated Payments
Medicaid	15%	37%	37%	$4,654,900.00
Medicare	19%	23%	23%	$2,893,700.00
Private Insurance	57%	22%	31%	$3,900,100.00
Out-of-Pocket	2%	2%	2%	$251,700.00
Subtotal	**93%**	**84%**	**93%**	**$11,700,400.00**
Uncovered	7%	16%	7%	$880,600.00
Total	**100%**	**100%**	**100%**	**$12,581,000.00**

There are significant caveats around the estimation of reimbursements, including the percentages applies to each payer and the likelihood that some payers will pay at all. In evaluation of potential funding that the county will need to contribute annually to the BCC, absence of payments from certain payers could significantly increase the funding gap that the county will need to cover.

Additional Recommendations

During the course of this project, additional topics were raised that may justify further study.

Twenty-Four Hour Pharmacy: A major identified gap in the system of care identified was the absence of a 24-hour pharmacy and, at times, an available prescriber. CRC licensing will require that medication access be available on a 24-hour, seven-day per week basis, making it imperative that the county investigate integrating access to a 24-hour pharmacy into their plans for the BCC. (An Automated Dispensing Device (ADDD) may serve such purpose.)

Day Treatment Programs: Another need most reported by service providers is supportive outpatient treatment or monitored follow-up care, and many providers referred to previously existing day treatment centers. The consultant team recommends exploring the feasibility of bringing these services back to the community.

Incompetent to Stand Trial (IST) Population: The consultant team was not tasked with analyzing the IST population as part of the scope of this work but recommends examination of the service demands for this population.

The report that follows provides details on the topics outlined above.

Introduction

Whatcom County: Basic Information

Whatcom County is the 12th most populous county in Washington State, with a population of approximately 227,000 residents. It encompasses a geographical area of 2,100 square miles with a density of 107 people per square mile. The County Seat and largest city in the county is Bellingham, with a population of approximately 95,000 people. The following two most populous cities are Lynden, with just over 16,000 residents and Ferndale, with just under 16,000 residents.[2]

Whatcom County is also home to two tribal nations, the Lummi and the Nooksack.[3] The County is located on the US northern border adjacent to the North Cascade National Park and Canada, with six border crossings.

Purpose of the Study

The purpose of this study is to develop need-based service recommendations for a Behavioral Care Center (BCC), focusing on mental health and substance use treatment for county residents. The consultant team has been tasked to investigate how a BCC can best interface with the county's criminal legal system to support opportunities for deflection and diversion from incarceration.

The highest priorities that were evaluated for potential inclusion in the BCC are:

- 23-Hour Crisis Relief Center (CRC).
- Co-Occurring Disorders (COD) - mental health and substance use disorder inpatient treatment.
- Psychiatric Urgent Care (PUC).

For the recommended services, this study provides the following:

- Estimated bed count based on forecasts of demand.
- Deflection and/or diversion opportunities.
- Licensure considerations.
- Staffing requirements and costs.

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[2] https://www.census.gov/quickfacts/fact/table/whatcomcountywashington,bellinghamcitywashington/PST045223.

[3] https://goia.wa.gov/tribal-directory/federally-recognized-tribes-washington-state.

- Overall estimated operating costs.

The location of the future BCC has been established at 2000 Division Street, Bellingham. This is a vacant site adjacent to the Anne Deacon Center for Hope, which provides excellent opportunities for the BCC to coordinate with existing services.

Several additional considerations are discussed based on input received during interviews with agency representatives and service providers as well as evolving best practices, which the consultant team believes are key to meeting the goal of expanding deflection and diversion opportunities for system-involved (or would-be system-involved) county residents who qualify for such out-of-custody options.

Note: In much of the previous documentation on a proposed BCC, the name "Behavioral Care Center (BCC)" refers specifically to co-occurring mental health and substance use disorder inpatient treatment beds. In this report, the BCC is an umbrella term referring to the facility that is proposed to house co-occurring treatment, crisis relief, and other potential future functions.

Process

The Owner's Representative, STV, Inc., retained Erin Persky & Associates (EP&A) to develop this needs assessment and feasibility analysis for the BCC to inform the Design-Build Team's subsequent programming and design efforts.

Work commenced in December 2025 with an in-person Crisis & Treatment Leadership Team kickoff meeting attended by representatives of several county agencies and third-party community-based service providers, including:

- Whatcom County Health & Community Services (WCHCS)
- North Sound Behavioral Health Administrative Services Organization (NS-BHASO)
- Lake Whatcom Center (LWC)
- Alternative Response Team (ART)
- Ground-Level Response and Coordination Engagement (GRACE) program
- Law Enforcement Assisted Diversion (or Let Everyone Advance with Dignity – LEAD)
- Lummi Nation – Behavioral Health
- Pioneer Human Services – Substance Use Disorder Services
- Compass Health
    - Crisis Triage
    - Mobile Crisis Outreach Teams (MCOTs)
    - Designated Crisis Responders (DCRs)

Remote follow-up meetings with service providers were completed as needed and additional meetings were held with agencies not present at the kickoff meeting to glean a fuller picture of the breadth of services available, perceived gaps in care, and their vision for optimized treatment opportunities for system-involved or vulnerable county residents. Other service providers and agencies interviewed include:

- Peace Health, providing inpatient mental health services at St. Joseph's Hospital
- Emergency Medical Services/Community Paramedics
    - Whatcom County Fire Department
    - Bellingham Fire Department
- Compass Health Mobile Crisis Outreach Team management team

Data Obtained and Limitations

Data were gathered to analyze demand for the proposed CRC, COD facility, and Psychiatric Urgent Care. Data obtained included:

- A joint study of emergency department (ED) admissions identifying annual cases that did not require an ED level of care by Peace Health and Compass Health.
- 2025 data workbook for the CSU (Compass Triage).
- 2025 data workbook for Whatcom Community Detox.
- 2024-25 behavioral health analysis data for ART.
- Seven monthly summaries of MCOT contacts and dispositions.
- Six-month count of cases eligible for COD treatment by Lake Whatcom Center.
- Emergency Services referrals to Peace Health and Compass Triage for the Bellingham area.

There were a few notable overlaps between data sets. For example, the data workbooks for the Compass Triage and Whatcom Community Detox identified referrals from Peace Health, which were easy to adjust for. It was similarly easy to adjust for ART referrals in the Compass Triage data. There were unreported hand-offs in both directions between DCR investigators and voluntary MCOT teams that were considered negligible. Overall, duplication was determined to have an insignificant impact on results.

There were also a couple of notable gaps in data. The Compass Triage and Community Detox summaries also noted law enforcement drop-offs, but these represented a small portion of law enforcement contacts. This tended to underrepresent demand.

Rather than spend extensive time trying to acquire data that was not readily available from the major sources of referrals, the analysis focused on establishing that there was

sufficient demand to justify each program, leaving the possibility that demand could be higher. This is considered in the bed need recommendations for the CRC and the COD facility.

Concurrent with these analyses, a branch of the EP&A team completed a quantitative analysis which resulted in a forensic reconstruction of the county's jail population, culminating in two distinct time series forecasts of its future population. The results of that analysis are presented in a separate report, *Whatcom County Jail Population Forecast Analysis,* which informed relevant portions of the BCC.

Prosecutorial Diversion

The BCC has also been identified as an alternative to traditional case disposition. Law enforcement, the Prosecuting Attorney's Office, the Public Defender's Office, and other key state and county stakeholders are interested in exploring the potential for the Co-Occurring Disorders (COD) facility of the BCC to function as a prosecutorial diversion placement for those with mental health and substance use disorders.

- Diversion of individuals from traditional carceral or other sanctions and into treatment at the COD facility may occur at several points in the legal process, including booking, first appearance, and post-charge/pre-trial through a conditional release order, and post-disposition as part of sentencing. The release orders for the first three entry points would all be conditional upon one's successful completion of their individualized treatment plan at the COD. If the individual completes the program charges may not be filed or could be dropped. If the treatment program is used as a sentence, the individual would be given time served for completion of the program.[4]

This report analyzes impacts of a prosecutorial program on two fronts:

- Its potential to reduce jail bed demand and by approximately how much.
- An estimate of approximate bed demand for the BCC.

[4] Correspondence regarding legal process, January 14, 2026.

National Trends & Models

This section begins with a description of jail deflection and diversion, distinguishing between the two and providing a foundation for the service model recommendations presented in the following sections of this report.

Next, this section provides descriptions of mental health and substance use disorder service models from around the country that are relevant to Whatcom County's immediate and long-term goals for its proposed Behavioral Care Center. These facilities were chosen because of their strong reputations and track records for successful outcomes. There are similarities and differences between the programs described below and those proposed for the BCC, but each is a strong example that should be referenced as any jurisdiction plans to expand their deflection and diversion service offerings. Sources of information about these services include communications with service providers and online materials. The following four counties are included:

- Bexar County, Texas: The Center for Health Care Services
- Davidson County, Tennessee: Behavioral Care Center
- Yavapai County, Arizona: Connections Center
- Spokane County, Washington: Regional Crisis Stabilization Center

Jail Deflection and Diversion

The Treatment Alternatives for Safe Communities' (TASC) Center for Health and Justice coined the term "deflection" in 2014. TASC created the new term to distinguish the emerging field from the more-established word, "diversion."[5]

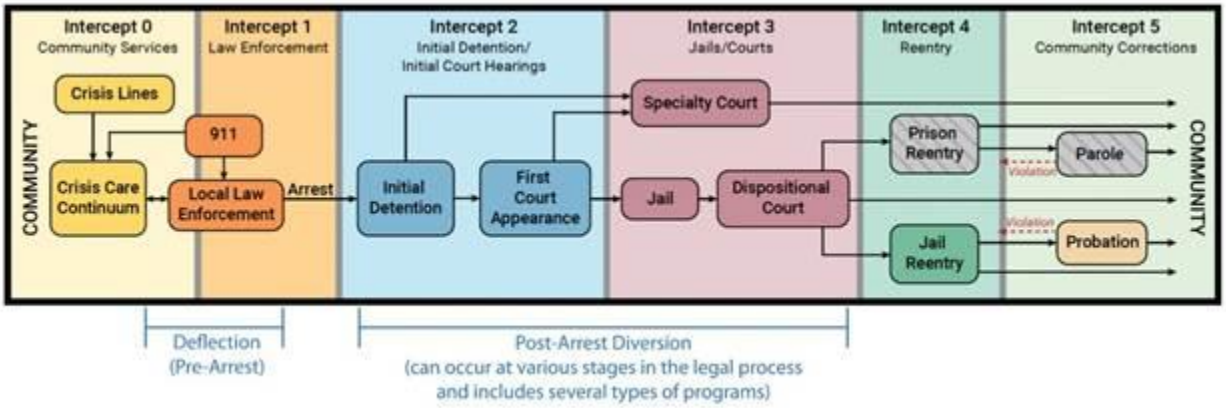
Traditional pre-trial diversion programs are post-arrest, meaning the individual has engaged with the criminal legal system. Diversion may include pre-charge, post-charge/pre-first appearance, or pre-adjudication alternatives to individuals in lieu of incarceration. Popular diversion programs include treatment courts or in- or out- patient treatment programs. Completion of programs may yield a dismissal of charges, while failure to complete a program may result in a sentence of incarceration.

Deflection (or "pre-arrest diversion"), by contrast, applies to interactions with individuals before those they become involved with the criminal legal system. Primarily aimed toward

[5] https://centerforhealthandjustice.org/chjweb/tertiary_page.aspx?id=62&title=Law-Enforcement-&-Pre-arrest-Diversion.

those with mental health or substance-use challenges, deflection programs provide services for those whose potential system involvement is considered to have derived from an acute underlying mental health or substance use disorder which led to (or may lead to) law enforcement interaction. Law enforcement or other first responders will have the option of bringing the individual to the deflection service or to the jail based on their assessment of the individual during their encounter.[6]

Figure 1: Sequential Intercept Model



Deflection and diversion both are becoming more widely used, as societal support for moving people out of the justice system, particularly those with mental health and substance use disorders associated with their criminogenic behavior, has increased significantly over the past ten to fifteen years. Post-arrest diversion has more established "roots" in legal systems, with implementations such as mental health treatment program, substance use disorder treatment programs, or therapeutic courts (as they are called in Whatcom County), but deflection – which keeps individuals out of jail entirely – has become a more intriguing option in recent years, as health care costs in carceral settings can be crippling, as is the added pressure the high number of high-need, vulnerable individuals causes correctional and health care staff.

Evolution in Medicaid reimbursements through section 1115 waivers may alleviate some burden, but pre-arrest deflection options and early post-arrest diversion options hold more promise for keeping those, who would not be in the legal system if not for their underlying conditions, out of the criminal legal system, at earlier intercepts. Not only does earlier "off-ramping" save costs and mitigate jail staffing challenges, but it aligns more closely with trauma-informed, human-centered philosophies of care that oppose criminalizing illness.

[6] https://documents.ncsl.org/wwwncsl/Criminal-Justice/Deflection-Diversion-f02.pdf.

This BCC has the potential to advance the practice of person-centered care for Whatcom County residents whose underlying illnesses may make them vulnerable to criminal legal system involvement. Whatcom County boasts robust community-based crisis teams that use alternatives to incarceration when appropriate, and they have expressed the desire to use them more frequently. This report looks at deflection opportunities that the BCC can provide beginning at intercepts 0 and 1.

Example 1: Bexar County, Texas: *The Center for Health Care Services*

The Bexar County Jail Diversion Program Model (BCJDPM) was designed and developed through an expansive effort of community leaders and stakeholders to address the jail how to more thoughtfully manage individuals with mental health or substance use issues and to minimize arrest and booking of those who, by their conduct, are subject to being charged with a minor non-violent criminal offense.

This effort led to the establishment of guidelines that enabled officers to exercise discretion over deflecting non-violent, misdemeanor detainees with apparent mental health or substance abuse use challenges into community-based crisis care. The development of the 23-Hour Crisis Care Center (CCC) was one of a number of pre-booking deflection resources, which also include a community crisis care hotline, mobile crisis teams, and crisis-trained law enforcement officers. Deflection guidelines were created to help officers easily make decisions and officers were trained on procedures for deciding when to deflect an individual to this care center.

Note that when this facility opened, *diversion* was still the predominant term for all types of system "off-ramping." The term *deflection* was not commonly used until later.

Services

The 23-Hour Crisis Care Center facility functions primarily for law enforcement drop-off, though a number of services (not all) also take public walk-ins. Each month over 1,400 people are connected to care in an effort to reduce arrests and emergency room visits. Law enforcement wait times have been reduced from several hours at the hospital and jail, to five to fifteen minutes at the CCC.

Building upon the success of the original CCC, more programs have been added to the campus space:

- The Extended Observation Unit provides 24-hour, 7 day per week assessments and intervention services addressing psychiatric crisis leading to crisis resolution, extended observation and referral to alternative care settings. The EOU has 16 beds

and takes both voluntary and involuntary patients. Involuntary holds are determined by treatment staff. This unit accepts walk-in clients.

- A minor medical clinic that provides 24-hour care with immediate access for law enforcement to obtain a medical clearance and for treatment of people detained and injured during the apprehension process. This area is reserved for law enforcement drop-off only; no walk-ins are accepted.
- The Substance Use Withdrawal Management program, which has a capacity of 18 within the sobering unit (for less than 24-hour lengths of stay on sobering mats and easy chairs) plus a 28-bed detoxification unit (20 male, 8 female) with a length of stay of three to seven days. Patients are accepted 24/7. Walk-ins are accepted for detox but not at the sobering unit. All services are voluntary. The detox unit only takes individuals with Medicaid or who are unfunded.

Adjacent to these three units, the CCC also has a number of outpatient programs. They include:

- Opioid Addiction Treatment Services, a licensed narcotic treatment program
- Office-Based Opioid Treatment, Suboxone only
- Intensive Outpatient (IOP) mental health treatment
- Mommies program
- Drug Court/probation reporting
- Ambulatory detox and SUD treatment.

Across the street from the CCC is Haven for Hope, which provides residential treatment for substance use disorders. Individuals seen at the CCC often receive ongoing services at Haven for Hope.

Staffing

The CCC is open and staffed 24 hours per day, seven days per week. Clinical and administrative staff are county employees, security staff are contracted providers, and transport (ambulance) is provided by a contracted vendor. Including both inpatient and outpatient components, the CCC requires approximately 90 clinical and administrative staff.

"Blueprint for Success"

The publication "Blueprint For Success: The Bexar County Model (How to set up a jail diversion program in your community),"[7] was developed to share the success of the Bexar County model for other jurisdictions wanting to follow suit. It provides a roadmap for successful deflection program start up.

Example 2: Davidson County, Tennessee: *Behavioral Care Center*

The Davidson County Sheriff's Office Behavioral Care Center (BCC) is a state-licensed adult supportive treatment facility providing gender-responsive, trauma-informed care to residents in a short-term residential setting as an alternative to jail. Residents who successfully complete the program will not face criminal charges and will be provided resources for continuation of care.

The BCC is a 60-bed facility that can house 30 males and 30 females. At maximum capacity, it is estimated that the facility will impact 1,500-2,000 individuals annually. The facility is designed to be a treatment setting rather than a correctional one.

Program

The Davidson County Sheriff's Office works in collaboration with the Metropolitan Nashville Police Department, the District Attorney, and the Metropolitan Public Defender toward the goal of decriminalizing mental illness. These agencies, along with Wellpath and the Mental Health Cooperative implement needs assessments and guidelines to determine which arrestees qualify for treatment at the BCC.

Criteria for admission to the BCC include:

- Mental health or substance use disorder diagnosis
- Misdemeanor and felony charge level
- Acuity level low enough to actively participate in programming.

Qualifying individuals will be diverted to the BCC rather than jail and will begin the process of decriminalizing their arrest.

[7] https://www.whatcomcounty.us/DocumentCenter/View/636/Jail-Diversion-Toolkit-PDF.

Treatment Planning

Each resident receives an individualized treatment plan upon arrival at the BCC. Therapists use assessment tools to determine targeted areas of focus during treatment and anticipated length of stay.

Figure 2: Davidson County BCC Services

After stabilization at the BCC, the discharge specialist's goal is to connect each resident with community resources and ensure continuity of care. Residents receive follow-up calls after discharge to confirm their plan is still working and to provide additional services as needed.

From the perspective of the jail, locating a 60-bed unit for individuals with serious and persistent mental illness outside of the jail, near jail's booking area helps staff evaluate arrestees' emotional and psychological needs at the early stages of processing. The mental health facility has medical and program spaces for therapy. It provides a pleasant environment for visits with family members and healthcare staff.

Example 3: Yavapai County, Arizona: *Connections Center*

Yavapai County, AZ is a rural county located to the north of Phoenix, with a population of approximately 200,000. They recognized a systemic problem in their community several years ago, whereby those who were in behavioral health crises were being arrested due to manifestations of their mental illnesses or intoxication (e.g., drunk in public, trespassing, disorderly conduct). Often, these individuals were being taken to jail for behavior that would not have been a crime had the police not responded; for example, a citizen calls about bizarre behavior, police respond, and the person with serious mental illness lashes out at the officer.

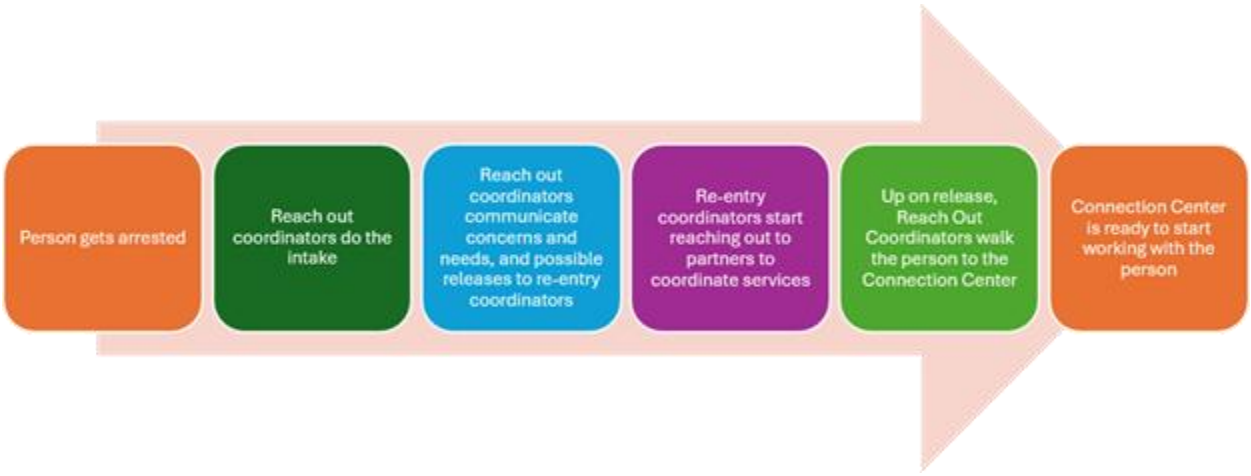
The Yavapai County Connections Center is a new facility separate from, but adjacent to and coordinated with, the new Yavapai Criminal Justice Center in Prescott, Arizona. The Connections Center is run by Yavapai County Health Services, in collaboration with the Sheriff and the Justice and Mental Health Coalition. It opened in the summer of 2023. It is part of a coordinated program to reduce unnecessary incarceration and achieve better

outcomes by addressing all appropriate needs in the community rather than in the jail. In addition to the jail, the Criminal Justice Center accommodates courts (eliminating the need to transport detainees to the downtown courthouse) and related justice agency staff (e.g., probation).

The Connections Center currently serves individuals who are being released from custody and reentering the community through assistance with referrals and other services. In addition, they have a separate crisis stabilization unit that law enforcement uses for deflection options, as well as a mobile crisis team.

The re-entry portion of the center provides a location for community agencies to meet releasing citizens, conduct on-site intakes, assessments, and other care management services to support behavioral health, housing, veterans services, employment, transportation, and other needs.

Figure 3: Yavapai Process Model



Yavapai deals with involuntary commitments, as well. Providing such service may be something that Whatcom would benefit from evaluating and has been included as an option for the Co-Occurring Disorder facility in the BCC.

Example 4: Spokane County, Washington: *Spokane Regional Stabilization Center*

Spokane County is located at the easternmost edge of Washington State, bordering Idaho. It is the fourth most populous county in Washington State, with approximately 550,000 residents, including the 2,900 enrolled members of the Spokane Tribe of Indians.[89]

The Spokane Regional Stabilization Center (SRSC) is the first jail deflection center in the State of Washington. This collaboration was spearheaded in 2017 by the Spokane County Regional Law & Justice Council, and includes representatives from Spokane County, local municipalities of the Spokane Regional Service Area (RSA), and their contracted provider, Pioneer Human Services.[10] SRSC's mission is to focus on chronic recidivism prevention and recovery for those grappling with serious mental illness or substance use disorder. The SRSC's approach is to deliver medically necessary behavioral health treatment and facilitate a smooth transition to reentry care, including housing, employment, and case management. Its capacity includes:

- 16 withdrawal management beds with a length of stay from three to seven days.
- 16 crisis stabilization beds with a length of stay from three to 10 days.
- 16 co-occurring disorder treatment beds with a length of stay of up to 60 days.

SRSC referrals are accepted from law enforcement, hospitals, and community agencies; walk-ins are not permitted. First responders can bring non-violent individuals directly to the SRSC for comprehensive treatment in lieu of the county jail, provided they agree to participate in services and meet the eligibility criteria for jail deflection. The facility is open to residents of the RSA service region, but at times receives individuals from Coeur d'Alene and other travelers to the area. Thus far, law enforcement has been the primary source of referrals. Nursing staff must medically clear all individuals upon arrival, prior to intake. Trueblood class members are prioritized for admission to the extent possible. The facility does not require a crime to have been committed for admission.

The SRSC is located on a county-owned site that contains three buildings. The county is in the process of expanding the SRSC to include a Crisis Relief & Sobering Center, providing 23-hour care, and will be open for public access.

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[8] U.S. Census Bureau QuickFacts: Spokane Valley city, Washington; Spokane County, Washington.

[9] Spokane Tribe of Indians – Improving the lives of our Members.

[10] Criminal Justice Reforms | Spokane County, WA.

Existing Whatcom County Service Offerings

Introduction

The County is fortunate to be able to offer a wide variety of effective programs at many levels and stages. The following are brief descriptions of the main services offered in the county which address behavioral health and substance use challenges and are most relevant to this study's focus. These descriptions are summarized from the relevant sections of the County's website, each provider's website, and interviews conducted for this study. The text that follows reports on services provided and perceived gaps or shortfalls that are evaluated in context of the development of service recommendations for the proposed BCC and discussed in the subsequent sections of this report.

Outreach Services

Whatcom County has a number of outreach teams serving various populations and geographic areas. They all share a common general purpose, which is to provide a community-based response to people who are having difficulties or are in crisis for mental health or behavioral issues, substance use disorders, or other causes. Their over-arching goals are to get these individuals their needed services in the most efficient and effective way in the community (and thus to prevent or avoid involvement with the criminal justice system).

There are five main teams providing these services, each of which is described in more detail on the pages that follow.

- Mobile Crisis Outreach Teams (MCOTs) and Designated Crisis Responders (DCRs)
- Ground-Level Response and Coordinated Engagement (GRACE) program
- Law Enforcement Assisted Diversion (LEAD)
- Alternative Response Team (ART)
- Community Paramedics (EMS - Emergency Medical Services)

Mobile Crisis Outreach Teams (MCOTs) and Designated Crisis Responders (DCRs)

MCOTs and DCRs are described together because they are part of the same program serving two segments of the population (and both are operated by the same provider, Compass Health). MCOTs serve patients on a voluntary basis, while DCRs can detain involuntarily, if that is justified by the degree of seriousness.

Mobile Crisis Outreach Teams (MCOTs) are available to help those in the community experiencing a crisis due to mental illness and/or substance use issues. They are professionals trained to evaluate a person's need for safety, de-escalate a crisis, provide information and education, and refer people to community behavioral health services if they need additional support.

MCOT consists of behavioral health providers, including mental health professionals, certified peer counselors, and substance use disorder professionals. They collaborate with the individual in crisis and their family members and/or support network to develop a plan to get through the current crisis, manage future crises, and progress toward recovery. The goal of MCOT is to provide support in the least restrictive manner possible.

The Designated Crisis Responders (DCRs) provide a legal assessment of grave disability and/or danger to self or others due to a mental health or substance use disorder for possible involuntary admission to a behavioral health facility if it is determined that they are unable to engage in safety planning and crisis stabilization on a voluntary basis. Upon determining that an individual meets the legal criteria, DCRs may detain an individual to an available psychiatric or SUD bed for up to 120 hours.

As a component of the evaluation, it must be determined that other less restrictive options for stabilization of the crisis have been ruled out or deemed inappropriate. Additionally, it is expected that the investigation include attempts to interview other significant professional and community providers who have worked with the client as well as reviewing the client's behavioral health history to develop a more complete picture of their current needs.

Ground-Level Response and Coordinated Engagement (GRACE)

The GRACE program seeks to find alternative solutions for individuals who are high utilizers of emergency and criminal justice system services, typically with six or more contacts in a year. GRACE serves people dealing with multiple and complex issues, including disabilities, medical problems, mental or behavioral health needs, substance use and lack of housing.

The aim is to offer intensive, coordinated services to these "familiar faces" whose needs reach beyond what can be provided by a single agency. Referrals come from paramedics, law enforcement officers, hospital workers, the jail, and social services.

Intensive case managers support community service providers in finding those services that respond to the complex and particular needs of GRACE clients. The GRACE team works with fire departments, law enforcement agencies, and emergency medical services to identify potential clients. GRACE then facilitates connecting these clients to the care

they need, seeking to reduce reliance on emergency services and gain access to effective care in order to help them build a more stable, independent life.

Case managers develop a "community support plan" for each client to ensure coordinated services and ongoing support. They may drive members to appointments, assist with intakes, and coordinate services. In addition, a mobile nurse practitioner offers medical care visits.

In some cases, GRACE provides an alternative to arrest and incarceration for persons with multiple contacts with law enforcement. It may also assist with reentry referrals on release from custody for client who have been incarcerated.

GRACE staffing consists of five intensive case managers. Two are at the Bellingham PD, two are at the Bellingham Fire Department, and one is in the office. They are funded by tax revenue and consider themselves to be understaffed. Reported gaps in services are significant, with a current wait list of 135 (of which, 130 have had eight or more contacts per year). Issues are reported with required spending limits prior to placement, particularly for the aging population. Essential Health & Community Services assessments can be also lag.

Law Enforcement Assisted Diversion (LEAD)

LEAD (also known as *Let Everyone Advance with Dignity*) enhances safety, health, and equity through community-based alternatives to arrest and incarceration for people whose unlawful behavior stems from unmanaged substance use, mental health challenges, or extreme poverty. It can function pre-arrest as a deflection from jail or post-arrest as a re-entry and diversion program.

LEAD focuses on recovery navigation by providing intensive case management for people who have had one or two interactions with law enforcement per year (compared to GRACE, whose participants may have had many more) that do or might result in low-level criminal offenses emanating from mental health challenges, substance use, homelessness and extreme poverty.

After joining the program, members get help with their immediate needs, which may be a meal, place to sleep, or clean clothes. They then continue building a relationship with their case manager to deal with the roots of their challenges and can get help with needs that are difficult to manage alone, including stable housing, medication management, drug treatment, job opportunities, and family reconciliation. A wide range of governmental, justice and community organizations participate in the LEAD partnership.

Alternative Response Team (ART)

Unlike GRACE and LEAD, ART provides short-term, rapid response and deflection to people in an immediate crisis and is limited to Bellingham. The program sends two behavioral health specialists to respond to non-violent behavioral health-related 911 calls from people having an immediate or emergent crisis, including mental health, substance use, or the inability to care for themselves. It frees police staff to respond to other emergent calls requiring law enforcement intervention.

Examples of 911 calls ART would respond to include:

- A person outside in the wintertime without proper clothing.
- Someone who is having a mental health crisis and is not a threat to themselves or others.
- Someone who needs immediate transportation to help solve their crisis; e.g., help getting to the crisis triage center, detox facility, or from the hospital back to their home.
- People experiencing homelessness or living in a hoarding situation, and locations with needles or other drug paraphernalia.

ART is a collaborative effort by state, regional, and local agencies, including the Whatcom County Health and Community Services' Response Systems Division, the City of Bellingham, What-Comm Dispatch, and Compass Health.

The full ART team consists of seven behavioral health specialists plus a manager. Teams of two respond to non-violent mental health 911 calls instead of a police officer. Their function is to stabilize the individual in the field and make a referral to the appropriate program, potentially transporting them directly to it. ART also has a staff member embedded at 911 Dispatch to help screen calls that are appropriate for it to respond to.

The program operates Monday through Friday, from 8 am to 6 pm, which limits its ability to meet needs at other times. If more staffing were available, it could extend hours to 8 or 9 pm and weekends, which data show could raise program effectiveness.

Community Paramedics (EMS - Emergency Medical Services)

Community paramedics are provided by the fire departments to offer support for people who frequently call 911 (and may make from 14 to 115 calls per year) for complex medical issues (but of lower acuity and which may not require a hospital visit or advanced life support in the field), substance abuse, mental illness, complications related to aging, disability, fall risks, and/or homelessness. After a person has made several 911 calls,

community paramedics begin working to connect them with services that can better meet their needs. The primary goals are to provide more appropriate community-based services and to reduce demand on the hospital emergency room.

These paramedics currently work out of the Bellingham Fire Department (serving the city) and Whatcom County Fire Department Station 7 in Ferndale (serving the balance of the county – a total of 11 fire precincts). Staff consist of a total of two paramedics and one case manager (who is in Bellingham) who get referrals internally (85% come from the fire department) and the hospital (15%). Many are referred to GRACE for services.

The paramedics may transport clients to care providers or, if the needs are greater, refer them to MCOT. They identified the need for a "true first door" that could take any case needing stabilization (such as the CRC should provide, supplementing current Anne Deacon services). They also expressed a degree of frustration about the limitations on services available to meet client needs.

Anne Deacon Center for Hope

The Anne Deacon Center for Hope is a crisis stabilization center serving adults in Whatcom County and the North Sound Region. It offers short term, inpatient mental health support and substance use disorder services in two interconnected facilities:

- Crisis Triage and Stabilization Center, which provides voluntary assistance to those experiencing a mental health crisis and helps them restore and stabilize their health.
- Community Detox, which provides a monitored inpatient setting for safe withdrawal from alcohol and other drugs as well as substance use disorder assessments and referrals to treatment.

Crisis Triage and Stabilization Center

This is a short-stay facility for individuals in a behavioral health crisis, providing support in a safe, recovery-oriented setting. It offers assessment and short-term treatment to support the resumption of typical levels of functioning. Multi-disciplinary teams of peer counselors, mental health technicians, clinicians, nurses, and psychiatric providers coordinate to address each patient's needs.

The Center can accommodate up to 16 individuals who are experiencing a mental health crisis. It provides crisis stabilization, safety planning, and referrals for ongoing care. Individuals may self-refer or be referred by a community partner such as an outreach team, behavioral health provider, hospital social worker, or medical provider. The facility can also

accept drop-offs from law enforcement and emergency medical technicians as a deflection alternative to jail or the emergency room. It is operated by Compass Health under contract to the County.

Triage is a voluntary program for individuals in crisis who need the additional support of 24/7 staffing to manage their safety and stability. Lengths of stay can vary from hours to several days (3-7 days) and is dependent on the individual's needs. During their stay, patients are assessed by both a mental health professional and a nurse. Individually tailored care plans are developed to help them meet their unique needs.

Triage provides a vital component of the continuum of care. Its goals are to ensure ready access in a crisis to a supportive, stable environment; to reduce the need for individuals to go to EDs for care; to create alternatives to jail for individuals whose disruptive behavior may be the result of their behavioral health condition; and to create a step-down option for individuals transitioning back to the community from a higher level of care such as a psychiatric hospitalization.

Community Detox

Community Detox offers a safe and supportive environment for adults withdrawing from alcohol or drug use. The facility provides 24/7 care and serves as a starting point for recovery. Operated by Pioneer Services, it has a capacity of 16 beds and accepts a variety of insurance programs. Referral sources can include the clients themselves or their family or friends, law enforcement, hospitals or healthcare providers, and mental health providers or agencies. Services include:

- Safe detox: supervised support for withdrawal from alcohol and other drugs.
- Medication-assisted treatment (MAT): supportive medications such as Suboxone to aid in withdrawal and recovery.
- Referrals to treatment: connections to long-term recovery programs.

Patients usually stay for three to seven days and then transition to the next step of treatment, either residential or outpatient, based on their medical needs. The treatment team consists of advanced registered nurse practitioners (ARNPs), licensed mental health counselors, substance use professionals, and peer support specialists.

Peace Health, St. Joseph's Hospital - Inpatient Behavioral Health Services

In addition to immediate psychiatric services provided in the emergency department, Peace Health offers acute inpatient psychiatric care for adults on either a voluntary or involuntary basis. They have a 20-bed unit, which is reported to typically operate at about 75% of capacity with an average length of stay of about nine days. Staffing follows a 1:5 ratio of RNs to patients plus mental health associates, recreational therapists, physicians, and support staff. In addition to the hospital's general license, the psych unit operates under an Evaluation and Treatment (E&T) license. Its services include:

- Psychiatric assessment, evaluation, and treatment
- 24-hour nursing care
- Recreational therapy assessment
- Individual and group therapy
- Social work assessment
- Discharge planning.

There is no formal co-occurring disorders program at this facility.

Referrals are accepted either through a physician, a mental health provider, or from the county triage system, including outreach services. The majority of patients are referred from the ED following a formal assessment.

The ED also provides medication injections for incarcerated psychiatric patients transported by guards for this purpose from the jail where they cannot be forcibly medicated. These patients often reach the hospital in a highly decompensated state.

Upon discharge, referrals are made to community services. Most patients leave with appointments, some step down to crisis triage at the Anne Deacon Center for Hope, and a small percentage go to long-term care.

This facility is particularly helpful as a component of the system of care because it can take patients with wounds, who use durable medical equipment, or who pose an imminent danger to themselves or others. However, it appears that there are gaps in the availability of longer-term treatment upon release from the hospital including both inpatient and outpatient options. Other gaps in care include those tailored to the special needs of geriatric and adolescent populations (the latter is beyond the scope of this study), and those with a focus on individuals who lose functional independence and face challenges with guardianship and placement.

Lake Whatcom Center

Lake Whatcom Residential and Treatment Center (LWC), is a licensed not-for-profit organization providing an array of residential and community mental health services to adults with severe and persistent mental illness in Whatcom County. They provide assistance with psychiatric and medical care, housing, employment and education, help with financial and legal issues, and social and personal growth. They serve as an important referral source for social and mental health services as well as jail diversion and reentry.

Lake Whatcom has a total of 49 staff across all its programs and serves over 750 clients.

Their services are in substantial demand, and they are only able to admit a total of three clients per week (while turning away another three to five walk-in clients for evaluation). This limitation has led to reductions in referrals by some agencies, though the demand is still present.

Facilities most relevant to this report's objectives are described below: Baker Creek Residential Treatment Facility and Maplewood Enhanced Services Facility. Others are outlined at the end of this section.

Baker Creek Residential Treatment Facility

Baker Creek is a co-occurring, 34-bed facility providing 24/7 clinical support for individuals diagnosed with persistent mental illness and substance use challenges. It offers psychiatric, MAT, and counseling services through an integrated approach facilitated by qualified professionals including clinical and medical staff. Primary services include:

- Comprehensive screening.
- Medication-Assisted Treatment (MAT) coordinated with psychosocial services.
- Mental health and substance abuse counseling for treatment and relapse prevention.
- Motivational interventions in basic living skills, nutrition, health, mindfulness, recreation, and recovery lifestyle groups.

Baker Creek has a typical population of approximately 23 clients (roughly two-thirds of its capacity) and operates with a total of nine staff.

Maplewood Enhanced Services Facility

Maplewood is a 16-bed facility specializing in providing recovery-oriented, community-based residential behavioral health services to individuals transitioning out of a hospital, inpatient or institutional setting who would otherwise have no other placement options due

to their experiencing complex behavioral, medical, chemical dependency and/or mental health needs but who do not require continued acute inpatient treatment. Currently, referrals are taken from Eastern and Western state hospitals in Spokane and Pierce counties, respectively.

Maplewood provides more intensive services than what are available in a typical adult family home or assisted living facility. Primary services include:

- Daily activities and community engagement.
- Person-centered service planning with behavioral health and crisis prevention emphasis.
- Onsite nursing services available 24/7.
- Individual rooms and meals prepared at the facility daily.

Other Lake Whatcom Facilities and Programs

Agate Heights and Alabama House are being merged into one facility, to be called Birchwood. Agate Heights is a non-traditional 67-bed assisted living facility providing 24/7 staff supervision to clients experiencing severe and persistent mental illness in a residential treatment setting. Residential treatment offers a safe location for clients to receive mental health treatment in a community-like setting. Alabama House offers assisted living and services with 12 beds.

The Orchard Outpatient Office offers the following services:

- Community Case Management
- Intensive Outpatient Program (IOP)
- Program for Assertive Community Treatment
- Employment Services
- Treatment Services
- Administration.

Lummi Tribal Health Center

The tribal health center serves the Lummi tribe's approximately 6,000 members and sees about 800 people per month. In addition to general health-related services, the center provides a wide range of behavioral health and substance use services.

Many tribal members are living unhoused (in the range of 65-100), and the unhoused tend to have greater behavioral health needs. The tribe currently has 30 housing units plus 10 tiny homes (40 total), and they anticipate funding for additional portable and mobile units.

They have a total of 16 clinicians (full-time and part-time staff) including a tribal-designated crisis responder (DCR) and a walk-in counselor available to see two intakes each day. However, they have about a two-month backlog for intakes and need to increase staffing to respond.

Gaps in services include being able to treat those with high acuity needs especially in the fall, winter, and early spring who are suffering from Seasonal Affective Disorder and other mental health conditions, such as bipolar disorder or schizophrenia, which are exacerbated in the colder, darker months.

Conclusion

Understanding of the array of services provided in Whatcom County was critical for the consultant team's current investigations. There are a number of services not described here (see Whatcom County's SIM in Attachment A of this report), such as those focused on outreach to unhoused populations, certain involuntary, residential, and outpatient programs, adolescent and youth programs, and others. The team believes that the proposed BCC has the potential to reach many vulnerable populations in the county who most require care.

Service Model Recommendations

Introduction

The Whatcom County Behavioral Care Center is intended to round out and complement the extensive services already provided by the County's behavioral health system. This system primarily deals with behavioral health and substance use disorders (SUDs).

This study's principal goals are to help the county define more precisely which services are needed and to quantify the levels of service required.

A key goal of the study is to help the County provide as robust a set of services as possible in those early SIM intercepts (levels 0 or 1), where users come into contact with the general health and justice systems in order to support deflection to services in the community rather than more expensive and restrictive accommodation in hospital or the jail.

A more specific goal is to assess the level of jail population reduction that a prosecutorial diversion program might support to move people out of the system at SIM Intercept 2.

The analysis identifies gaps and quantifies demand through user group interactions and statistical inquiry.

The consultant team was initially charged with studying three principal candidate facility types: a crisis relief center, a co-occurring disorders program, and a psychiatric urgent care. Each is described briefly below, and the results of our analyses are summarized.

The **23-Hour Crisis Relief Center (CRC)** would be the "first door" for the mental health care system where first responders and outreach workers can bring clients who are suffering from mental health crises and/or substance use challenges for initial assessment and intervention. Individuals also have the option of voluntarily accessing services at this location. Within less than 24 hours (per licensing limitations), they would be referred out to treatment. Evaluation of demand for crisis care and sobering yielded approximately 35 clients daily, with up to 22 at any given time. This CRC would be in addition to the existing Crisis Triage and Stabilization Center at the Anne Deacon Center for Hope.

The **Co-Occurring Disorders (COD) Facility**: The COD facility would provide treatment for mental health or substance use and comorbid disorders. Evaluation of current demand yielded a need for a 32-bed COD inpatient treatment program. Expected population growth would increase demand for an additional 16-bed unit before 2045. Preliminary analysis

indicated that this facility, in conjunction with a prosecutorial diversion program, could reduce jail population by about 16 beds.

The **Psychiatric Urgent Care** (PUC) was intended as a crisis response for very short-term outpatient evaluation and treatment in a clinic setting. The decision point is whether these services need to stand alone or be incorporated into another facility as a separate function. When demand was evaluated for these outpatient psychiatric services, it was found to be low enough for the foreseeable future, determining that this demand could be met as a function of the CRC.

The detailed analyses and results are presented on the following pages.

Crisis Relief Center

Description

A 23-hour Crisis Relief Center (CRC) is a resource for individuals experiencing a mental health or substance use crisis. The facility would provide an initial assessment of needs, short-term intervention and stabilization, medical clearances for law enforcement, and connection to community resources or referrals to a higher level of care, as needed. This type of crisis response aims to fill current gaps or long wait times for needed services by providing an alternative to hospital emergency rooms, detention facilities or longer-term in-patient care. As shown below, this analysis strongly supports the creation of a CRC.

The Washington Administration Code (WAC) 246-341-0903 establishes certification standards for a 23-hour crisis relief center and defines it as "a place for Immediate support for mental health or substance use crisis.[11] One of the requirements of the WAC is that patients not spend more than 24 hours in the facility (which is why it is referred to below as a "23-hour facility," meaning that they can stay for up to 23 hours and 59 minutes.

This model has found success in other states and counties, by reducing unnecessary trips to the ER and providing an alternative to incarceration or frustration built from waiting for other inpatient care. The Bexar County model described earlier in this report is one example of this model's success.

Principal Services

- All care is based on a trauma-informed care model to ensure that individuals feel safe and supported. This reduces the potential for re-traumatization and promotes a trusting environment.
- Psychiatric Care: the CRC functions as a walk-in clinic for individuals with an urgent mental health need. It offers a client-centered program that focuses on providing immediate relief to individuals and families in distress.
- SUD Treatment: the CRC will provide services to address substance use crises, which may include referral to inpatient treatment for withdrawal management.
- Medical Care: the CRC will have the capacity to deliver care for minor, nonlife-threatening wounds, and for most minor physical or basic health needs that can be identified and addressed through a nursing assessment. The provision of onsite

[11] WAC 246-341-0901, WAC 246-341-1140.

pharmacy services is addressed in the *Additional Considerations* section of this report.

Key Features

- Walk-in/Drop-off: people can arrive at the CRC by themselves, with family, or be brought by police, EMTs, or outreach teams. Individuals will not be refused unless they are not cooperative or need to be evaluated medically in the emergency room.
- Alternative Care: the CRC provides a less restrictive option than emergency rooms or incarceration.
- Multidisciplinary Teams: the CRC is staffed by mental health professionals, SUD counselors, crisis providers, nurses, and peer counselors.
- Community Connection: the CRC provides post-stabilization referrals to longer-term treatment and support services.

Program Features

- The facility is staffed 24 hours per day, seven days per week, with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis
- Patient stays are limited to a maximum of 23 hours and 59 minutes except for patients waiting for a Designated Crisis Responder (DCR) evaluation or making an imminent transition to another setting as part of an established aftercare plan. Exceptions to the time limit made under this subsection would not cause a CRC to be classified as a residential treatment facility, which has different and more stringent licensing requirements.
- Insurance may cover the 23-hour stay but no person will be refused admission for lack of insurance.
- The responsible authority will be required to take steps necessary to make the CRC's services, including on-site physical health care, eligible for Medicaid billing to the maximum extent allowed by federal law.
- The CRC may only refuse law enforcement referrals when the individual's health needs require more intensive services than the facility is able to provide.
- The CRC must have access to 24-hour, 7 days per week pharmacy services.

Service Demand

Service demand for the Crisis Relief Center was established using two analyses designed to provide complimentary information. The first analysis estimated annual and average daily demand using historical data from the dominant sources of referrals for this service. The second estimated the average daily number of patients that could be assessed and

treated with the minimum staffing pattern for this type of program and demonstrated that demand is sufficient to operate a program of this scale.

Service Demand Estimate

Demand data were compiled from an analysis of referrals from the sources listed below, plus an earlier study of local ED cases that providers determined could have been treated with a lower level of care.

- Cases that fell below ED level of care for calendar year 2024 were compiled by Peace Health. Annual ED visits were flagged to exclude visits likely to be medical emergencies, with the remaining visits representing visits that could be served in a setting serving lower acuity cases.
- DCR investigations include referrals to voluntary outpatient treatment, voluntary inpatient services, and others. Excluded here are involuntary detentions, custody authorizations issued and referrals to non-behavioral health resources because the CRC would not be the appropriate disposition in these cases. Referrals to crisis triage are not included because they are counted in the Compass triage line item below.
- Compass voluntary MCOT cases for January through November 2025 were extrapolated for the full year. There is some indeterminant overlap between the DCR investigations and voluntary MCOT cases due to cross referrals to one another that is considered to reduce the precision of the results but not the overall findings.
- Compass triage referrals for January through November 2025 were extrapolated for the full year and known duplications with the other sources were deducted from either the triage numbers or the other sources annual counts.
- ART referrals were included with deductions for known duplication with Compass triage.
- Pioneer detox referrals for January through November 2025 were extrapolated for the full year and adjusted for known duplications.

Compass triage and PHS data specifically break down MCOT, ART, law enforcement, EMS, Peace Health transfers, jail transfers, and self-referrals. This helped with decisions of how to adjust for double counting and sources of referrals to leave out due to data limitations.

The sources used did not include emergency medical services (EMS) for a number of reasons. The primary one is that most EMS referrals are included in the data from Peace Health, Compass Triage, and the PHS detox program. Another reason is that the EMS data is limited to the Bellingham Fire Department, Whatcom County Fire District 8, and the

South Whatcom Fire Authority. These agencies cover almost 55% of the county's population, with other areas served by the Lynden Fire Department and 11 other fire districts. Given that most cases relevant to this study are currently taken to St. Joseph's Hospital by the agencies we have data for and EMS drop-offs at Compass Triage and Community Detox, their data were considered more reliable indicators of EMS referrals.

Similarly, law enforcement referrals were not included because no data were received directly from them (though at least some of them show up in other data, for example St. Joseph's ED is their primary drop off for those with psychiatric and intoxication problems and non-serious offenses and the Peace Health, Compass Triage, and PHS data typically identify law enforcement referrals.

In summary, demand for the assessment, stabilization, and referral functions of a CRC were determined with the following process:

- Use the described source's annual referral data, or extrapolate a sample into annual data, to determine annual demand for the year 2025.
- Make the adjustments described above for double-counting and proposed service level changes.
- Divide by 365 to convert annual demand to the average number of daily patients.
- Extrapolate the annual and daily averages of estimated population growth by 2045 from the Washington State Office of Financial Management (OFM) population projections to calculate demand about 20 years in the future.

Table 4 below shows the estimated daily demand for 2025 to be an average of 43.4 referrals (or average number of daily clients) that could grow to 60.6 referrals by 2045.

Table 4: Potential Demand for Expanded Short-Term Assessment and Community Connection Function

Referral Source	2025 Demand		2045 Demand	
	Annual	Daily	Annual	Daily
Below ED Level of Care	2006.0	5.5	2799.7	7.7
DCR Investigations	502.2	1.4	700.9	1.9
Compass Voluntary	3581.6	9.8	4998.8	13.7
Compass Triage	1818.4	5.0	2537.9	7.0
ART	5922.0	16.2	8265.2	22.6
PHS	2011.9	5.5	2808.0	7.7
Total Referrals		**43.4**		**60.6**

1. Adjusted for Peace Health transfers in Compass Triage and PHS.
2. Adjusted up for additional coverage 5 pm to 9 pm on weekdays and 16 hours per day on weekends.
3. Adjusted down for ART in triage data.

Daily Patient Capacity

The staffing requirements for the CRC are described below, based on the daily patient capacity to determine the likely numbers of patients on hand over the course of a typical day and the number of staff who would be needed to effectively care for them. Identifying the daily patient capacity is an important step in determining the potential reimbursements to support the program. Further study should look at payer sources that are applicable to this type of facility

The time per patient to perform the following basic intake, assessment, charting, and release functions were compared with the intake nurse's time available allowing for breaks and a meal, using the following assumptions:

- Intake nurses will have one hour out of every eight hours for breaks and a meal. Collectively, they will spend a total of 18 hours per day on assessment and six hours on charting and other tasks.
- Administrative staff will check patients in and out during the day shift. Intake nurses will conduct check-in and check-out functions during all 23 hours, serving 100% of intakes.
- Providers and other professional staff will be engaged in follow-up specialized assessments, coordinate referrals, and provide outpatient treatment. Providers will be either onsite or on-call 24 hours a day.
- Patients will be served more timely in an urgent care (such as the CRC) rather than ED setting in from 30 minutes to 23 hours, 59 minutes with an average of 1.8 hours.[12] The term "bed" was used to indicate a measure of treatment space, regardless of its form (e.g., cot, mattress, recliner).
- Minimum client wait time is assumed to be 15 minutes for assessment and seven minutes for check-out.
- Outpatient treatment is assumed to take 1.3 hours following assessment, including 0.4 hours waiting.

Table 5 below shows the analysis of the daily patient capacity based on the staffing plan described in the *Staffing Requirements* section for a CRC.

[12] Published in the Western Journal of Emergency Medicine; http://scholarship.org/uc/item/01s9h6wp.

Table 5: Daily Patient Capacity

Activity	Minutes
Check-In	3.0
Intake Assessment	15.0
Charting	15.0
Check-Out	3.0
Minute per Client	**36.0**
Hours per Client	**0.6**

Activity	Hours
Nurse Time per 8 Hours	7.0
Hours per Client	0.6
Number of Clients per 8 Hours	11.7
Eight-Hour Periods per Day	**3.0**
Nominal Intakes per Day	**35.1**

Bed and Exam Room Needs

The assessment and treatment of patients can be supported by a few types of spaces:

- Beds will support assessment, treatment, and patient sleep when needed.
- Some comparable facilities use reclining chairs as a flexible option for waiting, rest, and dozing.
- A medical exam room will be needed for medical examinations and may be used for other assessments if space becomes limited.
- Clinician offices would be used for assessments and discussions with family.
- Unassigned "living room" spaces can be used in the manner of clinician offices.

The analysis is structured to provide guidance for the facility programming team following completion of this study. The number of beds needed is based on the average number of patients assumed to need sobering or are waiting for an inpatient bed, a family pickup, or referred outpatient care facility to open. All other assessment and treatment spaces are estimated as a group, with additional guidance to inform the programming team.

The number of rooms needed for exams, assessment, and treatment are based on the assumption the data below. Assuming that each person who utilizes the CRC will get an initial assessment and recommendations and/or linkage to additional follow-up. Table 6 shows the calculation of the need for exam or interview room, based on these assumptions, rounded up to the nearest integer.

Table 6: Exam/Interview Spaces Needed

Variable	Number/Time
Intakes per Day	35.1
Multiplied by Waking Hours Intake	0.8
Multiplied by Hours with Clinician	1.0
Divided by Waking Hours	16.0
Average Number Needed	1.8
Peaking Factor	10%
Exam/Interview Spaces Needed	**2.0**

These spaces would be difficult to add in small numbers, and the basic demand grows to three spaces by 2045 at the predicted usage. The initial staffing plan is for a clinician to be in the facility at all times. We recommend one exam room and three additional interview spaces of any type to serve through the life cycle of the building.

The CRC will need also beds for over half of psychiatric patients, sobering, and members of both groups that need a quiet setting. Table 7 below shows the analysis and assumptions for beds needed by each group, rounded up to the nearest integer:

Table 7: Beds Needed

Variable	Number/Time
2045 Intakes per Day	60.6
2045 Psych Intakes per Day	38.1
Percent needing Beds	55%
Hours per Bed	10
Psych Hours per Day	209.6
Psych Bed Demand	8.7
Less 18.2% Quiet Bed Demand	7.1
Peaking Factor	10%
Bed Need	**8.0**

Variable	Number/Time
2045 Detox Intakes per Day	7.7
Other Daily Intakes	52.9
Detox Percent	7%
Average Other Daily Intakes	3.9
Total Daily Detox Intakes	11.6
Hours per Detox	5.3
Detox Hours Per Day	61.4
Detox Demand Per Day	2.6

Variable	Number/Time
ETOH & Intox Percent	28%
Average Daily Intakes	14.8
Hours Per Sobering	12.5
Sobering Hours Per Day	185.2
Sobering Demand Per Day	7.7

Variable	Number/Time
Total Sobering Demand	10.3
Less 18.2% Quiet Bed Demand	8.4
Peaking Factor	10%
Sobering Bed Need	**10**

Variable	Number/Time
Quiet Bed Need	**4.0**

It is important to note that the availability of the CRC as a resource for first responders and the public may result in a more rapid growth in demand than anticipated. Additionally, the allocation of bed/recliner space must consider that the CRC will serve all genders in one setting.

Sobering

The need to accommodate sobering patients within the bed need was examined. The analysis treated the need for initial intake and assessment of patients needing medical detox, and sobering without medical intervention separately, although these two components of demand were added together to express total need.

Medical detox cases included average daily referrals to Whatcom Community Detox, plus the percentage of subacute detox cases from St. Joseph's ED that did not require an ED level of care, applied to the average daily referrals from other sources. It was assumed these patients would spend 30 minutes for intake and assessment and be moved to Whatcom Community Detox or another MAT/MOUD provider when a more extended period of detox is needed.

Sobering demand used the percentage of subacute alcohol and other intoxication cases from St. Joseph's ED sample data applied to the average daily referrals. It was assumed these patients would spend 6 to 9 hours, averaging 7.5 hours, in sobering, separate from other patients.

The two groups were assumed to need beds or recliners for their time in the CRC, and the possibility of separating them from other patients was considered. It was assumed that they would not need to be separated from one another, other than expedited transfer of patients needing medically assisted detox into Whatcom Community Detox.

Programming Recommendations

The consultant team recommends the following client spaces in the CRC:

- 22 spaces (cots, beds, recliners) to accommodate the anticipated demand and the lifecycle of the CRC. This number is based on the data analysis conducted, with consideration of expanded adoption by first responders, recycling bed use for cleaning, wait times for outside referrals, and patient comfort in the environment.
    - 10 spaces dedicated to behavioral health crisis. Two of these beds should be in separate, semi-private alcoves with pony wall for separation.
    - 8 spaces dedicated to sobering. Two of these spaces should be in separate, semi-private alcoves with a pony wall for separation.

    - Some separation between these two bed areas (behavioral health and sobering) for quiet and for staff convenience but also available to flex either way as needed.
- 4 quiet rooms available to all clients.
- One medical exam room.
- Reception area and open waiting.
- Three confidential interview rooms.

Deflection & Diversion Opportunities

The CRC adds a resource that will provide the network of outreach teams and first responders a new option to deflect potential subjects of law enforcement responses away from jail. It does this in four ways:

- It expands the scope and depth of initial assessment at a central location from which referrals to the appropriate community resources can be made.
- It provides a primary placement for law enforcement to take intoxicated people or those in crisis that avoids the jail or hospital emergency department.
- It provides a one-stop drop-off that enables assessment and transfer to Crisis Triage or to Whatcom Community Detox for those who need more care without further transport.
- It provides the opportunity to connect people with behavioral health and substance use challenges with community treatment resources.

Licensure Considerations

Crisis relief centers must meet the requirements outlined for outpatient crisis services in WAC 246-341-09013 and for crisis relief centers in RCW 71.24.916. The Washington Department of Health licenses a crisis relief center as a Behavioral Health Agency with a certification as a crisis relief center.

Staffing Requirements

The staffing plan proposed below is based on requirements outlined in WAC 246-341-0903 and RCW 71.24.9167.

For positions that are required 24/7, a relief factor of 1.92 has been used to determine the number of positions needed. Relief factors can vary widely based on an organization's policy, philosophy, legal decisions or experience. For the CRC, the consultant team wanted a slightly higher and consistent, Washington State-based factor. The relief factor of 1.92 used here is based on the Washington State Hospital budget year 2026 request to the

Legislature.[13] This relief factor gives this facility the resources to be fully staffed for high levels of intake and the ability to flex staff to the needs of the facility without the reliance on staffing agencies.

The staffing model below projects what the facility will need at opening and may be considered generous. However, to build success into the provision of this type of service it is best practice to have a multidisciplinary team on hand 24/7 so patients move in and out efficiently and with the appropriate assessment, care, and referrals provided.

Staffing costs are based on a salary survey of similar positions in Washington State and Whatcom County. Each position was calculated at the median point of the range of the survey.

Non-salary employee costs are also included in the total and at the national average for healthcare staff, which is an additional 30% of each position's cost. The following are examples of those costs but is not meant to be all inclusive.

- Employer payroll taxes (Social Security, Medicare)
- Federal unemployment tax (FUTA)
- State unemployment insurance (SUI)
- Workers' compensation insurance (higher healthcare class rates)
- Medical insurance (employer portion)
- Dental insurance
- Vision insurance
- Life insurance
- Short-term disability insurance
- Long-term disability insurance
- Retirement contributions (401k or pension)
- Paid time off (vacation)
- Sick leave
- Paid holidays
- Overtime pay
- Shift differentials (evening, night, weekend)
- On-call pay

[13] https://ofm.wa.gov/tech-support/agency-budget-requests/.

Staffing will include[14]:

- A registered nurse onsite 24/7 for treatment, intake interviews and nursing assessment.
- A provider (MD, APRN PNP, or PA) each day for 10-12 hours and on call for the remaining hours.
- A prescriber for psychiatric medications (likely on call). A mental health therapist each shift (AM, PM, overnight) for behavioral health assessment, treatment, planning and interventions.
- A substance use disorder (SUD) counselor on each shift (AM, PM, overnight) for SUD assessment, planning, and interventions.
- A peer counselor (potentially for each shift as the intakes grow).
- An administrative staff member or unit clerk during business hours to maintain records, make appointments, and obtain initial patient information. A 12-hour shift for this role is ideal (7 AM – 7 PM).
- A housekeeping or a janitorial service daily.

It should be noted that if this facility is co-located with the COD facility, there are some opportunities for staff coverage shared between the two programs (e.g., Program Director, Clinical Director, Medical Director, and possibly provider assignments). In the table below, for example, the Program Director and the RN Supervisor are accounted for in the COD Facility staffing chart. As more information is known about the operations of the BCC programs, these assignments should be updated and allocated accordingly.

[14] Per WAC 246-341-1140, WAC 246-341-0903 and RCW 71.24.916.

Operational Costs

Staffing Costs

Table 8: Staffing Costs

Crisis Relief Center	FTEs	Staffing Costs Annual
Program Director	0	$0.00*
Clinical Director	1	$133,524.00
ARNP	1.5	$153,807.00
RN Supervisor	0	$0.00*
RNs - Triage/Intake Psych RN Included	8	$882,168.00
Medical Director	0.5	$98,475.00
Behavioral Health Therapist	8	$850,137.00
Substance Use Counselor	8	$886,412.00
Mental Health Technicians	8	$669,926.00
Peer Supervisor	1	$51,625.00
Office Administrator/Clerk	2	$161,200.00
Housekeeping/Janitorial	1.5	$77,578.00
Position Total	**39.5**	**$3,964,852.00**
30% Employee Expenses		$1,189,456.00
Fully Loaded Employee Costs, Annual Estimated		**$5,154,308.00**

*See note above under *Staffing Requirements*.

Employee work hours are figured at 2,080 hours a year.

These fully loaded employee salaries represent 70% of total compensation, while benefits represent 30%. This estimated percentage aligns closely with national compensation data published by the U.S. Bureau of Labor Statistics in its Employer Costs for Employee Compensation reports.

Total Operational Costs

The estimate of operating costs for the CRC is based on standard costs for a healthcare program. Staffing is usually 65-70% of the costs with operations, supplies, medications and IT and administrative costs rounding out the other 30-35%. For this analysis a 70%/30% ratio was utilized.

Table 9: CRC Estimated Operational Costs

Crisis Relief Center	Estimated Cost
Staffing (70%)	$5,154,308.00
Facility Operations (12%)	$883,596.00
Clinical Supplies/Medications (8%)	$589,064.00
Administration/IT Compliance (10%)	$736,330.00
Total Estimated Operational Costs	**$7,363,298.00**

CRC Cost Reimbursements

Reimbursements were examined based on the types of health coverage and their breakdown within Whatcom County's adult population. Table 10 presents an example of how the reimbursements of estimated costs could break down with the 6% gap described above. The sources of data and methodology used were the same for the CRC and COD programs and described in detail along with a corresponding table for the entire BCC in the *Payer Reimbursement* section near the end of this report.

Table 10: CRC Reimbursements Breakdown and Estimate by Payer

Payer	Percent of Adults	Percent Utilization	Percent of Payments	Estimated Payments
Medicaid	15%	37%	37%	$2,724,400.00
Medicare	19%	23%	23%	$1,693,600.00
Private Insurance	57%	22%	31%	$2,282,600.00
Out-of-Pocket	2%	2%	2%	$147,300.00
Subtotal	**93%**	**84%**	**93%**	**$6,847,900.00**
Uncovered	7%	16%	7%	$515,400.00
Total	**100%**	**100%**	**100%**	**$7,363,300.00**

Caveat

More information on how payers and associated ratios of payments were derived, as well as caveats to the analysis, can be found in the *BCC Total Reimbursements* section of this report, but it is important to highlight here the most significant limitations in the cost reimbursement analysis:

Knowledgeable local sources have noted the likelihood that Medicaid could contribute a substantially higher percentage of reimbursements and that private insurance could be a correspondingly lower percentage than shown. There are local programs that receive less than one percent of revenue from Medicaid to one hundred percent from Medicaid and at

least two with proportions in between. This is influenced not only by heavy utilization rates by Medicaid enrollees, but by the business models and associated policies of each operator.

In addition to consideration of the estimated percentages applied to each payer, it is also critical to consider the likelihood of receipt of payments *at all* from certain payers, even if services have been billed for. There is notable concern on the part of county stakeholders and facility operators regarding dependence on reliable receipt of payments, in particular, from Medicare and private insurance. As mentioned, the consultant team received data from other facilities in Whatcom County and elsewhere in the state, which indicated a wide range of payers and significant variation in payer ratios.

In evaluation of the potential funding that the county will need to contribute annually to the BCC, and particularly the CRC, absence of payments from private insurance and Medicare could significantly increase the funding gap that the county will need to cover.

Since Whatcom County contracts with third-party providers to deliver care, it is currently up to these operators to contract with payers directly. Moving forward, the county should establish what their financial goals are and discuss these with existing and potential operators to ensure that the providers they contract with meet the county's requirements for various forms of contracts/payments, including Medicaid and others.

The example shown in the table above is based on a real local case study, but the percentage of financial support needed from the county will require detailed analysis to develop a financial plan and policies for BCC services in advance.

Co-Occurring Disorders Facility

Description

Co-occurring disorder (COD) treatment involves an integrated approach to address mental health disorders and substance use disorders simultaneously. When these conditions occur together, the effects of each are often exacerbated. Using a single team of providers, treatment combines medication management, behavioral therapies, therapeutic communities, and support groups to improve outcomes, reduce symptoms, and prevent relapse. While the focus is on co-occurring condition, this facility may also be utilized for clients without a comorbid condition.

Key treatment approaches include:

- An integrated treatment team. Treating both disorders simultaneously by one team is considered to be the best practice of care for this population. Integrated care combines mental health and substance use treatment so patients can receive more convenient and coordinated care in one place from one treatment team.
- Comprehensive assessment. Comprehensive diagnostics are key to identify both disorders clearly and how they interact, which leads to a more focused and individualized treatment plan.
- Behavioral therapies. Evidence-based, trauma-informed approaches are utilized, such as Cognitive behavioral therapy (CBT), contingency management to change thinking and help patients build strong coping skills and manage self-harm.
- Medication management. Patients will have access to psychiatric medication to manage mental health symptoms and, if also needed, medications for withdrawal or addiction treatment. Some medications may be helpful in treating multiple disorders.

Combining these treatments may reduce barriers to care by addressing needs holistically, providing a more comprehensive path to healing and recovery, and reducing the chances of relapse and incarceration.

The analysis here presents demand based on community need. The demand based on analysis of prosecutorial diversion opportunities will be included as Attachment B of this report.

Service Demand

Assumptions:

- The foundation datum is PHS' record of 1,035 referrals to ongoing treatment from 1/1/2025 to 6/30/25:
- Flags on St. Joseph's ED analysis suggests 54.7% have a COD. Thus, annual referrals were multiplied by 54.7% to exclude cases that do not meet the criteria for a co-occurring disorder.
- In addition to the demand demonstrated by PHS, the role of the COD program in supporting a more ambitious use of diversion to reduce jail ADP is included in the estimated service demand. The analysis of service demand includes current utilization of treatment courts, prosecutorial diversion, and a general examination of the potential to improve both paths, consistent with what other jurisdictions have accomplished. The details of these analyses are provided in the section below on Deflection and Diversion Opportunities.
- A paper in the National Institute of Health National Library of Medicine[15] found 31% of COD treatment capacity in residential treatment programs. Annual referrals were multiplied by 31% to account for referrals to residential rather than outpatient programs.
- In terms of length of stay, the demand analysis conservatively assumes a four-week initial stay in line with private insurance reimbursements that require further authorization for extended periods of time. Annual intakes were multiplied by 28 days and divided by 365 days per year to determine the average number of daily patients.

[15] McGovern, Mark P. (2014, May). *Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems*. American Psychiatric Association, Philadelphia, PA.

Table 11: Bed Demand for Co-Occurring Residential Treatment

Variable	Number/Time
181-Day Sample of Referrals	1,035.0
Extrapolate to One Year	2.0
Annual Community Referrals	2,070.0
Recovery Court Referrals	55.0
Mental Health Court Referrals	21.0
Additional Diversion ADP	16.0
Misdemeanor ALOS	9.7
Additional Annual Diversions	603.3
Combined Annual Referrals	2,749.3
Percent COD	55%
Percent Inpatient	31%
Annual Intakes	466.2
Length of Stay	28.0
Average Daily Patients 2025	**35.8**
Average Daily Patients 2045	49.9

The average daily patient demand estimate is 35.8 beds, growing to 49.9 by 2045. The demand profile would support the initial development of a facility with two 16-bed units with the ability to add a third unit near 2045 for a total of 48 beds.

Programming Recommendations

The consultant team recommends the following client spaces in the COD facility:

- 32 beds in two units of 16 beds to meet the requirements of an RTF license; the two units could be operated by the same treatment staff to ensure continuity in care and efficiency of staffing.
- 1 exam room.
- 1 medication room.
- 4 interview/treatment spaces.
- 2 quiet rooms.

Deflection & Diversion Opportunities

The inpatient COD facility would provide an expanded resource supporting more ambitious use of deflection and diversion.

Observations on Current Use of Diversion

There is currently a discrepancy between the level of diversion from the jail in Whatcom County and what other jurisdictions are accomplishing. Jail data indicate that 71% of the jail population have a mental health disorder and 41% have a serious mental illness. While there is not a comparable statistic for SUDs, it appears that less than 11% of the jail population is referred to SUD treatment, which seems too low compared to other jurisdictions.

Local ED data for visits that are non-emergent indicate that 36.2% are for substance abuse issues and 64.8% are for mental health issues. At the same time, the Recovery Court closes more than twice as many cases per year as the Mental Health Court, the opposite of what would be expected based on the data. In 2025 there were 55 cases closed by the Recovery Court and 21 closed by the Mental Health Court.

We assume that there is significant potential to divert more arrestees. The *Whatcom County Jail Population Forecast Analysis,* conducted concurrently with this study, estimates that 70% of 11 types of charges could be diverted with the potential to reduce the jail ADP by 22.0. This would be accomplished by both the Therapeutic Courts and prosecutorial diversion.

Other jurisdictions have reached similarly ambitious levels of diversion. It would take a systemic approach, working with jail, prosecutorial, and court leadership to coordinate jail screening, prosecutorial diversion criteria, and Therapeutic Court criteria and resources.

There was specific interest in the impacts of increased prosecutorial diversion on:

- Reducing jail ADP
- Bed demand at the COD facility.

An additional data collection effort is underway by the county at time of publication of this report. Upon receipt and analysis of the data, estimates of jail ADP reduction and COD facility bed demand based on utilization of this facility for prosecutorial diversion will be included as Attachment B to this report.

Licensure Considerations

With the current demand considered and for the multiple services this facility provides we recommend obtaining a Residential Treatment Facility license and meeting DOH requirements for Behavioral Health Agencies.

Residential Treatment Facility License

To license a Residential Treatment Facility (RTF) in Washington State, you must meet DOH requirements for facilities providing 24-hour mental health/chemical dependency care, requiring detailed applications, adherence to quality care and safety standards, proper insurance, and staff credentialing (often DOH-issued), and working with the DOH to meet specific regulations for inpatient services, including potentially Ricky's Law compliance, and securing necessary business licenses from the state and city.[16] Addiction treatment consultants can help with licensing, policies, curriculum, and grant applications.

Key Agencies and Requirements

- Washington State Department of Health (DOH)licenses over 100 RTFs for inpatient care for mental health/chemical dependency.
- Application involves submitting forms, fees, and proof of quality care, a safe environment, and adherence to laws.
- Standards require that the facility must provide high-quality care, maintain safety, and comply with all regulations.
- Washington State Department of Social & Health Services (DSHS): May be involved in assisted living aspects or specific populations.

Staffing Requirements

A full staffing complement for a 32-bed residential treatment facility with a Behavioral Health license (substance use disorder or mental health treatment) requires a multi-disciplinary team designed to provide 24/7 coverage, typically operating with a minimum direct care staff-to-client ratio of 1:10 during the day and 1:15 during the night. To meet these regulations while ensuring safety and therapeutic programming, a 32-bed facility often requires a team of roughly 25-35 full-time equivalent (FTE) employees depending on the intensity of care. The following positions must be covered.

[16] WAC 246-341.

- Leadership and Administration
    - Facility Administrator/Program Director: Oversees daily operations, regulatory compliance, and budget for both programs.
    - Clinical/Medical Director: Licensed professional (LCSW, LMFT, LPC) overseeing staff, treatment needs and treatment plans for both programs and/or a psychiatrist or physician for medical and psychiatric oversight.

Administrative Assistant: Manages scheduling, intake, and records for both programs.

- Clinical and Nursing Staff
    - Registered Nurses (RNs): Responsible for medication administration, detox monitoring, and health assessments. A 32-bed facility needs 24/7 nursing coverage.
    - Licensed Vocational Nurses (LVNs)/Psychiatric Technicians: Support nursing duties and medication administration. This may be optional depending on how the facility wants to distribute the nursing duties and medication delivery. (LVNs were not included in this staffing matrix)
    - Case Managers/SUD: Responsible for group sessions, assessments, individual counseling, and discharge planning.
    - Clinical Behavioral Health Providers: provide assessment and treatment.
    - Psychiatric Nurse Practitioner/Physician Assistant: For medication management, treatment planning, physical assessments; available every day.
- Direct Patient Care (24/7 Coverage)
    - At least two staff members on duty and awake at all times.
    - Behavioral Health Technicians (BHTs)/Chemical Dependency Technicians: Provide around-the-clock supervision, safety checks, and monitor client behavior.
    - Peer Supervisor
    - Support Services
    - Dietary/Chef: Professional meal preparation (3 meals/day). Staffing not included here given the option to provide meals
    - Housekeeping/Janitorial: Facility cleanliness and laundry.

Staffing Requirements

For positions that are required 24/7, a relief factor of 1.5 (healthcare industry standard) has been used to determine the number of positions needed. Relief factors vary based on an organization's policy, philosophy, legal decisions, or experience and can vary widely. For

the COD Facility, given the number of staff assigned and the flexibility provided by a solid treatment team, the relief factor is slightly lower than the relief factor for the CRC.

Although the county can operate an RTF without RN coverage 24/7, it is best practice to have a multidisciplinary team on hand and RN coverage around the clock to address ongoing admissions, timely crisis interventions, and medication orders and medication administration on all shifts. These staffing costs are based on a salary survey of similar positions in Washington State and Whatcom County. Each position was calculated at the median of the given salary range. Non-salary employee costs are included as part of a 30% loading factor, as were listed in the CRC service model section. Required staff are listed below and presented in a table in the section on operating costs that shows their cost.

Administrative

- Program Director: 1 FTE
- Clinical/Medical Director: 1 FTE
- Administrative/Intake: 1 FTE
- Utilization Management: 1 FTE

Clinical and Nursing Staff

- Registered Nurse: 2 daily on 12-hour shifts, requires 6 FTE plus 1 RN Supervisor.
- Licensed Vocational Nurse: optional depending on medication delivery preferences and nursing support needed. Often this role is covered by BHT or PT.
- Case Managers/Therapist: LCSW or MHT per day per am and pm shift (8-hour shifts)., 9 FTEs.
- Psychiatric Nurse Practitioner/Physician Assistant: 1 each day for 8-hour day, 1 FTE.

Direct Patient Care (24/7 Coverage)

- Mental Health Providers (daily), 9 FTEs.
- Peer Support, 1 FTE.

Suggested Support Services

- Security – Optional but recommended to have security services available 24/7.
- Housekeeping/Janitorial: 1 person 7 days a week, 1 FTE.
- Maintenance: Optional, part-time or contracted service.

Operational Costs

Staffing Costs

Table 12: Staffing Costs

Co-Occurring Disorder Facility	FTEs	Staffing Costs Annual
Program Director	1.0	$116,217.00
Clinical Director/Medical Director	1.0	$133,524.00
Utilization Management	1.0	$141,032.00
Office Administrator	1.0	$80,600.00
ARNP - Psych	1.0	$102,538.00
RN - Supervisor	1.0	$141,032.00
RNs/Psych RNs	6.0	$405,264.00
Case Managers/Therapist	9.0	$956,403.00
Peer Supervisor	1.0	$51,625.00
Behavioral Health Technician	9.0	$603,720.00
Housekeeping/Janitorial	1.0	$77,578.00
Position Total	32.0	**$2,809,533.00**
30% Employee Expenses		$842,860.00
Fully Loaded Employee Costs, Annual Estimated		**$3,652,393.00**

These fully loaded employee costs align closely with national compensation data published by the U.S. Bureau of Labor Statistics in its Employer Costs for Employee Compensation reports.

As noted above, if this facility is co-located with the CRC, there are some opportunities for staff coverage shared between the two programs (e.g., Program Director, Clinical Director, and possibly provider assignments).

Total Operational Costs

Calculating operating costs for the COD Facility was done using the same methods as for the CRC and is based on standard operating costs for a healthcare program. For this analysis a 70%/30% ratio of staff cost to other operating costs was utilized.

Table 13: Total Operational Costs

Co-Occurring Disorder Facility	Estimated Cost
Staffing	$3,652,392.00
Facility Operations	$626,124.00
Clinical Supplies/Medications	$417,416.00
Administration/IT Compliance	$521,770.00
Total Estimated Operational Costs	**$5,217,702.00**

COD Facility Cost Reimbursements

As for the CRC, reimbursements were examined based on the types of health coverage and their breakdown within Whatcom County's adult population. Table 14 presents an example of how the reimbursements of estimated costs could break down. This includes utilizing a 7% gap as a result of the unwinding of Medicaid eligibility. The sources of data and methodology used were the same for the CRC and COD Facility. These are described in detail, along with a corresponding table for the entire BCC and important caveats for consideration, in the *BCC Total Cost Reimbursements* section of this report. Please also refer to *CRC Facility Cost Reimbursements,* in the previous section, for important caveats relating to the receipt of Medicare and Private Insurance reimbursements.

Table 14: COD Reimbursements Breakdown and Estimate by Payer

Payer	Percent of Adults	Percent Utilization	Percent of Payments	Estimated Payments
Medicaid	15%	37%	37%	$1,930,500.00
Medicare	19%	23%	23%	$1,200,100.00
Private Insurance	57%	22%	31%	$1,617,500.00
Out-of-Pocket	2%	2%	2%	$104,400.00
Subtotal	**93%**	**84%**	**93%**	**$4,852,500.00**
Uncovered	7%	16%	7%	$365,200.00
Total	**100%**	**100%**	**100%**	**$5,217,700.00**

Psychiatric Urgent Care Clinic

Description

A psychiatric urgent care (PUC) facility provides services on a voluntary, walk-in basis available to all adult residents of the county who are experiencing a mental health and/or co-occurring substance abuse crisis, regardless of their ability to pay. These facilities are an alternative to hospital EDs for those in crisis or experiencing an urgent mental health need and seeking care.

Most of the psychiatric urgent care facilities the consultant team reviewed were clinics that were open Monday to Friday, 8 to 12 hours a day. This leaves a significant gap for individuals, families, crisis workers and first responders during the off hours.

There are some models, such as Bexar County and many other counties who have incorporated the function of a psychiatric urgent care into a crisis relief facility. Given the demand discussed below, the recommendation is to provide the functions of a PUC from within the CRC.

Service Demand

Demand for a PUC is based on the following data and assumptions:

- Demand will be based on the same referrals as for the CRC, minus SUDs.
- For Peace Health referrals, we will subtract data coded "Drug," Alcohol, Detox, etoh, and "intox."
- Data were adjusted for known duplications between sources as was done for the analysis of CRC demand.
- Pioneer Detox referrals were omitted.
- Remaining referral sources assume 35.2% are deducted based on the breakdown of drug codes from Peace Health's referrals
- Beds unavailable at Anne Deacon Center were considered for inclusion, but were less than 0.1/day and therefore not considered.

Table 15 shows an average daily demand of 31.5 patients growing to 43.9 by 2045.

Table 15: Potential Demand for Psychiatric Urgent Care Services

Referral Source	2025 Demand		2045 Demand	
	Annual	Daily	Annual	Daily
ED Deflection	1,297.9	3.6	1,811.4	5.0
DCR Investigations	324.9	0.9	453.5	1.2
Compass Voluntary	4,866.4	13.3	6,791.9	18.6
Compass Triage	1,176.5	3.2	1,642.0	4.5
ART	3,822.4	10.5	5,334.8	14.6
Total Referrals		**31.5**		**43.9**

Similar to the analysis of demand for a CRC, the key staffing factors to determine daily patient capacity were examined based on the ratio of care staff to patients, as shown in Table 16.

Table 16: Psychiatric Urgent Care Daily Patient Capacity

Based on Patients/Mental Health Clinician		Number/Time
Hours per Day		12.0
Hours per Client	+	1.8
Treatment Blocks per Day		6.7
Mental Health Clinicians	x	1.0
Clients per Clinician	x	4.0
Daily Patient Capacity		**26.8**

Since the CRC's licensing would enable both assessment and treatment, there would be significant overlap between the demand profiles of the CRC and the PUC. The CRC demand profile showed current demand exceeding capacity, whereas the profile for a PUC showed demand at about 70% of patient capacity. A breakdown of combined assessment versus treatment demand was examined and compared to the expected growth rate of Whatcom County to determine when demand might match the capacity of separate facilities as shown in Tables 17 and 18.

Table 17: Breakdown Between Assessment and Treatment

	2025		2045	
	Demand	Capacity	Demand	Capacity
Assessment	22.7	35.1	31.8	35.1
Treatment	31.5	33.5	43.9	33.5

Table 18: Years to Demand Justifying Separate Facilities

Variable	Intakes per Day
CRC Capacity	35.1
PUC Capacity	33.5
Combined Capacity	68.6
2025 Assessment Demand	22.7
2025 Treatment Demand	31.5
2025 Combined Demand	54.2
Annual Growth Rate	7%
Years Until Demand = Capacity	**18.1 Years**

Conclusion

At this point in time, much of the demonstrated demand is duplicative between the CRC and a PUC, leaving insuffient demand to operate and staff both efficiently. However, as the year 2045 approaches, projected population growth should result in sufficient demand to either operate separate a CRC and a PUC, to add beds to the planned CRC, or to build a second CRC at another location to provide more convienient access.

Locating this service as part of the CRC function gives patients the opportunity to receive assessment, treatment, and referral in the least restrictive setting. In addition , since 50 to 70% of individuals with a mental illness also have a substance use issue, it makes sense to evaluate and refer –or treat - this population a single place where the interdisciplinary treatment team can make appropriate recommendations.

Another advantage is that a CRC is a one-stop facility, so law enforcement, crisis workers, and community members do not need to determine what the most acute problem is to get the patient to the most appropriate facility.

In summary, the team found no advantage to providing psychiatric urgent care services separate from SUD assessment and services available through the CRC. These services are more fully explained in the section on the CRC, earlier in this report.

BCC Total Cost Reimbursements

The consultant team examined the approximate scope of concerns around payer reimbursements with a focus on Medicaid reimbursements that BCC operations will have to navigate. Moving forward it is recommended to engage a consultant that specializes in this field to develop a more detailed analysis and recommendations at critical decision points in the planning and implementation of the BCC.

Medicaid reimbursements have usually not fully met the costs of providing services. For example, a fact sheet by Peace Health entitled *Peace Health Financial Stewardship*[17] breaks down the billings and reimbursements for major payers across the organization's network. Medicare and Medicaid combined are responsible for 72% of Peace Health's billings but only 53% of payments. An indication of how Peace Health manages this demonstrated by the 26% of billings that were to private insurance accounted for 45% of payments. The remaining 2% of payments were out-of-pocket.

A second issue is the unwinding of Medicaid funding that had been implemented during the COVID-19 pandemic. Beginning in February 2025 the additional funding that had been authorized began a 5-year drawdown to previous levels. Prior to the pandemic 15% of Whatcom County adults were enrolled in Medicaid and 21.8% were covered by 2023. Over half of that additional funding will be gone by the time the BCC can start operating, and will be fully lost within the second or third years of operation.

An analysis was run using Current Procedural Terminology (CPT) billing codes and 2026 reimbursement rates, our estimates of operating costs, and information from Peace Health and the U.S. Census Bureau. While the Peace Health information covered 14 facilities in three states, we used it as a surrogate for Whatcom County, lacking comparable information for the county only. The analysis incorporated the following assumptions based on available information:

- 21.8% of the population were responsible for 53% of the payments to Peace Health, so a multiplier of 2.4 (which is 53 divided by 21.8) was used to adjust for the heavier demand associated with Medicaid enrollees.
- the rate of adult Medicaid enrollees was assumed to roll back to pre-pandemic levels of 15% and be responsible for 37% of costs based on their high utilization.

[17] https://www.peacehealth.org/sites/default/files/2023-03/Financial-Stewardship-Series_final.pdf.

- Medicare recipients are 19% of the adult population, which were assumed to be responsible for 23% of costs related to increased utilization of Medicaid enrollees ageing into Medicare.
- 2% of payments would be out-of-pocket.
- There would be a 7% gap based on our analysis of typical billing codes for services.
- The remaining 22% of patients would have insurance paying 31% of costs.

The above assumptions were used to illustrate the likely gap between expenses and revenues. Table 19 shows the combined breakdown of estimated payments for the BCC.

Table 19: BCC Reimbursements Breakdown and Estimate by Payer

Payer	Percent of Adults	Percent Utilization	Percent of Payments	Estimated Payments
Medicaid	15%	37%	37%	$4,654,900.00
Medicare	19%	23%	23%	$2,893,700.00
Private Insurance	57%	22%	31%	$3,900,100.00
Out-of-Pocket	2%	2%	2%	$251,700.00
Subtotal	**93%**	**84%**	**93%**	**$11,700,400.00**
Uncovered	7%	16%	7%	$880,600.00
Total				**$12,581,000.00**

Caveats and Limitations

Another key issue for Whatcom County will be how to structure its sources of revenue to cover expenses. One major challenge will be how to compensate for Medicaid payments that barely cover the expenses of providing services and how to fund services to the 7% of adult patients who will be ineligible for Medicaid. Note that the analysis above only shows 31% of payments coming from private insurance, whereas Peace Health generates 45% of payments from 26% of billings.

The BCC reimbursements presented here and broken down for the CRC and the COD Facility in their respective sections, are examples, and not meant to be the proposed solution. For instance, there are knowledgeable local sources who expect private insurance will only be available, at most, to a very small percentage of those receiving treatment at the BCC. As mentioned in the CRC cost reimbursement discussion, there is concern around the likelihood that payments will be received at all from Medicare and from private insurance. As stated previously:

In evaluation of the potential funding that the county will need to contribute annually to the BCC, and particularly the CRC, absence of payments from private insurance and Medicare could significantly increase the funding gap that the county will need to cover.

The consultant team recommends that the county establish what their financial goals are for BCC services and discuss these with existing and potential operators to ensure that the providers they contract with meet the county's requirements for various forms of contracts/payments, including Medicaid and others

Assessment of payer reimbursement ratios must be ongoing, and must account for flexibility over time, incorporating payments from Medicaid, Medicare, private insurance, grants, mental health tax revenues, and evaluating the benefits of partnership with a private non-profit. Developing and adjusting this strategy will require careful integration of reimbursement data, staffing costs, overhead allocation, and productivity analysis. This level of financial evaluation is typically conducted by a consultant specializing in healthcare reimbursement and cost accounting.

Additional Behavioral Health Recommendations

During data gathering for this project, additional concerns were raised that the consultant team believes requires further study.

Twenty-Four Hour Pharmacy

A major identified gap in the system of care identified was the absence of a 24-hour pharmacy and, at times, an available prescriber.

CRC licensing (and the Co-Occurring Disorder Facility) will require that medication access be available on a 24-hour, seven-day per week basis, making it imperative that the county investigate integrating access to a 24-hour pharmacy into their plans for a BCC.

In Washington State, a 23-hour crisis relief center must follow medication management and storage rules contained primarily in WAC 246-341 and related medication-management standards. These rules apply even though the facility is considered an outpatient crisis service rather than an inpatient hospital.

24/7 pharmacy services for either facility can be provided by contracting with a national pharmacy service such as Diamond Pharmacy Services or a local pharmacy system such as CVS. Another option is to install and license an automated dispensing machine, also known as Automated Pharmacy Dispensing Systems, Automated Medication Dispensing Systems, unit-based cabinets, or robotic prescription dispensing systems.

Note that a 24-hour pharmacy does not necessarily require much space. An Automated Drug Dispensing Device (ADDD) may serve such a purpose if the following requirements are met.[18]

Automated Dispensing

In Washington State, an automated dispensing system is legally classified as an ADDD. For a Residential Treatment Facility (RTF) to utilize an ADDD in 2026, it must meet specific licensure and pharmacy oversight requirements.

[18] Refer to WAC 246-874, WAC 246-872, and WAC 246-945 for more information on requirements identified in this section.

1. Licensing Requirements

An RTF cannot simply install an ADDD; it must establish a legal framework for possessing and storing the legend drugs contained within it. The facility must meet one of the following conditions:

- Health Care Entity (HCE) License: The RTF must obtain a Health Care Entity license under Chapter 18.64 RCW.
- Prescriber Ownership: The ADDD may be used if it is leased or owned by a licensed prescriber who maintains sole responsibility for the drugs.
- Hospital Pharmacy Extension: If the RTF is operated in connection with a hospital, the hospital may list the RTF on its hospital pharmacy license as a "hospital pharmacy associated clinic". (This condition is less likely to apply.)

2. Pharmacy Oversight

Every facility using an ADDD must have a designated Pharmacist-in-Charge licensed in Washington. The Pharmacist-in-Charge is responsible for:

- Ensuring the device is stocked and maintained by a licensed pharmacy.
- Performing annual audits of compliance with all ADDD policies and procedures.
- Managing user access and drug privileges for credentialed health care practitioners.

3. Operational and Safety Standards

The facility must implement the following:

- Written Policies: Maintain comprehensive policies covering diversion prevention, record retention (minimum two years), and user privileges based on staff type.
- Inventory Control: Controlled substances must be perpetually inventoried with a blind count (physical verification without seeing the system's expected quantity) performed by a licensed professional each time the medication is accessed.
- Waste Management: A mechanism must exist for securing and accounting for wasted, expired, or unused medication removed from the device.
- Quality Assurance: Establish a program that monitors the device's performance, including a method for reviewing "override" data and medication errors.

4. Physical Installation

- The ADDD must be located in a secure area with restricted access.

- If the facility is new or undergoing structural changes to accommodate the device, it must submit plans to Construction Review Services for approval.

Day Treatment Programs

During the consultant's data gathering process, one of the needs reported most by Whatcom County service providers is supportive outpatient services or monitored follow-up care. Many providers referred to previously existing day treatment centers. Intensive outpatient programs are described below.[19]

Intensive Outpatient Programs (IOP)

- Time Commitment: Usually requires a minimum of 9 hours per week, often divided into three 3-hour sessions.
- Intensity: Focuses more on therapy and group work than on constant medical oversight.
- Clinical Focus: Heavy emphasis on group therapy, developing coping strategies, and relapse prevention.
- Ideal Candidates: People with a stable home environment who can manage daily responsibilities like work or school while attending therapy several times a week.
- IOPs have a defined structure that typically involves a specific number of sessions weekly. These sessions might range from 9 to 15 hours per week.
- Sessions often include a mix of group therapy, individual counseling and family therapy. This variety aims to address the complex needs of participants.

Intensive Outpatient Program Requirements

Participants need to meet certain criteria to join an IOP. These requirements vary by program but often include an initial assessment. The assessment helps determine whether the person's condition matches what an IOP can address. Typical requirements include the following:

- Complete an initial assessment
- Have mild to moderate addiction levels
- Ability to maintain daily tasks alongside treatment
- Be free from the need for detoxification.

This structured approach ensures effective treatment while providing the support needed for recovery.

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[19] https://highlandsbhs.com/blog/how-do-intensive-outpatient-programs-iops-work/#:~:text=Intensive%20outpatient%20programs%20(IOPs)%20are,and%20more%2C%20in%20this%20guide.

Other requirements include:

- Participants must commit to regular attendance and active participation, which requires strong personal motivation. Another challenge is the need for a supportive home environment, which is essential for success in IOPs.
- Programs are generally less costly than a partial hospitalization or inpatient stay.
- A key benefit of Intensive Outpatient Programs is their flexibility. Unlike inpatient care, IOPs allow patients to continue working or attending school. This makes them suitable for those who can't afford to pause their regular activities.
- Flexibility also aids in the transition back to everyday life, reducing the risk of relapse.
- Patients must develop effective time-management skills. These skills can contribute to balancing treatment sessions with personal obligations successfully.
- Intensive Outpatient Programs consist of several core elements. Each component plays a vital role in fostering recovery. Understanding these elements can help people maximize their treatment experience.
- Therapy and counseling services form the backbone of IOPs. They provide emotional and psychological support critical for healing. These services help address mental health challenges.
- IOPs often incorporate medication management to support treatment. Medication can be crucial for those with co-occurring disorders. Alongside traditional methods, some programs also embrace holistic approaches.

Incompetent to Stand Trial (IST) Populations

The consultant team was not tasked with analyzing Whatcom County's IST populations as part of the scope of this work. In other projects the team has found the IST population to cause some backlogs and add to bed needs. The consultant team recommends further examination of the service demands for this population will help to inform the county's need for additional beds.

Site Considerations

During the course of the study, a site was confirmed for location of the proposed BCC: 2000 Division Street, Bellingham. This site is immediately adjacent to the existing Anne Deacon Center for Hope which, as described previously, provides crisis triage and substance use disorder services in two separate wings of the facility.

Treatment Campus– Colocation Model

Location of the BCC at this site, fleshes out the vision of a "campus" model, where a wide array of interrelated services is provided in one location. This presents valuable opportunities for the delivery and coordination of behavioral health and substance use treatment to county residents who are involved in the criminal legal system or are vulnerable to such involvement.

Adding the BCC to this site expands the treatment options available at a single location for law enforcement, emergency medical services, and other first responders to lean on to ensure the individuals they encounter receive the treatment services they require without having to depend on the criminal legal system. First responders, with sufficient training, can make appropriate recommendations for alternatives to incarceration based on the nature of their interaction, with the Division Street site, and particularly the Crisis Relief Center, - as the "true first door"[20] into the public health system for those who need care and might otherwise be sent to the jail.

It also increases the ability to provide more effective "warm handoffs" as individuals transition between levels of care. For example, individuals receiving diagnostics and care at the proposed CRC may be able to transition to crisis triage at the Anne Deacon Center, just a few yards away, before moving offsite to a residential facility. Or, those identified by Community Detox at the Anne Deacon Center may transition to the Co-Occurring Disorders facility once they have gone through acute detoxification and are ready for the next phase of withdrawal management. It is well documented that individuals often are "lost" when the handoff between providers and/or services requires travel to a different location to receive services. Establishment of multiple, complementary services in one location may greatly reduce the number of individuals whose treatment program ends because of the geographical and transportation hurdles required to reach the next step in

[20] Commentary from Emergency Medical Service – Community Paramedic staff, January 15, 2026.

their care. On a co-located campus, one can be guided by a staff member to the next location with very little effort.

Access & Transportation

Public transportation (a bus stop) is available immediately across the street from the Division Street site at Division Street and Bakerview Spur, which is another advantage to location of the BCC at this site.

Should an individual be rejected from the services at the Division Street site and law enforcement must subsequently bring them to the jail, it will take an additional 10-15 minutes and does not require highway travel.

Baker Creek Residential Treatment Facility is a 15-minute walk or nine-minute drive or bus ride,[21] In the instances where movement between these two facilities might be necessary.

It may be worthwhile to consider creating (and funding) a position dedicated to transportation of clients between services. Doing so would reduce the number of individuals "falling through the cracks" when moving between services. Alternatively, transportation subsidies for staff members who transport clients between services should be considered.

Site Development

The following considerations should be incorporated into site development:

- The site should be planned to accommodate future growth in addition to current needs. It should be large enough to allow the addition of 16 and planned so that they can be added in a way that properly connects to the new BCC's circulation paths and services, and infrastructure. Oversizing of certain support functions to accommodate the potential increased capacity should also be considered.
- The facility should be designed with a "front door" and "back door," easily distinguishable and identifiable upon arrival:
    - The back door provides a secure vehicle drop-off area, sized for ambulances, law enforcement, and other first responders to park and escort clients into the facility. To the extent possible, this area should be shielded from public view to protect the dignity and confidentiality of those being transported in what might be a highly acute state.

[21] Google Maps.

    - A separate front door will serve members of the public voluntarily seeking services as well as visitors seeing loved ones or present for another purpose.
- Wayfinding and signage for both vehicle access and pedestrian access for first responders and members of the public must be clear and distinct.
- Pedestrian access is required between the Anne Deacon Center and the BCC to support warm handoffs between services.
- Safe pedestrian access between the site and across Division Street must be accommodated.
- Parking accommodations are to be determined. There is an existing parking lot associated with the Anne Deacon Center for Hope and the jail's Work Center at the adjacent site, though it is likely that the BCC will require its own parking. The BCC will also require its own loading zones at the public and secure entrances.
- Exterior areas, such as courtyards, should be provided for both the client populations and for staff. Access to and views of the outdoors, as well as fresh air, are well documented to contribute to health and healing.

Conclusion & Recommended Next Steps

The Whatcom County Behavioral Care Center is intended to round out and complement the extensive services already provided by the County's behavioral health system. This system primarily deals with behavioral health and substance use disorders (SUDs).

A key goal of the study was to help the County provide as robust a set of services as possible at the early points as individuals' problems develop, where they come into contact with the health and justice systems in order to support deflection or diversion to services in the community rather than more expensive and restrictive accommodation in a hospital or the jail.

A more specific goal is to assess the level of jail population reduction that a prosecutorial diversion program might support to move people out of the justice system.

Key Recommendations

This study identified gaps and quantifies demand through user group interactions and statistical inquiry and resulted in the following major recommendations:

- Create a **23-Hour Crisis Relief Center (CRC)** which would be the "first door" for the mental health and substance use disorder system. It would serve up to 35 clients daily, with up to 22 at a time.
- Create a **Co-Occurring Disorders (COD) Facility**: The COD facility would provide treatment for mental health, substance use, and comorbid disorders with 32-beds, potentially needing to expand to 48 beds by 2045.
- A **Psychiatric Urgent Care** (PUC) was initially intended as a crisis response for very short-term outpatient evaluation and treatment in a clinical setting. However, it was determined that this demand could be met at the CRC, so **it is not recommended to create a standalone PUC** at this time, but rather to include this function as part of overall CRC functions, which is incorporated into the CRC proposal in this report.

Other Considerations and Next Steps

- **Operational Costs.** Very important, along with the anticipated construction costs, will be ongoing confirmation of the BCC's annual operating budget as the project progress. Staffing will be the most substantial operating cost for the BCC. Medicaid reimbursements and other potential sources of income for the BCC will also require ongoing, detailed analysis, as policy and funding opportunities may change year after year.

- **Facility Programming Is the Next Step.** Programming will articulate user, functional, space, design, and technical requirements to give direction to the architects. The program will be needed to accurately estimate capital and to refine operating costs for the BCC, which will help to inform its feasibility.
- **Long-term Flexibility.** Consideration must be given to long-term flexibility in order to accommodate potential future demand.
    - The presence of the BCC will draw out demand not readily apparent in the community at this time because the service is less available. While there are some co-occurring disorders services in the county, the CRC is uniquely important and, if only part of the BCC can be built at one time, the CRC should be the first step.
    - In the longer-term, there is likely to be sufficient demand to justify creating a standalone PUC. Facility planning should consider how future growth will be accommodated, perhaps including some added support space initially, and planning the site, infrastructure, and interior layout to effectively add capacity as needed.

Attachments

Attachment A: Whatcom County Sequential Intercept Model 2022

SEQUENTIAL INTERCEPT MODEL UPDATE 2022

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
Community Services	**Law Enforcement**	**Initial Detention / Initial Court Hearings**	**Jails / Courts**	**Reentry**	**Post-Incarceration Community Supports**
Programs in Place:	***Programs in Place:***	***Programs in Place:***	***Programs in Place:***	***Programs in Place:***	***Programs in Place:***
0.A ● Community Paramedic ● Ground-level Response & Coordinated Engagement (GRACE) Program ● Law Enforcement Assisted Diversion (LEAD) ● Homeless Outreach Team (HOT) ● Alternative Response Team (ART) ● Way Station (hygiene, medical, behavioral health services, medical respite for homeless individuals) – funding & planning in place ● Downtown Safety Ambassadors ● Lummi Cedar Project ● Community providers of mental health treatment services ● Community providers of substance use disorder treatment services ● Crisis Stabilization Center (detox & mental health crisis stabilization) ● Community Medicated Assisted Treatment ● Lighthouse Mission Programs (Street Connect Outreach Program), Base Camp (Low Barrier Shelter) ● Opiate Outreach & Engagement (Prescription Take Back, prescription lockboxes & safe storage, opiate addiction outreach & education) ● School District Prevention Programs (Strengthening Families, Building Healthy Communities, Community Coalitions, In-School Prevention/Intervention Services, Communities in Schools, Sendan Center, Community Resilience Research)	**1.A** ● Ground-level Response & Coordinated Engagement (GRACE) Program ● Law Enforcement Assisted Diversion (LEAD) ● Sheriffs' Office behavioral health trained deputies ● Co-Responders with Sheriff Deputies ● Alternative Response Team (ART) ● Specialized training for law enforcement & 1st responders ● Truancy/discipline school-based services ● Law Enforcement Crisis Intervention Team (CIT) training ● Crisis Stabilization Center (12-hour Law Enforcement holds) ● Specialized training for case managers ● Crisis Intervention/Hostage Negotiation Training ● Cite & Release ● NWYS (Teen Court) ● Law Enforcement direct referral (direct line) to Mobile Crisis Outreach Team (MCOT)	**2.A** ● Law Enforcement Assisted Diversion (LEAD) ● Jail Behavioral Health Program (mental health screening & suicide assessments) ● Juvenile Court Behavioral Health Services ● Superior Court & District Court Pretrial Risk Assessment ● Superior Court Pretrial Services Unit ● Electronic Home Monitoring (EHM) in lieu of detention when applicable ● District Court phone call and text reminders for select court calendars ● District Court electronic monitoring (SCRAM & Soberlink) ● Bellingham Municipal Court: Pretrial SCRAM, Pretrial GPS EHM, Pretrial Risk Assessment, and 2x/week warrant quash ● District Court: Pretrial Unit and Pretrial Electronic Equipment Program	**3.A** ● DUI Victim Impact Panel ● Work and school release ● Inside facility and In-custody work crew ● Specialized courts (Teen Court, Drug Court, Family Court, Mental Health Court) ● Jail Behavioral Health Services (MHPs, Psy, ARNP) ● Medications for Opioid Use Disorder (MOUD) program ● Jail Health Program (M.D., ARNP, & Dentist) ● Sheriff's Office reduced fees and increased eligibility for jail alternatives ● Expanded and increased out-of-custody work crew and work release capacity ● District Court Post-Conviction Electronic Equipment Program ● Homeless Outreach Team (HOT) ● Bellingham Municipal Court: Mental Health Court, DV Court, EHM in lieu of incarceration ● District Court High Risk DV Unit, court text messaging ● Juvenile Court Behavioral Health Program ● Law Enforcement Assisted Diversion (LEAD) ● Bible study & 1-1 faith-based counseling ● Domestic Violence Sexual Assault Services (DVSAS) group meetings & emergency notification resource for victims ● Self Help support groups (AA/NA)	**4.A** ● Short-term housing for stabilization ● Program for Assertive Community Treatment (PACT) specializing in jail referrals ● Peer Pathfinders (Pilot) - warm handoffs, case management ● Prescriptions and access to prescriptions upon release ● Specialized Behavioral Health Unit in District Court ● GRACE Program ● Substance use disorder assessments & treatment coordination ● Law Enforcement Assisted Diversion (LEAD) ● Jail Behavioral Health Support & Reentry Services	**5.A** ● Peer-to-peer community supports (12-step programs, volunteer organizations) ● Community Medicated Assisted Treatment ● GRACE Program ● Whatcom Dispute Resolution Center (WDRC) (adult conflict resolution training and skill building workshops, Youth restorative practices/justice services & conflict resolution training) ● Parent Child Assistance Program (PCAP) ● Homeless Outreach Team (HOT) ● Offender Reentry Community Safety (ORCS) – DOC ● Scattered site housing & permanent supportive housing (22 North, Francis Place, Sun I Street apartments, Greggies House, Sun House Shelter, City Gate) ● Shelter Plus Care/Supportive Housing Program Vouchers, Veterans Affairs Supportive Housing, Supportive Services for Veteran Families ● Opportunity Council Community Leasing, Subsidized Housing Program (SHP) for Chronic Homelessness ● Bellingham Comprehensive Treatment Center (Methadone) ● Men's Recovery House (clinically managed low intensity residential services)

1 = Behavioral Health Gap Analysis Team rating highest priority program/service to reduce jail population
2 = Behavioral Health Gap Analysis Team rating high priority program/service to reduce jail population
3 = Behavioral Health Gap Analysis Team rating medium priority program/service to reduce jail population

12/28/22

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
Community Services	**Law Enforcement**	**Initial Detention / Initial Court Hearings**	**Jails / Courts**	**Reentry**	**Post-Incarceration Community Supports**
• Youth Marijuana Prevention & Education • Syringe Support Services (mobile & State Street) • Northwest Youth Services (NWYS) (Ground Floor Drop-In Center, Supported Employment for Youth) • Whatcom Dispute Resolution Center (WDRC) (adult conflict resolution training & skill building workshops, youth restorative practices/justice services & conflict resolution training) • Domestic Violence & Sexual Assault Services (DVSAS) (survivor advocacy, shelter, and perpetrator services • Parent Child Assistance Program (PCAP) • Brigid Collins Parenting Academy • Northwest Regional Council (provides nursing and medical services in jail. Support for individuals with disabilities and complex medical conditions) • Nurse Family Partnership (prevention-based programming)			• Substance use disorder assessments provided in the jail – Criminal Justice Treatment Account (CJTA) funding		• Law Enforcement Assisted Diversion (LEAD) • Lighthouse Mission (Ascent Program & Agape Home) • Law Advocates – Access ID • Crisis Stabilization Center (detox & mental health crisis stabilization)

1 = Behavioral Health Gap Analysis Team rating highest priority program/service to reduce jail population
2 = Behavioral Health Gap Analysis Team rating high priority program/service to reduce jail population
3 = Behavioral Health Gap Analysis Team rating medium priority program/service to reduce jail population

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
Community Services	**Law Enforcement**	**Initial Detention / Initial Court Hearings**	**Jails / Courts**	**Reentry**	**Post-Incarceration Community Supports**
Programs in place with resource shortage:	***Programs in place with resource shortage:***	***Programs in place with resource shortage:***	***Programs in place with resource shortage:***	***Programs in place with resource shortage:***	***Programs in place with resource shortage:***
0.B ● Scattered-site Permanent Supportive Housing (additional locations) and onsite or improved access to clinical support and intensive case management 1 ● Intensive case management needed for facility-based Permanent Supportive Housing Programs 1 ● Mobile Crisis Outreach Team (MCOT) (additional staff for reduced response time when law enforcement comes in contact) 2 ● Transportation Van (EMS currently – expansion to all individuals needing transport related to services 2 ● Clean and sober housing 2 ● Domestic Violence Perpetrator Opportunity for Treatment Services (DVPOTS) 2 ● Housing Case Management (additional capacity/training to support people with behavioral health needs) 3 ● Sex offender ADA accessible housing 3 ● 2nd Chance Employer Program 3 ● Eviction prevention assistance (Case Manager) 3 ● Homeless Outreach Team – expand services outside of Bellingham and 24/7 3 ● Student Assistance Programs (mental health counseling, substance abuse counseling, & family resource coordinators) 3 ● Youth Mental Health First Aid Trainings 3 ● 988 Roll Out Community Access Point 3	**1.B** ● Mobile Crisis Outreach Team (MCOT) (Additional staff for reduced response time when law enforcement comes in contact) 2 ● Behavioral health specialized law enforcement in multiple jurisdictions (additional capacity) 2 ● Community Outreach and Recovery Support (CORS) (additional capacity) 3	**2.B** ● Mental Health-Assisted Outpatient Treatment/Least Restrictive Alternative (LRA) (additional staff) 2 ● Public Defender Behavioral Health Specialist 3	**3.B** ● Court-ordered competency evaluation services performed locally in appropriate setting. 2 ● Increased work release capacity 2 ● Domestic and sexual violence jail-based women's support group 2 ● Video visiting capabilities (limited electronic tablets for incarcerated individuals) ● Vocational and literacy training for offenders, with bilingual accessibility 3 ● Increased warrant quash opportunities 3	**4.B** ● Jail Reentry Services, (additional capacity) – both in jail & in community reentry staff, 2nd Sheriff Corrections reentry specialist, reentry navigators) 1 ● Employment resources (i.e., 2nd chance employers, Goodwill reentry employment services) 2 ● Increased work release capacity 2 ● Coordinated Entry referral system (additional staff) 3 ● Brigid Collins Family Support Services 3	**5.B** ● Community Mental Health and Substance Use Disorder Treatment (additional capacity) 1 ● Scattered-site Permanent Supportive Housing (additional locations) and onsite or improved access to clinical support and intensive case management 1 ● Intensive case management needed for facility-based Permanent Supportive Housing programs 1 ● Program for Assertive Community Treatment (PACT) (additional capacity) 1 ● Domestic Violence Perpetrator Opportunity for Treatment Services (DVPOTS) 2 ● Sun House - emergency shelter (additional staff, operational costs, upgrades HVAC system) 2 ● Clean and sober housing 2 ● Additional rental assistance for post-incarcerated individuals 3 ● Shelters for individuals post-incarceration 3

1 = Behavioral Health Gap Analysis Team rating highest priority program/service to reduce jail population
2 = Behavioral Health Gap Analysis Team rating high priority program/service to reduce jail population
3 = Behavioral Health Gap Analysis Team rating medium priority program/service to reduce jail population

Intercept 0	Intercept 1	Intercept 2	Intercept 3	Intercept 4	Intercept 5
Community Services	**Law Enforcement**	**Initial Detention / Initial Court Hearings**	**Jails / Courts**	**Reentry**	**Post-Incarceration Community Supports**
Programs recommended but not in existence:	***Programs recommended but not in existence:***	***Programs recommended but not in existence:***	***Programs recommended but not in existence:***	***Programs recommended but not in existence:***	***Programs recommended but not in existence:***
0.C • Mental health & substance use disorder assessments on demand/no waiting 1 • Youth Street Outreach Team (NWYS) 2 • Sobering Center 2 • Services for youth Transitioning out of youth services (loss of care at age 25) – warm handoff to adult system 2 • 24/7 drop-in center for persons experiencing homelessness with BH, employment, case management services 3 • Trauma Informed Care training across all intercepts 3 • Homeless Outreach Stabilization Transition (HOST) Program with behavioral health clinical staff 3 • Projects for Assistance in Transition from Homelessness (PATH) 3 • SSI/SSDI Outreach, Access, & Recovery (SOAR Program) 3 • Safe storage 3 • Alternative shelters (Smaller capacity, low stimulation, increased sense of safety for participants/ individuals releasing from jail) 3 • Social Worker in jail for support of individuals with memory care needs	**1.C** • Dedicated Designated Crisis Responder to Bellingham Police Dept/Whatcom County Sheriff's Office (reduction of response time for law enforcement-involved potential Involuntary Treatment Act calls)1 • Neighborhood Policing 2 • Inpatient/Crisis facility for individuals with serious mental illness & violent behavior 3 • Triage mental health unit for juveniles 3	**2.C**	**3.C** • Court-ordered competency restoration services (state funded) performed locally in appropriate setting 1 • Intensive case manager for the jail 1 • Dedicated housing for therapeutic court members 1 • Mental health & substance use disorder assessments on demand/no waiting 1 • Evidence-based treatment for methamphetamine & other substance use disorders 1 • Parenting & family support programs for families with incarcerated caregivers 2 • Whatcom Literacy Council (1 on 1 tutoring as needed) 3 • In jail assistance with resume writing, interview techniques and skills 3 • Worksource group counseling (interview prep & finding employment) 3 • Parents for Parents support group (discontinued at onset of COVID) 3 • GED Program for incarcerated individuals (No available space in current jail facility) 3	**4.C** • Discharge planning and mainstream benefits enrollment or reinstatement 1 • Program for Assertive Community Treatment (PACT) dedicated to reentry 1 • Employment assistance in community 2 • Sheriff's Office Corrections Bureau: Reentry services for release from incarceration other than Whatcom County jail 3 • Peer reentry specialists' program 3 • Inpatient behavioral health treatment for parents with children 3 • Temporary housing for individuals who committed a violent domestic crime but need to abide by a protective order to stay away from their victim 3 • Funding for housing costs, utilities when wage earner is ordered to stay away from the home by protective order 3 • Housing Lab in jail run by Whatcom Homeless Service Center (discontinued due to COVID, workforce/remote ineffective) 3	**5.C** • Safe storage location 2 • Behavioral health consultation to housing providers 3 • Recovery house (3/4-way house after treatment) (female) 3 • Sex offender ADA accessible housing 3 • City Ambassadors employment program – i.e., Downtown Seattle Association (DSA) Clean Team, Safety Team, Outreach Team in Seattle 3

1 = Behavioral Health Gap Analysis Team rating highest priority program/service to reduce jail population
2 = Behavioral Health Gap Analysis Team rating high priority program/service to reduce jail population
3 = Behavioral Health Gap Analysis Team rating medium priority program/service to reduce jail population

Attachment B: Prosecutorial Diversion Analysis for the BCC's Co-Occurring Disorder Facility