Mental Illness and Drug Dependency Action Plan

June 2007

Mental Illness and Drug Dependency Action Plan:
Phase I
September 1, 2006

Background

In April 2006, King County Executive Ron Sims asked the Department of Community and Human Services (DCHS) to convene a workgroup to identify service system needs, and possible ways of addressing those needs, for individuals impacted by mental illness and chemical dependency. The workgroup was facilitated and staffed by Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), and included representatives from DCHS, the King County Council, Superior Court, District Court, DCHS Community Services Division, Office of Management and Budget, Jail Health Services, Department of Adult and Juvenile Detention, Judicial Administration, Community Corrections, Office of the Prosecuting Attorney, and Office of the Public Defender. The workgroup met during the months of April, May and June. There was in-depth discussion of service system needs and problems and the workgroup identified a number of new services and programs, as well as improvements and enhancements to existing programs.

On July 24, 2006, the King County Council approved Motion 12320 calling for the development of an action plan to "prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."

The first phase of the action plan is to address steps that can be taken in the next six months to initiate development of a full continuum of services. The following describes the service and housing improvements needed to achieve the full continuum of services, as well as those improvements that can be made in the near future with available and potentially available resources.

System Needs

1. A large number of adults and juveniles enter the criminal justice system due to mental illness and/or chemical abuse and dependency. The criminalization of mental illness is recognized as a nationwide problem. Nationally, an estimated 16 percent of adults and 24 percent of juveniles in county and city jails suffer from a mental illness. About six percent of adults in jail have a serious mental illness. The percentage of adults and juveniles in jails who have a chemical dependency problem is much higher, with estimates ranging from 60 to 80 percent. Many individuals suffer from a co-occurring mental illness and chemical dependency disorders. An epidemiological study conducted in 1998 by King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) found that adults in the mental health system who

abused drugs and alcohol were five times as likely to have been incarcerated as those who did not abuse drugs and alcohol.

2. Once in jail, adults who are mentally ill stay in jail longer than individuals who do not have a mental illness. A study recently conducted by the King County Department of Adult and Juvenile Detention found that the average offender who remains in jail more than 72 hours has an average length of stay of 12 days for misdemeanor offenses and 24 days for felony offenses. If the offender has a mental illness, the average length of stay is 158 days. In addition, the daily cost of care while in the jail is much higher for the mentally ill population than for the non-mentally ill population, due to the additional staff needed to observe and keep safe individuals who are at greater risk for suicide, and to the extra costs for psychiatric services and medications.
3. Individuals with mental illness and chemical dependency are frequent users of expensive hospital emergency room services. A July 2004 study conducted by the Washington State Department of Social and Health Services (DSHS) found that 94 percent of clients who visited hospital emergency rooms in King County 21 times or more in fiscal year 2002 had a diagnosis of either a mental illness, or a chemical dependency, or both. The cost for emergency room services alone for these 125 individuals was over $3.2 million in FY2002.
4. More than 8000 people are homeless in King County each night, and many of them have mental illness, chemical dependency, or both. A 1998 King County study found that individuals enrolled in mental health services that were homeless were four times as likely to be incarcerated as those who had housing. Less than 30 percent of homeless persons served in the public mental health system are able to secure housing within one year of beginning services. As the cost of housing skyrockets in King County, it is increasingly difficult for people on limited incomes to find affordable housing. For individuals whose sole source of income is public assistance related to a disability, affordable housing is virtually nonexistent unless they are fortunate enough to obtain subsidized public housing and find a landlord willing to accept them with this subsidy.
5. A study of children's health in Washington conducted in 2003 by DSHS found that eight percent of Washington's children needed mental health services, but only 43 percent of those children actually received them. Only 20 percent of youth who need chemical dependency treatment are able to receive it. The primary funding source for public mental health and chemical dependency treatment services is Medicaid, and access to services is severely limited for those who are not eligible for Medicaid. The state recently increased funding for chemical dependency treatment in order to increase access to treatment, but most of this funding is available only for those who qualify for Medicaid. Often the only services available to those who are not on Medicaid are the most expensive services: crisis intervention and hospitalization.
6. King County has the highest cost of living in the state, yet King County receives less mental health funding per person served than many other parts of the state, making it difficult for treatment providers to be able to pay livable wages to their staff and difficult to attract and keep high quality professionals. Low state payment rates have also resulted in very large caseloads, which limit the ability of staff to provide the best possible care to their clients. In fiscal year 2004, according to the DSHS state-wide publicly funded mental health performance indicator report, King County received

$2,996 in mental health funding for every Medicaid-eligible person served, compared to a state-wide average of $3,553 in funding per person served.

7. Juvenile Court has a number of highly effective programs to help youth and their families recover from mental illness and substance abuse. These include Family Treatment Court, Juvenile Drug Court, and Juvenile Treatment Court, in addition to proven best practice programs. Funding is limited, however, and many youth and families are not able to be served by these programs.
8. Adult mental health and drug courts have been proven to be highly effective in engaging individuals in treatment and reducing recidivism. Current programs are at capacity, and there are often waiting lists for treatment programs.
9. The Community Center for Alternative Programs (CCAP) was designed to serve up to 75 individuals, but is now serving approximately 225 individuals – stretching staff, programs and space beyond sustainable limits.
10. There are very limited vocational and employment opportunities available for individuals who are homeless, mentally ill, or chemically dependent. Without employment options, the likelihood for further criminal justice involvement remains high.

Program Recommendations

The following program recommendations reflect current thinking of the work group of county staff regarding what is needed – in order to build upon current successful programs, and to ensure a continuum of services for adults and youth in the mental health, chemical dependency and criminal justice systems.

1. Establish countywide crisis diversion facilities, serving adults and juveniles that divert individuals from criminal/juvenile justice by providing access to needed assessment, stabilization, services and treatment. Include a variety of "front door" access options that emphasize prevention/early intervention.
2. Provide crisis intervention training for the King County Sheriff, other police departments, and jail staff.
3. Maintain and expand therapeutic courts and associated community linkages and services for juvenile offenders. Include expansion of Family Treatment Court, Juvenile Drug Court and Reclaiming Futures.
4. Expand therapeutic courts and associated community linkages and services for adult offenders.
5. Expedite processes involving competency evaluations and restoration to reduce the time individuals remain in jail.
6. Provide access to co-occurring disorder treatment for all people being released from jail who need this type of treatment.
7. Increase capacity and programming at the Community Center for Alternative Programs (CCAP).
8. Provide a variety of appropriate, affordable housing options along with supportive services to help individuals maintain their housing.
9. Provide a wide range of employment opportunities for adults and juveniles who are at risk for involvement in the criminal justice system due to mental illness and/or

chemical dependency. Provide mental health/chemical dependency case management services for youth in work training.

10. Reduce caseload size in the mental health system to enable more responsive and intensive services.
11. Increase access to mental health and chemical dependency services for children and adults who are not on Medicaid. Prioritize services for those most in need.
12. Increase access to educational services for youth who are recovering from alcohol and drug abuse, including juvenile justice involved youth.
13. Increase resources for high need youth and their families.
14. Enhance case management for individuals who are chemically dependent.
15. Provide an ongoing "Access to Recovery" program. This grant-funded program, which will lose funding in late 2007, provides access to and payment for a range of treatment and recovery support services that help low-income people succeed in treatment.

Next Steps

While the foundation has been established for many of these programs, and incremental improvements may be possible with dedicated resources from the 2005 Veterans and Human Services Levy and through the Committee to End Homelessness in King County, the recommendations listed above cannot be fully implemented within current resources. For example, countywide crisis diversion facilities that can serve to divert both juveniles and adults from entering the criminal justice system could not be implemented without a significant investment of resources.

Short-term Action Steps

1. The State Mental Health Division received funding from the 2006 State Legislature to begin implementation of Programs for Assertive Community Treatment (PACT) in 2007. King County will receive funding to provide intensive services for up to 200 individuals with severe mental illness, many of whom are homeless and cycle in and out of the jail and hospitals. PACT uses a multi-disciplinary team of professionals to provide high-intensity services that are available 24-hours per day, and is a nationally recognized evidence-based program. The implementation of these teams is expected to reduce jail use by some of the more frequent users of the jail.

2. The Committee to End Homelessness in King County (CEHKC) intends to apply for state funds available under the Homeless Housing and Assistance Act (House Bill 2163). CEHKC plans to submit a proposal for a pilot program that will provide subsidized housing for individuals being discharged from the criminal justice system, Western State Hospital and Harborview Medical Center. Housing would be dedicated to those individuals who are enrolled in PACT services, as described above.

3. MHCADSD is partnering with the Seattle Office of Housing, King County Housing Authority, Seattle Housing Authority, King County Housing and Community Development, United Way of King County and others to help assure that funding for

new and renovated housing prioritizes housing for individuals with mental illness and chemical dependency who come into contact with the criminal justice system.

4. MHCADSD received additional state funding in the 2006 state supplemental appropriation, which has allowed for a substantial increase in the number of non-Medicaid eligible people who will be able to receive outpatient mental health services. Services are prioritized for those most in need, but funding is still far below the amount needed to serve those in need.

5. MHCADSD is continuing to work on implementation of its Mental Health Recovery Plan. MHCADSD has contracted with a consultant to help redesign the way that providers are reimbursed for services. The goal is to reward recovery outcomes, including increasing the number of consumers who are employed and in appropriate and stable housing, and decreasing the number of consumers who are hospitalized or incarcerated.

Mental Illness and Drug Dependency Action Plan:
Phase II
March 16, 2007

Executive Summary

Background

On July 24, 2006, the Metropolitan King County Council approved Council Motion 12320 calling for the development of an action plan to "prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."

The first phase of the action plan was completed on September 1, 2006 with the submission of a report to the council that presented an overview of system needs, a description of potential services to meet identified needs, and a description of current initiatives and action steps that could be taken within existing resources to assist those in need in the short-term.

The Council Motion called for the second phase of the action plan to "address changes in criminal justice case processing to more effectively deal with people with disabling mental illness and chemical dependency when appropriate service and housing options are available in the community. The areas to be considered in this planning process are prearrest diversion, prebooking diversion, the use of deferred prosecutions, alternative sentencing methods including therapeutic courts, improvements to the processes for evaluating defendant competency and for involuntary commitment and improvements in screening, assessment and discharge planning that connect directly with community service engagement and placement."

Process

Under the guidance of the Department of Community and Human Services, separate processes were followed to develop action plans specific to adult and youth populations. An adult workgroup was established and was co-facilitated and staffed by the Office of Management and Budget (OMB) and the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). Participants for the adult workgroup included representatives from the Department of Community and Human Services, King County Council staff, Superior Court, District Court, Seattle Municipal Court, Seattle City Attorney's office, Community Corrections, Department of Adult and Juvenile Detention, Judicial Administration, Jail Health Services, Health Care for the Homeless, Office of the Public Defender, Associated Counsel for the Accused, Office of the Prosecuting Attorney, MHCADSD, Downtown Emergency Services Center, King County Sheriff, Seattle Police, King County Mental Health Advisory Board, and Harborview Medical Center. The adult workgroup formed two sub-groups, one focused on community crisis and diversion services and one focused on the criminal justice case processing system. The sub-groups then reconvened as a larger workgroup to complete the planning process.

Rather than forming a new workgroup to develop the youth action plan, two existing workgroups (the Juvenile Justice Operational Master Plan (JJOMP) workgroup and the King County Systems Integration Initiative Executive committee) agreed to use some of their meeting times to work on the phase two action plan. Participants in these groups included representatives from the Mental Health, Chemical Abuse & Dependency Services Division, the Office of Management & Budget, King County Council staff, Department of Community and Human Services, Office of the Public Defender, Office of the Prosecuting Attorney (Juvenile Division), The Defender Association, Department of Child and Family Services, Children's Administration, Superior Court (Juvenile Division), Team Child, Puget Sound Educational School District, Seattle Police Department, Juvenile Rehabilitation Administration, and the Department of Adult and Juvenile Detention, among others.

Both the adult and youth workgroups met several times to identify the major intercept points at which opportunities for intervention exist that could divert people from entering or staying longer in the criminal justice system. The juvenile workgroups also did considerable work identifying process issues within other related systems, such as the dependency process, At-Risk Youth petitions (ARY), Child-in-Need-of-Services petitions (CHINS), the school truancy process, and the child welfare system. There was agreement among the JJOMP and Systems Integration group participants that intervening within these related systems creates opportunities to help children and youth and their families gain skills and access resources which should reduce the risks of future involvement with the youth justice system.

There are considerable differences between the adult and juvenile criminal justice systems, including the development of alternatives to incarceration. As a result of the JJOMP plan and the collaborative work done by the JJOMP workgroups, the Systems Integration Executive Steering Committee, and the Juvenile Detention Oversight Committee, many youth are already being diverted from juvenile detention. Due to these differences, the Phase II Action Plan has been divided into two separate action plans, one for adults and one for youth.

Action Plan for Adults

The action plan for adults follows the Sequential Intercept Model developed by the National Global Appraisal for Individual Needs Center for People with Co-occurring Disorders in the Justice System. This same model is also being followed by a statewide group that was convened following the King County Sheriff's Mental Health Summit in September, 2006. At each intercept point, workgroups identified who is the target population, who has discretion to make decisions regarding diversion, what information is needed by the decision makers, what policy or legal changes are needed in order to divert, and what community resources and services are needed for the diversion to be considered and to increase the likelihood of success. The intercept points used to organize recommendations for process changes and services are:

- Access to Appropriate Services. The Sequential Intercept Model defines community services as the ultimate intercept. A comprehensive system of community services is essential to the ultimate success of any program to divert people from jails, hospitals, prisons, and other emergency services. These services include the best clinical

practices that have been demonstrated to be most effective in preventing the criminalization of people with mental illness and chemical dependency. The rates community providers currently receive for chemical dependency and mental health treatment are not sufficient to develop a comprehensive, best-practice system of care that is accessible to all who need this level of service. A range of accessible housing options (emergency, interim, and long-term) is another major resource need that was identified by the workgroup.

- Law Enforcement and Emergency Services. Recommended services and programs at this intercept point include crisis intervention training for police and other front-line responders, crisis diversion or crisis stabilization centers, and short-term and permanent supported housing and services connected to the crisis centers.
- Post-arrest: Initial Detention and Initial Hearings. Diversion opportunities at this point include referring individuals for involuntary commitment evaluations prior to filing, and releasing some individuals prior to filing when appropriate and safe community treatment has been arranged. There needs to be a full safety net of services available before diversion from jail can be fully utilized.
- Post-initial Hearings: Jail, Courts, Forensic Evaluations and Forensic Commitments. Once charges are filed, there are a number of opportunities for diversion, depending on the nature of the crime. Options identified as the most promising include, deferred prosecution, expanding the current felony drop-down population, establishing a felony mental health court, expanding district mental health court to include suburban city cases, and staying the competency process to allow for individuals to enter and complete community-based treatment. Key resource needs identified at this diversion point include additional court liaisons and case managers, in-patient co-occurring disorder treatment capacity, housing, and employment options.
- Re-entry from Jails, Prison and Hospitals. This intercept point focuses on providing continuity of care when a person is released from institutional care or confinement. While King County already has devoted considerable resources to funding the Criminal Justice Continuum of Care Initiative, there are still gaps in services, particularly in the area of housing resources.
- Community Corrections and Community Support. Again, King County has devoted resources to this area in establishing the Community Corrections Division. However, some of the programs are overcrowded and more housing and other community treatment resources are still needed.

Action Plan for Youth

The action plan for youth builds upon the work already done by the JJOMP and Systems Integration Initiative, and on the Mental Health Task Group report that was recently completed. The results of the discussions are organized according to the following areas:

- Cross-System Priorities: Participants highlighted a set of high priorities that apply to decision points across all systems serving youth and families. These priorities include standardized screening and assessment; strategies to help youth and families navigate the complex mental health and chemical dependency systems and connect them to services; better supports for parents and guardians to maintain in their home, a child with mental health needs; training to front-line staff in the justice system to better recognize and respond to mental health and substance abuse issues; and additional capacity in the community for short-term crisis stabilization beds, reception/assessment centers, and psychiatric/psychological evaluations.
- Child Protective Services-Dependency Process: The report of a potential incident of abuse and neglect to Child Protection Services (CPS) within the Washington State Department of Social and Health Services (DSHS) could lead to services, placement of the youth in foster care, and/or the filing of a dependency petition in King County Superior Court. High-risk CPS families can face underlying issues such as mental health, substance abuse, and/or domestic violence. This process is an early opportunity to identify the treatment needs these families and to link them to services. A key strategy is to continue the cross-system collaboration underway in the Systems Integration Initiative to support CPS' efforts to develop standardized screening/assessment and linkages to services. If a dependency matter is filed, Family Treatment Court is an innovative model involving treatment, judicial monitoring, and individualized services. However, the lack of capacity in the community for residential treatment beds and mental health evaluations is a significant barrier to expanding this program.
- Family Reconciliation Services-ARY/CHINS Process: Families in crisis, which includes a child who is running away, can request services from Family Reconciliation Services (FRS) within DSHS. If these services do not resolve the crisis, an At-Risk Youth petition (ARY) or Child-in-Need-of-Services (CHINS) petition could be filed in King County Superior Court. During this discussion, the workgroup focused on ensuring police and other front-line responders have training, support, and options to assist youth and families in crisis. Particular strategies could include a centralized phone line for these responders to call, addressing the shortage of inpatient hospital beds, expanding crisis outreach and stabilization services, and piloting a reception/assessment center. If families in conflict seek assistance from FRS, there is an opportunity to identify youth with treatment needs and connect them to services. In those cases where a petition is filed, additional resources for case management and positions to help families navigate the treatment systems may be needed.
- Child Welfare Services: Youth with complex needs are often referred to Child Welfare Services within the DSHS because their parents are refusing to take them home. These cases often need the full range of support services for the family, particularly short-term residential placements and respite care.
- Schools-Truancy Process: Schools are a potential intercept point for early identification of youth with mental health or substance needs. One indicator of needs, in particular, is truancy. With 19 school districts and many competing

demands, this is a complex area to address. Nonetheless, the workgroup discussed a wide-range of strategies and policy issues. In particular, there was an interest in cross-system coordination and training on best practices related to mental health and substance abuse and in piloting promising approaches to reducing truancy at early intervention points in those communities with the highest truancy rates.

- Offender Process: After police respond to an alleged crime in the community involving a youth, they could refer the matter to the court system by either taking the youth to detention (if eligible) or referring the alleged offense to the prosecutor. The prosecutor based on the sufficiency of the information can file the case in King County Superior Court. One focus of the workgroup was to enhance diversion opportunities for low-level offenders whose treatment and other needs are driving their delinquent behavior. Strategies to assist police were already highlighted within the Family Reconciliation Services-ARY/CHINS Process. Once cases reach the court's diversion program, the workgroup proposed strategies to implement systemic screening and when indicated, linkage to assessment and services. For those cases that are filed, there is work underway to improve screening and assessment. This stage is crucial to trigger possible eligibility to therapeutic courts or disposition alternatives emphasizing treatment. The workgroup also supports the concept of funding positions that would help families navigate the complex process for accessing the publicly funded treatment systems and connecting them to services.

Other decision points and issues that need further discussion include domestic violence, detention, Unified Family Court Intensive Case Management, and youth transitioning out of Juvenile Rehabilitation Administration, foster care, and other systems.

Next Steps

The Phase III action plan will provide a profile, including prevalence estimates, of the target populations, as identified in the Council Motion; determine the services that will best serve the needs of the target populations; recommend options for early identification and prevention of mental illness and chemical dependency; set priorities for system changes and services; estimate costs for a comprehensive set of services and potential funding for these services; and estimate the cost offsets that might be realized if these services achieve their predicted outcomes.

MHCADSD staff have begun to meet with community stakeholders, including mental health and chemical dependency service providers, mental health advocate groups, school districts, suburban cities, and police jurisdictions. Once community input on the needs across the community has been received, a Phase III workgroup of key stakeholders will be established to develop the plan, building upon the prevalence profile and the work done in phases one and two of this process.

Mental Illness and Drug Dependency Action Plan: Phase II
March 16, 2007

Action Plan for Adults

Background

On July 24, 2006, the Metropolitan King County Council approved Council Motion 12320 calling for the development of an action plan to "prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."

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Process

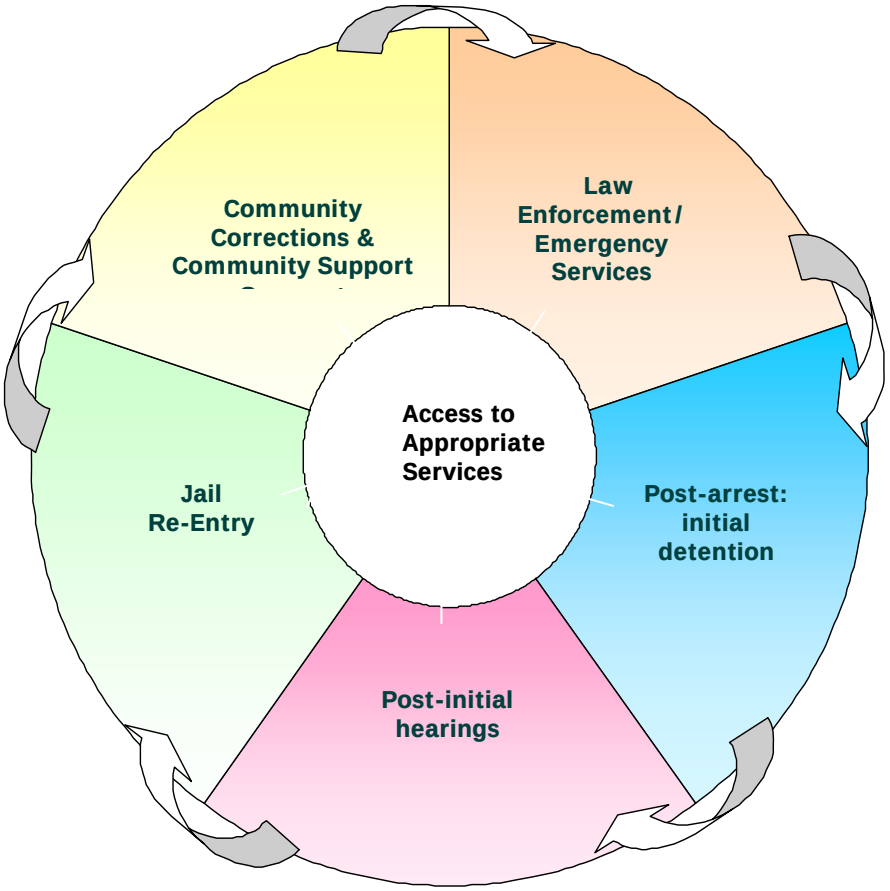
An adult workgroup of subject area experts and stakeholders was established under the guidance of the Department of Community and Human Services to carry out the mission of identifying ways to more effectively help people with mental illness and chemical dependency, while reducing inappropriate and expensive involvement in the criminal justice and emergency services systems. The workgroup was co-facilitated and staffed by the Office of Management and Budget (OMB) and Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). Participants for the adult workgroup included representatives from the Department of Community and Human Services, King County Council staff, Superior Court, District Court, Seattle Municipal Court, the Seattle City Attorney's office, Community Corrections, Department of Adult and Juvenile Detention, Judicial Administration, Jail Health Services, Health Care for the Homeless, Office of the Public Defender, Associated Counsel for the Accused, Office of the Prosecuting Attorney, MHCADSD, Downtown Emergency Services Center, King County Sheriff, Seattle Police Department, King County Mental Health Advisory Board, Emergency Medical Services (EMS), and Harborview Medical Center.

The writers of this report thank the participants in the workgroup for devoting considerable time from their busy schedules to assist in the development of this Phase II, Action Plan for Adults.

The adult workgroup met several times to identify the major intercept points at which opportunities for intervention for the target population exist that could divert people from entering or staying longer in the criminal justice system. The larger group also divided into community services and criminal justice process sub-groups. The community services group identified potential alternatives available for police and other crisis responders to use in place of taking people to hospital emergency rooms and jails. The criminal justice process sub-group worked through the various steps in the criminal legal system where there might be options for diversion from jail. At each intercept point, workgroups identified the target population, who had discretion to make decisions regarding diversion, what information was needed by the decision makers, what policy or legal changes were needed in order to divert, and what community resources and services were needed for both the diversion to be considered and to increase the likelihood of success.

The intercept model (Table 1), which forms the basic model for Phase II work is based on the Sequential Intercept Model developed by the National Global Appraisal for Individual Needs Center for People with Co-occurring Disorders in the Justice System. This same model is also being utilized by a statewide group that was convened following the King County Sheriff's Mental Health Summit in September 2006. The Sequential Intercept Model has been adopted as a best practice model by the Criminal Justice/Mental Health Consensus Project, and is being used as a planning model in Maine, Pennsylvania, Ohio, Virginia, and Oregon.

Table 1
Sequential Intercept Model



Intercept Points for Diversion from the Criminal Justice System

Access to Appropriate Services: Comprehensive Community Services as the Ultimate Intercept

At the center of the Sequential Intercept Model is access to appropriate services. These services include the best clinical practices that have been demonstrated to be most effective in preventing the criminalization of people with mental illness and chemical dependency. Services must be available to those who need them regardless of ability to pay or insurance coverage, and they must be provided by well-trained, experienced, and supportive staff. The rates community providers currently receive for chemical dependency and mental health treatment are not sufficient to develop a comprehensive, best-practice system of care that is accessible to all who need this level of service. The community work group identified a number of key components of an effective community based system of care which would reduce the likelihood of individuals coming to the attention of law enforcement. These include safe, accessible, and affordable housing options (emergency, transitional, and long-term); case management by competent, well-trained, supportive clinicians; Programs for

Assertive Community Treatment (PACT) for individuals with serious mental illness; crisis respite and crisis diversion facilities; street outreach and engagement services; ready access to medication; co-occurring mental health and chemical dependency treatment; vocational training and employment services; 24-hour crisis response services; and consumer-run and consumer-involved services such as clubhouses.

Intercept A: Law Enforcement and Emergency Services

The first opportunity for diversion from the criminal justice system occurs when police come in contact with someone in the community. In order to take advantage of the opportunities that could be created at this intercept point, police need to have training to recognize and distinguish mental illness and chemical dependency, to know how to most effectively interact with people who have these problems, and to know the resources available to resolve the immediate crisis. The Seattle Police Department has had a Crisis Intervention Team since 1998. In this program, officers volunteer to receive comprehensive training, and are then available to respond to situations involving persons who may be mentally ill, developmentally disabled, or under the influence of drugs or alcohol.

In order for diversion to occur at this point of contact with law enforcement, officers need to have easily available, accessible and safe alternatives to incarceration. A number of communities across the country have developed facilities known as jail diversion, crisis diversion, crisis stabilization, or reception facilities. A common characteristic of these facilities is that they have a no refusal policy for referrals from police, that they are available 24 hours per day, and that they are staffed by professionals with expertise in working with people who have both mental illness and chemical dependency. These facilities also need the capacity to directly link individuals with short-term housing and on-going treatment. The community alternatives planning group identified a number of other resources.

This is also an intercept point for other first responders, such as EMS and Designated Mental Health Professionals, to divert people, when appropriate, from hospital emergency rooms. All first responders would need the same access to a facility as police, and training tailored for their needs.

Intercept B: Post-arrest: Initial Detention and Initial Hearings

Even with the accessible and high-quality community services, trained police crisis intervention teams, and crisis diversion facilities in place, a number of individuals with mental illness and chemical dependency will still be arrested. For those individuals who commit less serious, violent crimes and who pose a lower risk to community safety, a number of alternatives to incarceration have been identified. These include referring individuals for civil commitment under either the mental illness or chemical dependency commitment statutes (71.05 RCW and 70.96A RCW) and providing assessments to all eligible offenders in order to increase the opportunity for judicial release to community services or community corrections services. There would need to be policy and criteria established for the target population based on the event and the risk. For felons, the release would be at the discretion of the judge at first appearance or other hearings upon referral by the defense or prosecuting attorney. For misdemeanants, discretion would be

by personal recognizance staff through Felony Administration Recognizance Release guidelines and/or by the judge. In both cases, there would have to be the full range of safety net services available in the community.

Intercept C: Post-initial Hearings: Jail, Courts, Forensic Evaluations and Forensic Commitments

Once charges are filed, there are a number of opportunities for diversion, depending on the nature of the crime. Options identified as the most promising include:

- Deferred prosecution. Establishing a "bright line" to identify the target population which would be individuals assessed as being a low public safety risk who have an assured connection to community treatment.
- Expand the current felony drop-down population in the King County Mental Health Court. Legislative changes may be needed for consideration.
- Establish a felony mental health court. This would be similar to drug court, but would require legislative changes to establish eligible charges and the period of jurisdiction.
- Expand the mental health court to city cases (Seattle already has a mental health court). This could be done through contract changes with District Court. New court and community resources would be needed.
- Stay the competency process for misdemeanants when the person agrees to appropriate community treatment. Waiting time for competency restoration is a major factor in long jail stays for inmates who have mental illness. Intervening in this process may require legislative changes.

Key resource needs identified at this diversion point include additional court liaisons and case managers, in-patient co-occurring disorder treatment capacity, housing, and employment options.

Intercept D: Re-entry from Jail, Prison and Hospitals

This intercept point focuses on providing continuity of care upon discharge from jail, prisons, and hospitals. King County is already a leader in this area, although there are still major gaps in resources that need to be addressed. Since 2003, King County has funded the Criminal Justice Continuum of Care Initiative, managed by MHCADSD. This project provides jail liaisons who provide jail inmates with assessments and linkages to community services, a jail-based opiate dependency engagement and treatment program, housing vouchers, comprehensive co-occurring dependency treatment, and assistance with applications for publicly funded benefits, including the Alcoholism, Drug Addiction, Treatment and Support Act and Medicaid. King County also has two programs, both run by Seattle Mental Health, providing housing and community services for individuals leaving prisons. The major barrier to the success of all these programs is access to permanent supported housing. Transitional housing, such as might be available through a crisis diversion/reception center, may be an option to ensure that individuals leaving the

jail have a safe place to go where treatment will be available. Another service needed is transportation from jail directly to the housing and treatment sites.

Intercept E: Community Corrections and Community Support

King County has greatly expanded the use of sentencing individuals to community corrections alternatives, to the point that the Community Center for Alternative Programs is now operating far above its projected target population. Additional resources, including a new facility, may be needed to meet the demand for this successful diversion program.

Each of these diversion strategies is dependent on the presence of comprehensive community strategies. At each intercept point, criminal justice officials agreed that they would not be likely to release individuals into the community without assurances that appropriate treatment and housing services would be available.

Next Steps

The work done in the first two phases of the action plan will serve as the basis for the final phase III work. The phase III action plan will provide a profile, including: prevalence estimates of the target populations, as identified in the Council Motion; determination of the services that will best serve the needs of the target populations; recommended options for early identification and prevention of mental illness and chemical dependency; setting of priorities for system changes and services; estimation of costs for a comprehensive set of services and potential funding for these services; and estimation of the cost offsets that might be realized if these services achieve their predicted outcomes.

Mental Illness and Drug Dependency Action Plan: Phase II
March 16, 2007

Action Plan for Youth

Background

A chorus of concerns is rising among elected officials, youth-serving professionals, and youth advocates about the need for greater access to mental health and substance abuse services for youth and families, particularly for those coming into contact with the education, child welfare, and court systems. As noted in the recent report from the King County Systems Integration Mental Health Task Group:

> Failure to intervene early and effectively treat these youth with mental health disorders results in tremendous human and financial costs. . . . Youth who do not receive treatment often end up cycling through the child systems and falling deeper into the criminal justice system.[1]

Contributing to these concerns is the multifaceted and complex set of the barriers to early identification, assessment, engagement, and treatment of youth. Key barriers cited in the aforementioned report include:

- Lack of a crisis stabilization facility for youth
- Lack of standardized screening and assessment
- Confusion and misconceptions about what information can be shared and how it should be used across multiple service systems
- Shortage of crisis stabilization and step down beds that provide an appropriate level of safety and can serve the most challenging and aggressive youth
- Inadequate treatment funding for youth and families not eligible for support in the publicly funded mental health system (Medicaid)
- Poor coordination across service systems to ensure youth and families are adequately identified and linked to treatment and other support services
- Lack of systemic and culturally appropriate approaches to identify youth early – such as in school – and link them to appropriate services
- Lack of psychiatric inpatient beds, particularly for youth who have co-occurring developmental disability or who have past or current history of violent acts.

Council Motion 12320 recognizes the complexity of these barriers in outlining a three-phased action plan to "prevent and reduce . . . unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services." While the first phase focused on the gaps and

[1] Final Report of the Systems Integration Initiative Mental Health Task Group, November 2006

opportunities to develop a full continuum of services, the second phase – the subject of this report – addresses changes to the processes of systems serving youth and families to better identify, assess, and connect clients to services.

Approach for Report

Under the guidance of the Department of Community and Human Services, two initiatives, the Juvenile Justice Operational Master Plan[2] (JJOMP) and King County Systems Integration Initiative[3], joined together to develop strategies for youth. Two existing committees (the JJOMP Workgroup and the Systems Integration Executive Committee) held three extended work sessions focusing on different (but related) youth-serving systems. The JJOMP Workgroup examined the offender and Becca systems. The Systems Integration Executive Committee focused on Child Welfare and Education systems. The report resulting from the work of these groups was reviewed at a joint meeting of the JJOMP Oversight Committee, the Juvenile Detention Oversight Committee and the Systems Integration Executive Committee on March 2, 2007.

The workgroups were asked to envision a major transformation in the response for addressing the needs of youth with mental health and substance abuse issues and to outline strategies for overcoming the barriers to achieve this transformation. Each group followed a similar approach:

- List potential decision points in these systems where youth with mental health and substance abuse needs could be identified, assessed, and connected to services.
- Prioritize these decision points placing at the top those points that lead to early and effective identification, assessment, and linkage of the most youth to treatment and related services.
- For each prioritized decision point, identify potential strategies/options, target population, key decision-makers, information needs, legal/policy issues, and gaps in services.

The results of the discussions are organized according to the following areas:

- Cross-System Priorities: Participants highlighted a set of high priorities that appear to apply to decision points across all systems.
- Child Protective Services-Dependency Process: The report of a possible incident of abuse and neglect to Child Protection Services (CPS) within the Washington State Department of Social and Health Services (DSHS) will trigger a series of activities which could lead to placement of the youth in foster care and the filing of a dependency petition in King County Superior Court.

[2] Since 1998, the committees and workgroups associated with the Juvenile Justice Operational Master Plan (JJOMP) have sought to reduce juvenile delinquency, avoid the cost of detention and court, and serve the needs of at risk youth and their families by supporting innovative policies, practices, and services.

[3] The King County Systems Integration Initiative is a pioneering effort to improve the outcomes of youth and families involved in multiple systems – juvenile justice, child welfare, mental health, and education – through a more coordinated and seamless delivery of services across these systems.

- Family Reconciliation Services-ARY/CHINS Process: Families in conflict, which includes a child who is running away, can request services from Family Reconciliation Services (FRS) within DSHS. If these services do not resolve the crisis, an At-Risk Youth petition (ARY) or Child-in-Need-of-Services (CHINS) petition could be filed in King County Superior Court.[4]
- Schools-Truancy Process: Schools are a potential intercept point for early identification of youth with mental health or substance needs. One indicator of needs, in particular, is truancy. Schools are required to track and respond to youth with unexcused absences. However, when there are seven unexcused absences in a month or ten unexcused absences in one year, school districts are required to file a truancy petition with Superior Court. If the court makes a truancy finding, it can order the youth to attend school and participate in services.
- Offender Process: After police respond to an alleged crime in the community involving a youth, they could refer the matter to the court system by either taking the youth to detention (if eligible) or referring the alleged offense to the prosecutor. The prosecutor based on the sufficiency of the information can file the case in King County Superior Court.
- Child Welfare Services: Older youth with complex needs are often referred to Child Welfare Services within the Department of Social and Health Services because their parents are refusing to take them home.

The final section of the report – Other Noted Decision Points and Issues – covers decision points and issues that generated interest but needed additional discussion. These include Unified Family Court Intensive Case Management, domestic violence, detention, and youth transitioning out of Juvenile Rehabilitation Administration (JRA), foster care, and other systems.

These working sessions provided valuable insights and concrete strategies. All participants contributed not just their time, but also a willingness to challenge assumptions and barriers. It should be noted that those decision points that were not designated as a high priority hold important opportunities for improvements and should be subject to further review.

Cross System Priorities

While opportunities within individual systems are discussed in other sections of this report, there are crucial priorities shared by all systems for effectively identifying youth with mental health and substance abuse needs and linking them to services. These priorities were raised consistently at all decision points. Many of them are also outlined in the Final Report of the Systems Integration Initiative Mental Health Task Group. A summary of these priorities include:

[4] Families can also file an ARY/CHINS petition without having gone through FRS previously; however, as part of the filing requirement, families are to seek an assessment from FRS to accompany the petition at filing.

Screening and Assessment	• Use standardized screening and assessment instruments for mental health and chemical dependency concerns across all service systems at the earliest appropriate point. • Develop an age-appropriate screening instrument for youth under the age of 13.
Information Sharing	• Develop information sharing protocols for the timely and appropriate sharing of information across and within systems serving youth and families. In particular, screening and assessment information consistent with these protocols should be shared between care agencies to avoid subjecting families to redundant and duplicative requests for information and to ensure providers can deliver timely services.
Linking and Engaging Clients to Treatment	• Provide positions with expertise in helping families navigate the complex mental health and chemical dependency systems and connecting them to services.[5] • Provide Parent Partner positions to help families understand the child welfare and justice systems and engage with needed support services.
Treatment Funding	• Provide funding support for at risk youth and families who are not eligible for publicly funded treatment services.
Availability of Services	The Mental Health Task Group Report provides a comprehensive discussion of the desired continuum of care. In particular, the workgroups emphasized the following critical needs: • Short-term crisis stabilization beds appropriate for the most challenging and aggressive youth. • Child psychiatrists and psychologists to conduct psychiatric and psychological evaluations. The current wait can be six months or longer. • Respite care for parents, guardians, and/or other family members. • Comprehensive in-home services such as Family Preservation Services. • Other models (e.g., wraparound) that support not only treatment to youth but also services for the whole family (including siblings) such as respite care, parent coaching, and care coordinators and parent partners. • Long-term residential beds. • Develop reception/assessment center(s) as a resource for police, schools, social workers, and families for youth to receive non-crisis services including screening and assessment.

[5] Responsibilities could include determining whether the client is already enrolled in publicly funded treatment systems, enrolling eligible clients in these systems, working with community treatment providers to identify available services, and arranging for transportation and other supports to ensure families are able to receive services.

Training	Two areas of training were highlighted: • Provide training to front-line staff in the justice system such as police, detention officers, social workers, and probation counselors on how to recognize possible indications of mental health and substance abuse issues and help families connect to resources and services. • Similar to the cross-system training piloted by the Systems Integration project, provide regular training to personnel at all levels within these youth-serving systems on how other systems work and in particular on how to appropriately share information and access resources.
Cross-System Coordination and Accountability	Cross-system efforts such as the King County Systems Integration Initiative should address the following: • Provide a significant role for families and communities to shape these priorities. • Ensure partnerships are in place to develop and implement the information sharing, training, services, coordination protocols, and other priorities. • Establish mechanisms to track and report progress on implementing priorities (e.g., quality assurance measures). • While there is a critical need for additional resources, many improvements are possible within current resources by improving coordination, reducing delays, blending funding, reducing redundant efforts, and other steps that lead to implementing best practices. • Moreover, the priorities and recommendations noted in this report are intended to complement the responsibilities of each agency – not replace them. Without each agency delivering on the services and programs within their core responsibilities, new measures will not be as successful.

Child Protective Services-Dependency Process

Families with complex needs may first come into contact with the child welfare system via Child Protective Services (CPS) within the Washington State Department of Social and Health Services. Addressing mental health and substance abuse concerns may prevent out of home placement, and/or improve the chances of reunification. It may also reduce the likelihood of future involvement in the juvenile and criminal justice systems. The chart below is a simplified representation of the major decision points in the CPS-Dependency Process. The highlighted boxes are the priority points to achieve early identification and connection to services.

<table>
<tr><td rowspan="5">Referral of an Allegation of Abuse & Neglect</td><td>Screened Out</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Low Risk</td><td>Referred to alternative response system</td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">High Risk</td><td>A) Child stays in home and services provided (Voluntary)</td><td></td><td></td><td></td></tr>
<tr><td>A) Child is placed out of home[6] (Voluntary)</td><td></td><td></td><td></td></tr>
<tr><td>A) Child is placed out of home (Not Voluntary)</td><td>Dependency Petition Filed</td><td>B) Court Hearings (e.g., Shelter care, Fact Finding, Disposition)</td><td>Permanency Planning</td></tr>
<tr><td></td><td></td><td></td><td>C) Family Treatment Court (including Order of Dependency & Disposition)</td><td>Permanency Planning</td></tr>
</table>

<u>High Risk CPS Families</u>

In discussing high-risk CPS families, the workgroup noted that mental health, substance abuse, and domestic violence issues are often underlying factors. In particular, families with a recurring pattern of neglect fit this profile. Moreover, most CPS cases do not result in placement or in the filing of a dependency petition.

Starting in January 2007, CPS is required to administer the GAIN Short Screen[7] to children (13 and older) and parents. In addition, children may receive other screening instruments. With these efforts, there appears to be standardized screening at this early point except for children under the age of 13. As the GAIN Short Screen is a new requirement, CPS is working on mechanisms to refer (when indicated) children and parents to providers for assessment. As noted in the section on Cross-System Priorities, there is a need to develop an age-appropriate standardized screening instrument to indicate potential mental health concerns for children under the age of 13.

CPS also noted at this stage that, if the client is not eligible for publicly funded treatment services, families may not have the resources for treatment. CPS has a limited pool of funds that, while primarily focused on services for children, falls short of the need. Specifically, there is a resource gap for children and parents who are not eligible for publicly funded treatment services.

Engaging families in treatment services faces some of the same challenges outlined in the Cross-System Priorities Section, including helping families navigate complex treatment systems, a shortage of residential beds and respite care, and the need for wraparound services such as family preservation services.

[6] Placements included licensed family foster care, therapeutic foster care, in-home behavioral rehabilitative services, and relative care (unlicensed).

[7] Global Appraisal for Individual Needs (GAIN)

In cases where the legal threshold for dependency is not met, CPS may have difficulty in engaging families who need services but refuse to participate. This may limit the response to families where mental health, substance, and domestic violence issues are contributing to a recurring pattern of neglect. Further cross-system discussions are needed to address this situation.

Shelter Care – Disposition Hearings

If the case reaches the point of the filing of a dependency, the court has the opportunity to order screening, assessment, and services at the initial shelter care, 30-day shelter care, disposition, and other hearings.

Family Treatment Court

A relatively new option for families involved in a dependency matter is to participate in an innovative therapeutic court called Family Treatment Court. Families opt into this voluntary program when the dependency is filed. This model provides parents access to treatment, judicial monitoring, and individualized services to support the entire family. It appears that more families could benefit from Family Treatment Court, but the lack of treatment capacity (e.g., residential treatment beds and mental health evaluations) place limits on its use.

Family Reconciliation Services-ARY/CHINS Process

Many youth experiencing serious conflict with their parents may have underlying mental health and substance abuse concerns. Addressing these concerns is an opportunity to improve family functioning, increase educational outcomes, and reduce the likelihood that the youth will become involved in the juvenile offender system. The chart below is a simplified representation of the major decision points in the Family Reconciliation Services (FRS) – ARY/CHINS Process. The work group recommended focusing on the points (highlighted in the gray boxes) to achieve early identification and connection to needed services.

<table>
<tr><td rowspan="2">A) Families/ youth in conflict in contact with police or community agencies</td><td rowspan="2">B) Families in conflict contact FRS</td><td>Conflict resolved; no petition</td><td></td><td></td><td></td></tr>
<tr><td>C) Petition is Filed</td><td>Fact Finding Hearing</td><td>Court finds youth in contempt</td><td>Youth held in contempt ordered to detention</td></tr>
</table>

Families/Youth in Conflict Come in Contact with Police or Community Agencies

Youth who have run away from home or in other ways are engaged in risky behaviors may come into contact with police. This decision point is an opportunity to take youth to a safe place and begin the process of resolving the family conflict as well as screening, assessment, and connecting the youth to services. However, triaging the needs of the youth, determining the appropriate response, and finding an available resource can be difficult circumstances for police to address. For example, police may not be aware of the available resources and how to access them.

One potential recommendation to assist police (and other responders) is to create a centralized 24/7 place to call. Police could receive information about the appropriate response and where resources are available at that moment. Training is also a crucial component to ensure police have the latest information on available services and are familiar with the protocols in working with this population. In particular, training tailored for school resources officers, community service officers, and other specialized police units should be developed.

There are different levels of intervention, as follows:

- Mental Health Crisis Intervention: For youth requiring the highest level crisis intervention, there is "a critical shortage of inpatient hospital beds capacity for youth, leaving many youth who are in crisis"[8] without a voluntary placement option. To address this need, the King County Mental Health, Chemical Abuse & Dependency Services Division (MHCADSD) is working in partnership with North Sound Regional Support Network to open a new evaluation and treatment facility for youth. Most crisis situations do not require inpatient hospitalization. For these situations, King County created the Children's Crisis Outreach Response System (CCORS) which provides crisis outreach and stabilization services. As this service becomes known, it may need to expand to meet the demand. The Mental Health Taskgroup Report notes, however, that there are no step up/step down beds as an option between community-based treatment and inpatient hospitalization. While relatively few in number, there are also cases of youth whose disruptive behavior in hospitals and other placements has resulted in being denied admittance to needed in-patient services. Appropriate in-patient beds for these youth are needed.
- Youth Unwilling or Unable to Go Home: In situations when youth are runaways, or when police are unable to contact a parent or guardian to take the youth home, police have few options. There is one Secure Crisis Residential Center located in Seattle near the Juvenile Detention Center. However, this option is limited to situations where a secure environment is required and it is not readily accessible to other parts of the county. While no crisis residential centers (non-secure) currently exist, there are some community-based shelter beds. Other options such as drop-off centers and additional short-term beds should be considered. For example, as a resource for police, Bernalillo County (New Mexico) collocated a reception center and a shelter bed facility. This type of center can address the appropriate placement of youth and offer screening, assessment, and other services. Staff at the center would also know when and how to refer families to Family Reconciliation Services.
- Partnerships with Community Agencies/Programs: When police are able to return youth to their parents or guardians, they have an opportunity to refer families to community agencies or FRS that can provide services including standardized screening and assessment for mental health and substance abuse concerns. If

[8] Mental Health Task Group Report

needed, these community agencies can help families understand the FRS/ARY process and initiate contact with FRS. Programs involving police and providers such as Seattle-Team-for-Youth (STFY) are potential models for creating the partnerships that effectively work to connect youth to services and minimize the need for involvement in the justice system.

It is important to recognize that many of the decision points discussed in this section are voluntary. As noted in the Cross-System Priorities Section, their success depends on effective outreach and engagement, assistance with navigating complex processes, and a service model that supports the entire family. In particular, it is critical to develop approaches for outreach and engagement that are culturally competent and address transportation and other barriers. In addition, a significant number of these clients may not qualify for publicly funded treatment services. Finally, training for police and other partners is critical component of any approach.

Families in Conflict Contact Family Reconciliation Services (FRS)

Families in conflict can seek assistance from the Washington State Department of Social and Health Services' FRS. This voluntary process includes a family assessment and, beginning in 2007, the GAIN Short Screen for youth. Since the use of the GAIN Short Screen is relatively new, FRS is developing the mechanisms for referring families to assessment and services. However, the lack of funding to pay for services for non-Medicaid eligible clients is a significant issue for this population. In addition, the workgroup noted the same lack of residential treatment and crisis beds at this point that exists across all systems.

Most FRS cases are resolved and do not advance to the filing of an ARY or CHINS petition. Since, in some of these cases, the treatment needs of the family may not be complete when the crisis is resolved and/or the case is closed, a successful hand-off to a community provider is critical. As a voluntary process, this decision point also requires effective outreach and engagement, navigation support, and family-based treatment models. Expansion of successful models such as Project Team and Family Preservation Services should be considered at this decision point.

Petition is Filed

While most FRS cases are resolved, 400-500 cases per year result in At-Risk Youth (ARY) or Child-In-Need-Of-Services (CHINS) petitions. Parents initiate ARY petitions because they may see court intervention as a last resort to address the uncontrollable, risky behavior of their child. FRS involvement will usually end after an ARY petition. CHINS petitions are mainly initiated by the child or parent when seeking a temporary, separate living arrangement for the child. This arrangement is needed to facilitate services for the child and for family reconciliation.

When the petition is filed, FRS forwards its assessment to the Court. This information can allow the Court and, in some ARY matters, assigned court case managers to seamlessly continue the process of working with these families. In addition to potentially increasing the number of court case managers, positions with expertise in navigating the

treatment systems and connecting families to available treatment services may be necessary to support the work of the case managers.

As noted in prior decision points, many of these families are not eligible for publicly funded treatment services and will need financial assistance for treatment. The workgroup also recommended the wraparound model called Project Team which had previously shown promising results with this population.

Child Welfare Services

Some of the most difficult cases that come before the Department of Social &Health Services are through Child Welfare Services (CWS). These cases often involve children and youth coming out of institutions and whose parents are refusing to take them home. Many of these youth have significant mental health and developmental disability needs and are involved in multiple systems, including juvenile justice. Even if these youth are tiered in the publicly funded mental health system, they face a lack of in-home services or short-term residential services. Moreover, if a youth needs services related to a brain condition or developmental disorder, such as autism, these services are not currently eligible for funding through the mental health Regional Support Networks. The state Division of Development Disabilities, which has the responsibility for many of these cases, does not have the resources to serve these individuals.

Beginning in 2007, youth should receive the GAIN Short Screen so that CWS could initiate assessment and treatment if indicated. However, these cases often need the full range of support services for the family, particularly short term residential and respite care for which there are inadequate resources. Given that the age of consent in Washington State is 13, DSHS does not have the authority to require youth to participate in mental health services. Moreover, since family participation is voluntary, strategies for effective outreach and engagement are necessary to link families to services.

School-Truancy Process

Schools present one of the earliest opportunities to identify youth with mental health or substance abuse problems, and truancy may be one indicator of the existence of these problems. However, with 19 school districts in King County, there is no consistent, system-wide approach to the identification of potential mental health and substance abuse issues and linkages to services. The workgroup highlighted three decision points as high priorities.

A) School supported services at the earliest sign of need	B) Mandated school interventions for unexcused absences	Continued absences meets statutory threshold; school files truancy petition	Attendance Workshops or Settlement Conference	C) Finding of Truancy; court orders youth to attend school	D) Failure to attend school results in the court finding contempt	Youth held in contempt may be ordered to detention

School Supported Services at the Earliest Sign of Need

The workgroup had a wide-ranging discussion about the possible approaches or strategies to work effectively with King County's 19 school districts. One question raised by the group is whether there is a building knowledge-base on effective policies, practices, and programs. It should be noted that there are concerns about stigmatizing youth with treatment needs in a school setting and possibly triggering school policies that could lead to suspension or expulsion.

Cross-System Coordination and Training: At the policy and funding level, superintendents, school board members, and administrators should gain a better understanding of children's mental health issues and examples of model policies and practices. Moreover, leaders in the child welfare, justice, and treatment systems should learn from educators about the issues facing students and schools. For example, policy makers could be convened to share this type of information and build momentum toward systemic changes. On the front lines, teachers, counselors, and principals should receive training on how to recognize and respond, in a culturally sensitive and appropriate way, to students who present with mental health and substance abuse issues.

School-Based Resources: Over time, funding cuts have eroded the number of social workers, counselors and programs that were potential resources for helping students with treatment needs. Partnerships with community-based agencies partially fill the gap in some schools but funding is too limited to meet the need. Other schools have teen health centers which, if effective, are a valuable resource. If additional funding were available, the workgroup discussed targeting those schools at highest risk for youth involved in the mental health, juvenile justice, and other systems and provide these or other types of resources.

An emerging model through the Systems Integration Initiative called Pathnet is another possible approach for serving these youth. This model would assign a care manager to youth who have dropped out (or are at risk of doing so) to assist with marshalling resources in schools and the community to achieve educational outcomes. While during its pilot phase, Pathnet will focus on youth involved in the juvenile justice and child welfare systems, it can eventually work with at risk youth at early points who may need treatment services.

Intervention Points: Three points were noted – school discipline, non-attendance, and transitions between schools or between residential placements and school. With the proper tools, training and resources, these points are possible opportunities to screen youth for mental health and substance abuse concerns. Creating pilot projects in several schools to test different approaches is a possible strategy. Again, it would be important to ensure these projects take into account the cultural dynamics surrounding mental health issues.

Mandated School Interventions for Unexcused Absences

Ideally, schools would be systematically identifying and working with youth with unexcused absences consistent with State statute. This could include screening for

mental health and substance abuse concerns. The reality is that the range of responses from King County's school districts to attendance problems is considerable. While the workgroup recognized the potential of this decision point, it acknowledged that schools have limited resources and competing priorities. Moreover, it noted that the current educational funding formula provides little financial incentive for schools to address attendance issues.

Finding of Truancy; Court Orders Youth to Attend School. Failure to Attend School Results in the Court Finding Contempt

The workgroup discussed which of these points would be best as the first opportunity in the court process to screen youth for mental health/substance abuse concerns. While the point of a truancy finding is an earlier point and encompasses more youth, the concern is that the number of youth is too large. On the other hand, waiting for a finding of contempt may miss youth with significant treatment needs. In addition, court-related costs increase at the point of contempt as public defenders are assigned.

Regardless of which point is chosen, there is an important opportunity to initiate screening and interventions similar to those described under ARY/CHINS "Petition is Filed."

Offender System

While the next phase of planning will take a closer look at the prevalence of mental health and substance needs of youth entering the offender system, gross estimates suggest many, if not most, of these youth are in need of some form of treatment. The workgroup discussion focused on two sets of decision points. Minor offenders should be diverted into programs that avoid formal court involvement and provide an opportunity to receive appropriate screening, assessment, and linkages to services. At latter decision points, more serious offenders should have opportunities for alternative approaches that are also structured to address their treatment needs. The highlighted decision points in the following chart represent these priorities.

<table>
<tr><td rowspan="2">A) Police contact</td><td rowspan="2">B) Police diversion</td><td rowspan="2">C) Court diversion</td><td rowspan="2">Filing</td><td>D) Arraignment – Case Setting</td><td rowspan="2">E) Disposition alternatives</td><td rowspan="2">Probation (including deferred disposition)</td><td rowspan="2">JRA/Parole and reentry</td></tr>
<tr><td>D) Therapeutic Courts</td></tr>
<tr><td colspan="3"></td><td colspan="2">Detention (Pre-adjudicated)</td><td colspan="2">Detention (Adjudication)</td><td></td></tr>
</table>

Police Contact

Police can come into contact with youth when the presenting issue is not a criminal offense but instead a mental health or substance abuse problem. There should be a range of accessible options for police in these situations. The discussion related to police contact under the FRS-ARY/CHINS process covers these options and equally applies to this decision point. Training is also a crucial component to ensure police have the latest information on available services and are familiar with protocols in working with this population.

Police also come into contact with youth where the alleged offense does not qualify for detention or the officer believes a suitable community setting would be preferable to detention. In some of these cases, police may have difficulty finding a parent or responsible adult and have few, if any, other options. A reception center is a potential option where police can take youth so that they would receive culturally appropriate standardized screening and assessment, engagement and linkage to other needed services.

Police Diversion

Some police agencies have partnered with community providers to offer first time, minor offenders and their families an opportunity to participate in services in lieu of referring the charge to the prosecutor. These diversion programs are an early point for youth and their families to receive standardized screening and assessment, culturally appropriate outreach and engagement, and other services.

Court Diversion

State law provides a diversion opportunity for certain first and second-time minor offenders in lieu of the prosecutor filing the charges. In King County, this opportunity typically takes the form of meeting between the youth and a Community Accountability Board (CAB) where an agreement is developed with conditions that the youth must meet. While most youth complete diversion and have minimal or no future contact with the justice system, some youth have significant mental health or substance abuse concerns and would benefit from a different approach to diversion.

To identify these youth, the workgroup discussed options for administering a short screen. Most notably, the "consultant" to the CAB could meet with the youth ahead of the meeting with the CAB. If the need for assessment is indicated, it could be required in the diversion agreement. However, since the number of hours allowed for counseling in the agreement is capped in statute, the agreement could not cover treatment. In line with the suggestions in this report, the community agency administering the assessment should have culturally appropriate outreach and engagement for the youth in need of treatment. This approach would require the development of a short screen, special training for the consultants, and additional reimbursement for the consultants. Many of these youth will not be eligible for publicly funded treatment and will need financial assistance.

A subset of diversion cases such as "minor in possession" go to community agencies for drug/alcohol screening and services. If they do not already, these agencies should also administer a mental health screen.

Arraignment through Case Setting; Therapeutic Courts

This decision point follows filing and arraignment and is the first opportunity for youth not appropriate for diversion to be screened systemically for mental health and substance abuse concerns. This point also triggers eligibility for drug court, treatment court, or disposition alternatives (unless found not guilty).

The Mental Health Task Group reviewed current efforts to systemically screen and assess youth at this point and concluded:

> It is clear that not all youth are consistently screened and/or assessed for mental health or chemical dependency issues. . . . More consistent and reliable screening would assist in the appropriate identification of youth in need of treatment. . . . There have been recent efforts to integrate the [Washington State Risk Assessment Tool] Pre-screen and the [GAIN Short Screener] across the state.[9]

Integrating these two tools would provide a systematic and standardized screening approach that could be used not only at this decision point, but also at diversion and Becca decision points. When necessary, it should lead to assessment. Currently, the GAIN is used for all youth referred for assessment in the publicly funded youth-serving agencies in King County. More systematic screening would increase the demand for assessments and require additional capacity for assessments in detention and for youth out-of-custody. These out-of-custody youth should be able to receive assessments at juvenile court, at a local community provider, or in their home.

As noted in the Cross-Systems Priorities, navigating juvenile justice, mental health, and chemically dependency systems is overwhelming for professionals working in these systems, let alone families involved in them. Experience in the therapeutic court models suggests that, once an assessment indicates treatment is needed, a navigator/connector position is key to support the families through these complex systems and connect them to treatment. In particular, this position could include the following responsibilities:

- Determine if the client (and family) is already enrolled and/or connected to treatment
  - Assist with paperwork, transportation, and other supports to reconnect to services
- If not enrolled, determine if the client (and family) is eligible for publicly funded treatment
  - Assist with paperwork
  - Locate an available treatment provider
  - Arrange transportation or other supports to connect family to treatment
  - Follow up with the family to ensure treatment is initiated
- If not eligible, assist with accessing other funds (if available)
  - Assist with paperwork
  - Locate an available treatment provider
  - Arrange transportation or other supports to connect family to treatment
  - Follow up with the family to ensure treatment is initiated

The defense attorneys and prosecutors in the workgroup noted that how assessment information is used prior to the adjudication of the case is a potential issue. If youth and their attorneys are concerned that this information has the potential for negatively influencing the outcome of case, youth may not participate or participate openly. However, there was willingness among the parties to discuss an immunity agreement related to information generated from these assessments.

[9] Mental Health Task Group Report.

When competency of the youth is at issue, the evaluation can take months. Youth are held in detention during this time even though it is not known whether the court has jurisdiction. Moreover, in many cases, the defense attorney seeks a separate evaluation.

Therapeutic Courts: Since 1999, King County Superior Court has operated a Juvenile Drug Court. This program serves youth whose primary presenting problems are substance abuse. Until recently, the court operated a pilot Treatment Court. This program focused on youth whose primary presenting needs are mental health treatment. (Treatment Court is on hold until July 2007. Currently, a working committee is meeting regularly to assure treatment and court improvements necessary for success are put into place.) These programs offer youth and their families evidence-based treatment, advocacy teams, mentoring, and other support services.

The recommendations noted above for more systematic screening and assessment should increase the number of youth eligible for therapeutic courts. However, to ensure these referrals occur, stakeholders should consider an objective and systematic process for determining eligibility for therapeutic courts. Another challenge, particularly for treatment courts, is the lack of capacity in the community for crisis stabilization beds, psychiatric assessment and monitoring, and evidenced-based family/parent support services.

Disposition Alternatives

The Chemical Dependency Disposition Alternative (CDDA) and the Mental Health Disposition Alternative (MHDA) are two options for youth that offer a combination of treatment and local sanctions in lieu of commitment to the Juvenile Rehabilitation Administration. The improvements and recommendations noted in other decision points are also needed for these options, in particular MHDA. These include psychiatric evaluation, crisis stabilization beds, and funding for non-Medicaid eligible clients. In addition, the group indicated a willingness to consider a potential change to the MHDA legislation to expand the offenses that would be eligible.

Other Noted Decision Points and Issues

Domestic Violence

To varying degrees in each of the areas discussed in the report, domestic violence may coincide with mental health and substance abuse concerns in the family. Children who experience domestic violence in their homes may need services to deal with this trauma. Moreover, many youth accused of domestic violence also have mental health needs. As law enforcement, social workers, detention, court, and other points come across these special situations, they need to have the training and resources to address the domestic violence and the attendant treatments issues.

One example of a promising program is Step Up. This program provides treatment specifically tailored to youth accused of domestic violence where there is an alleged

assault of a parent. In 2006, 47% of the youth participating in Step Up had mental health diagnoses. It also recently began a new component where it works on safety planning with parents of youth in detention accused of domestic violence.

These and other approaches require further discussion to outline the full range of, policy, needed legislative changes, process, and services necessary to address the needs of families in these situations.

Unified Family Court Intensive Case Management

Another decision point deserving further discussion is related to families with complex needs who are involved in family court. For example, these families may be involved in a multiple court matters – dissolution, paternity, domestic violence (civil), and/or dependency. If eligible for the Unified Family Court (UFC) Intensive Case Management Program, the families are assigned a UFC judge and case manager. This program serves to coordinate not only legal process and outcomes but also services for these families. Caseloads are currently limited to fifty in Seattle and in the Regional Justice Center.

Based on a recommendation in the recently completed Superior Court Targeted Operational Master Plan, the court is reviewing its UFC program including possible expansion. In addition, UFC can be explored as another opportunity to refer families for screening, assessment, and treatment services.

Secure Detention

Youth admitted to secure detention are likely to have a higher prevalence of mental health and substance abuse needs than other offender youth. While their length of stay in detention can range from one day to many months, this decision point is an opportunity to screen and assess youth and coordinate services with juvenile probation and outside agencies.

Currently, once admitted to detention, youth receive a mental health screening in the health clinic. The score from this screen indicates how a given youth compares with all other youth in the juvenile justice system (including short term and long term facilities). Warning scores identify youth for priority mental health intervention in Detention and priority referral to Superior Court contracted substance abuse personnel for D&A assessment. However, since the role of mental health in detention is to stabilize youth while in detention, there needs to be a more systematic process for referring youth to the mental health system.

One possibility is to change the role of the MHCADSD-sponsored Mental Health Liaison positions. Their role could be expanded to provide coordination and support to detention mental health services for the following: a) identification of a youth's current involvement in mental health system; b) coordinate with connect outside mental health providers and detention mental health services to ensue outreach and a continuity of care; c) if the youth is not currently involved in mental health system, determine eligibility so assessment and referral can happen; and d) follow-up to assure that the youth and family have followed through with referrals post detention.

Youth Transitioning Out of Foster Care, JRA, and other Systems

Youth may face a vulnerable time when transitioning out of Foster Care, Juvenile Rehabilitation Administration, and other systems to their community and potentially independent living. Without the proper supports and access to services during this potentially stressful period, these youth can fall into behaviors and transient living situations that place them at risk of involvement in the adult criminal justice system. This decision point is an opportunity to re-engage these youth into community supports and services including screening, assessment, and treatment. Further review is needed to understand approaches currently available for these youth and identify potential gaps and other obstacles.

Mental Illness and Drug Dependency Action Plan: Phase III
June 1, 2007

Executive Summary

Background

This action plan is the third and final report required under Metropolitan King County Council Motion 12320, which called for the development of a three-phase action plan to

> *"… prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."*

The goal of this third phase, according to the motion, is to "address what is needed to bring the continuum of services and the criminal justice improvements identified in the first two phases to full scale to meet the needs of the identified target population in a cost-effective fashion." As directed by the council, the Phase III report includes:

1. A prevalence study of the mentally ill and chemically dependent populations involved in the local criminal justice, psychiatric, chemical dependency, and homeless systems
2. A description of the service improvements needed to meet the needs of these populations
3. An estimate of the costs of providing these service improvements, and an estimate of benefits which might be realized in providing these services
4. A proposal for financing the full set of improvements, including consideration of the sales tax option provided by state law.

The need for the development of this action plan was clearly spelled out in the council's motion. There are insufficient resources to adequately serve people with mental illness and chemical dependency, and when these individuals do not receive the services they need, they end up in jails, juvenile detention facilities, hospitals, and other emergency services that cost taxpayers and communities as much or more than providing appropriate services would have cost.

Numerous national and local studies have shown that chemical dependency treatment reduces crime and health care costs; that the most frequent users of hospital emergency rooms are individuals who have mental illness and chemical dependency; that providing supportive housing to chronically homeless individuals saves public costs; and that early identification and treatment of mental disorders can help prevent more serious problems.

Prevalence Study Findings

Staff from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Services analyzed

information from numerous national, state and local sources, in order to approximate estimates of prevalence. Full results of the study can be found in Attachment 1.

Key findings of the study:

1. Almost half of all homeless individuals in shelters were identified as having a mental illness or chemical dependency.
2. Although adults released from King County jails with a serious mental illness represented only one-in-twenty of the individuals released, they comprised two-thirds of the jails' highest utilizers.
3. Two-thirds of the seriously mentally ill individuals in King County jails were detained for misdemeanors and non-violent felonies.
4. Half of the youth in the King County Juvenile Detention Center have symptoms of a mental disorder.
5. People of color are seriously overrepresented among the populations of people who are homeless and involved in the juvenile and adult justice systems.
6. A study completed by the city of Auburn of their jail population estimated that 83 percent had chemical abuse/dependency problems. Given that the population characteristics of those served in other city jails through King County is much like that of Auburn, it is estimated that of the approximately 400 inmates served on any given day, 332 would have substance abuse problems.

Service Improvement Recommendations

The recommendations for service improvements presented in this action plan were developed by the Community Crisis Alternatives Work Group, convened by MHCADSD and consisting of key stakeholders from community treatment systems and government, as well as community boards, consumers, and advocates. To determine service priorities, the work group adopted the following principles:

1. Follow intent of enabling legislation and Council Motion 12320
2. Serve all geographic areas of King County
3. Serve all age groups of those most in need
4. Address racial disproportionality
5. Focus on prevention and early intervention
6. Preserve public safety
7. Use best practices and promising practices
8. Maximize cost offsets
9. Continually evaluate programs and change or discontinue what doesn't work
10. Broaden and strengthen the community safety net.

Recognizing the importance of prevention, early assessment and intervention, and comprehensive and integrated community-based services, the work group developed an action plan that devotes considerable resources to service recommendations that build and support a community system that could serve to divert many individuals from the criminal justice and emergency medical systems, while also providing the infrastructure needed to help people who have entered these systems rejoin the community in a safe and effective manner.

Recommendations are grouped into twelve core strategies that fall into three categories – community based care, programs targeted for youth, and jail and hospital diversion.

1. **Community Based Care**

   Strategy #1: Increase Access to Community Mental Health and Substance Abuse Treatment
   Increase access to mental health and substance abuse treatment for people who are not covered by Medicaid; support outreach, engagement, and case management at homeless shelters, with a focus on those in shelters following discharge from crisis diversion, hospital, or jail; support increased outreach, engagement, and support services to homebound and older adults; provide increased short-term crisis services; provide follow-up short-term treatment services for those who enter hospital emergency departments with substance abuse problems; provide support to increase the number of certified chemical dependency professionals in King County; support families to find the services they need.

   Strategy#2: Improve the Quality of Care
   Provide funding increases to mental health providers to help decrease caseload size and help to improve services to clients and promote recovery; expand the availability and capacity for employment services provided by mental health and chemical dependency treatment providers.

   Strategy #3: Increase Access to Housing
   Use funds to support case management and other services within supportive housing projects; join with housing funders to serve people who have mental health and chemical dependency treatment needs who are homeless, exiting jails and hospitals, or who have been seen at a crisis diversion facility.

2. **Programs Targeted to Help Youth**

   Strategy #4: Invest in Prevention and Early Intervention
   Support expanded investments in prevention and early intervention programs in schools, including youth suicide prevention programs.

   Strategy #5: Expand Assessments for Youth in the Juvenile Justice System
   Improve access to assessments to help youth move through the justice system and be linked to appropriate services more efficiently and quickly.

   Strategy #6: Expand Wraparound Services for Youth
   Expand team-based approach helping youth with serious emotional disturbances and improving coordination of services between child-serving systems.

   Strategy #7: Expand Services for Youth in Crisis
   Expand capacity to help youth in crisis by creating crisis reception centers; and expand crisis outreach and stabilization services.

   Strategy #8: Expand Family Treatment Court
   Increase service capacity for Family Treatment Court.

Strategy #9: Expand Juvenile Drug Court
Increase capacity for youth to receive treatment under monitoring of the Court.

3. Jail and Hospital Diversion Programs

Strategy #10: Pre-Booking Diversion Programs
Support diversion programs to reroute people before they are booked into jail through crisis intervention training to police and other first responders; the creation of a Crisis Diversion Facility to which first responders and others could refer individuals in crisis; expansion of mobile crisis outreach teams and crisis respite beds; increased re-entry services at hospital emergency rooms.

Strategy #11: Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency
Expand capacity of mental health courts; provide training on mental illness and substance abuse for jail staff; increase jail liaisons in the King County Jail.

Strategy #12: Expand Re-entry Programs
Expand re-entry and respite services for people exiting the criminal justice system; expand services for medically fragile people with mental illness and chemical dependency leaving the hospital; and improve urinalysis services for people court-ordered to the Community Center for Alternative Programs.

Costs and Cost Benefit Analysis

The high costs of not providing services to individuals with mental illness and chemical dependency is well documented. The report notes a number of studies that have shown cost offsets in reduced use of hospitals, jails, courts, and emergency services when various services are provided to individuals who are mentally ill, chemically dependent, and homeless. Due to the variability in types of services, target populations, and programs studied, it is not possible to predict specific cost savings from the implementation of the service recommendations in this action plan. The plan includes funding for a thorough evaluation, including cost offsets. Budget information is provided in Attachment 2, Budget Summary Table.

Proposals for Financing

In evaluating federal, state and local fund sources, MHCADSD, in collaboration with the Executive's Office and the Budget Office, has determined that there are no current sources of revenue available to fund the recommended services identified in the action plan as necessary to prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems for persons with disabling mental illness and chemical dependency. The sales tax option of one-tenth of one-percent authorized by the State Legislature in 2005 provides a way for counties to generate funds for services that are not supported by current state funding. Counties may not use these funds to supplant

other funding sources. As of this date, five Washington counties – Spokane, Jefferson, Skagit, Clallam and Clark – have implemented a sales tax increase.

Mental Illness and Drug Dependency Action Plan: Phase III
June 1, 2007

I. INTRODUCTION

On July 24, 2006, the Metropolitan King County Council approved Council Motion 12320 calling for the development of a three-phase action plan to:

> *"…prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency by implementing a full continuum of treatment, housing and case management services."*

Per the motion, the action plan has been developed in three distinct phases. The first phase of the action plan called for a description of the system improvements needed to initiate development of a full continuum of services, as well as a description of specific proposed improvements that could be implemented within existing resources. The phase one action plan was submitted by the King County Executive to the King County Council and reviewed in September 2006. The second phase of the action plan addressed changes in the criminal justice case processing to more effectively deal with people with disabling mental illness and chemical dependency. This action plan was submitted by the Executive to the Council and reviewed in April 2007.

The third and final phase of the action plan is to:

> *"…address what is needed to bring the continuum of services and the criminal justice improvements identified in the first two phases to full scale to meet the needs of the identified target population in a cost-effective fashion."*

The Phase III report, as directed by Council Motion 12320, includes:

1. A prevalence study of the mentally ill and chemically dependent populations involved in the local criminal justice, psychiatric, chemical dependency, and homeless systems.
2. A description of the service improvements needed to meet the needs of these populations.
3. Estimates of the costs of providing these service improvements and the estimated benefits that might be realized by providing these services.
4. A proposal for financing the full set of improvements, including consideration of the sales tax option provided by state law.

The sales tax option was provided for counties in legislation passed in the 2005 legislative session. This legislation, known as the Omnibus Mental Health and Substance Abuse Act (E2SSB 5763), authorizes counties to impose a councilmanic sales tax that "shall equal one-tenth of one percent…that shall be used solely for the purpose of

providing new or expanded chemical dependency or mental health treatment services and for the operation of new or expanded therapeutic court programs." As of the writing of this report, five Washington counties – Spokane, Jefferson, Skagit, Clallam, and Clark – have implemented a sales tax increase.

The need for the development of this action plan was clearly defined in the body of Council Motion 12320. The motion described a major public problem common to communities across the country: there are insufficient resources to adequately serve people with mental illness and chemical dependency, and when individuals do not receive the services they need, they end up in jails, juvenile detention facilities, hospitals, and other emergency services that cost taxpayers and communities as much or more than providing appropriate services would have cost.

Numerous studies demonstrate that providing appropriate services to individuals who have mental illness or chemical dependency benefits communities by reducing crime and emergency medical and criminal justice system costs. More information on these studies can be found in the Cost Benefit Offset section of this report, but the following share key findings that provide convincing evidence of the need for a comprehensive public response to the problems of mental illness, chemical dependency, and homelessness.

A. Evidence of the Need for Treatment Services

1. **Chemical dependency treatment reduces crime.** In studies conducted by the Washington State Department of Social and Health Services (DSHS) Division of Alcohol and Substance Abuse, misdemeanor arrests of youth decreased by 40 percent between the year before treatment and the year after treatment. Felony arrests of youth decreased by 54 percent. Felony arrests of adults decreased by 33 percent in the year after treatment compared to the year before treatment (DSHS Research and Analysis Division).

2. **Chemical dependency treatment reduces health care costs.** Over a five-year period, individuals who received publicly funded chemical dependency treatment had medical costs that were 45 percent less than those of the average untreated client (DSHS Research and Analysis Division).

3. **Providing supportive housing saves public costs.** A study of supportive housing in nine cities, including Seattle, found that it costs about $26 per day to provide supportive housing (housing with on-site services) to homeless individuals who have a disability such as mental illness or chemical dependency. Depending on their need for more intensive services, off-site services would add another $7-$30 per day. This compares to the average cost of a day in jail at $87, prison at $95, psychiatric hospitalization at $555, and medical hospitalization at $2,184 (Lewin Group, 2004).

4. **The highest utilizers of expensive emergency services most often have mental illness and chemical dependency.** A study conducted by King County

MHCADSD in 2003 found that a year of public costs for 40 individuals who had the most number of admissions to either the Sobering Center or the Harborview Crisis Triage Unit was over $2 million, for an average of over $50,000 per person. This figure did not include ambulance, police, or court costs.

5. **There are substantial costs to the public when treatment is not provided.** There is now an enormous body of evidence to demonstrate how the availability of mental health and chemical dependency treatment impacts the use of jails and hospitals. In Colorado, admissions to hospital emergency rooms related to mental illness and substance abuse increased by 83 percent over three years following a 30 percent cut in funding for outpatient treatment for adults and children. In Texas, following cuts to mental health centers and to mental health treatment benefits for 128,000 Medicaid recipients, admissions to hospital emergency rooms for mental health treatment increased by 79 percent. Following a 45 percent reduction in Medicaid funding for community mental health, West Virginia experienced a 45 percent increase in involuntary commitments, and nearly a 100 percent increase in the number of people with mental illness entering jails.

6. **Early identification and treatment of mental disorders can help prevent more serious problems**. Unidentified and untreated mental disorders can lead to school failure, psychiatric hospitalization, youth suicide and involvement in the juvenile justice system. According to the United States Surgeon General, in the course of a year, half of all students with a mental disorder who are age 14 and older drop out of high school (Surgeon General's Report on Mental Health, 1999). This is the highest dropout rate of any disability group (U.S. Department of Education, 2001). Mental illness is the leading cause of hospitalization for Washington youth. Children with mental illness have health care costs 2.5 times larger than the costs for other children. (Archives of Pediatric Adolescent Medicine, Vol, 158, Aug. 2004).

7. **The public supports prevention services as an effective way to reduce juvenile crime**. A national opinion poll conducted in January 2007 about attitudes of Americans towards youth crime found that the overwhelming majority of people believe that the most effective ways to reduce crime by juveniles are to increase education and job skills training for youth (75 percent); increase prevention services in the community before youth get into trouble (71 percent); and increase mental health and substance abuse counseling while they are in detention (34 percent). Only 33 percent believe that harsher penalties are an effective way to reduce crime (Krisburg and Marchionna, February, 2007; National Council on Crime and Delinquency).

8. **There is a large funding gap for human services in King County.** The Healthy Families and Communities Task Force (HFC) co-chaired by King County Councilmember Larry Gossett and City of Renton Mayor Kathy Keolker identified an $83 million funding gap for human services in their final

report issued in 2006. While the Veterans and Human Services Levy approved by King County voters in 2005 will help meet part of the gap, huge unmet needs remain. The HFC proposed that the 0.1 percent sales tax increase be pursued as a way to fund substantial mental health and chemical dependency treatment needs in the community and to help further reduce the funding gap.

9. **Access to mental health services is limited for people who do not have Medicaid benefits.** Washington State relies heavily on Medicaid as a source of funding for mental health services. The Community Mental Health Act states that appropriate mental health services must be provided to everyone who is on Medicaid and meets statewide access to care standards, and that individuals who are not on Medicaid and who have mental illness must be served only if there are available resources. The state is not required to provide the resources needed, and, as a result, thousands of low-income individuals who have mental illness and who are not on Medicaid are unable to receive outpatient mental health services each year. These individuals include young people suffering from a first break psychosis, immigrants, individuals who are homeless and too disorganized or paranoid to complete necessary paperwork, and individuals who must spend their limited funds on medical care in order to be eligible for Medicaid. When not served, these individuals are more likely to use higher cost services such as jail and hospitals.

10. **Funding for Medicaid mental health services is not sufficient.** Medicaid-covered mental health services are funded through actuarially determined rates. Due to insufficient state match being available, the state has set payment rates near the bottom of the actuarial ranges. Those rates are insufficient to maintain essential mental health services and to meet the increasing costs of providing services.

II. PREVALENCE STUDY

A. Purpose

Council Motion 12320 called for a study of the individuals with mental illness and chemical dependency involved in the justice, emergency services and homeless services systems. The Veterans and Human Services Levy Service Improvement Plan called for a prevalence study of individuals involved in the criminal justice and emergency services systems who had problems with mental illness, chemical abuse and homelessness. This focus and exploration of behavioral health issues also runs through other studies and planning efforts of the executive and council in recent years, including the Juvenile Justice Operational Master Plan, Adult Justice Operational Master Plan, Criminal Justice Initiatives, King County Consolidated Housing and Community Development Plan, Ten-Year Plan to End Homelessness, Mental Health Recovery Plan, Children's Mental Health Plan, and the Public Health Operational Master Plan.

B. Method

Staff from the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Services analyzed information from numerous national, state and local sources, in order to approximate estimates of prevalence. The MHCADSD team included a PhD epidemiologist who completed a similar King County prevalence study in 1998, two PhD psychologists with expertise in program evaluation and research, and division specialists in data analysis and program management. The team was able to draw from a number of rich and credible sources of existing data to provide a much clearer understanding of the nature of the population of individuals who have mental illness and chemical dependency and are homeless and/or involved in the criminal justice and emergency medical systems.

C. Summary Findings: Users of the Justice System

1. Approximately five percent (~1,500) of adults released from King County jails in 2006 had some indication of serious mental illness. This five percent comprised two-thirds of the jails' highest users, and:
   - Almost a fifth had some indication of substance abuse
   - About half were homeless prior to entering jail.

2. A six-year study conducted by University of North Carolina (UNC) researchers using data provided by King County revealed that of the 20,200 individuals with serious mental illness receiving publicly funded mental health care:
   - 7,000 were jailed at least once; two-thirds were detained for 'minor' crimes (misdemeanors and non-violent felonies); a third were detained for violent felonies.
   - Those committing minor crimes were predominately Caucasian males (73 percent); a quarter of them were African Americans. Average age at first detention was 35.
   - Of those committing violent felonies, the majority were Caucasian (64 percent). A third of those committing violent felonies were African American. Average age at first detention was 32.

3. According to the UNC researchers, of the chronic, most severely and persistently mentally ill clients (~7,200) receiving mental health care in King County during the six-year study, almost half had a co-occurring substance abuse disorder. In addition:
   - One-fifth was homeless at some point
   - Of the 940 that were homeless and had co-occurring disorders, three quarters of these were users of psychiatric hospitals (with an average stay of 30 days) and had been jailed at least once (with an average of six bookings).

4. On any given day in city jails throughout King County, an estimated 15 percent of inmates have serious mental illness, 80 percent have substance abuse problems, and five percent have co-occurring mental health and substance abuse disorders (average daily census ~400).

5. About half of the 1,113 youth using the King County Juvenile Detention Center during 2006 had some symptoms of a mental disorder.

6. Of the 328 at-risk youth served in a King County grant-funded project from 1999-2004, nearly half were not eligible for Medicaid. Yet:
   - The majority had a history of outpatient mental health treatment
   - Approximately half had a history of substance abuse, special education involvement, or school failure
   - Nearly a quarter had a history of psychiatric hospitalization.

D. Summary Findings: Users of Emergency Services

1. The 600 highest users of Harborview Medical Center's Emergency Department in 2005 accounted for ten percent of all emergency cases, with almost 8,000 emergency room visits. Over a third of these high users were homeless. While approximately ten percent had a primary diagnosis of mental illness or substance use, many more had these issues secondary to the primary medical concerns that prompted them to seek care.

2. Half of the 3,487 people served in 2006 by Harborview's specialty psychiatric emergency department had co-occurring mental illness and substance abuse problems; a third were homeless—mirroring the 2005 percentages noted above for the entire Emergency Department.

3. In recent years, other hospital emergency departments in King County have experienced increased numbers of persons presenting with mental illness and chemical dependency problems. Although precise data are not available, one indicator of the magnitude of the problem is the persistent 'boarding' of involuntarily detained mentally ill individuals in emergency departments due to a lack of psychiatric inpatient beds. Approximately 30-40 individuals per month spend several days in emergency rooms and medical units waiting for a psychiatric bed to become available.

4. The vast majority of people admitted to the King County Sobering Center (~2,100) and Detox services (~3,000) in 2006 were homeless.

5. A 2004 national study of community hospital utilizations by persons with mental health and/or substance abuse disorders indicated that adults with these problems accounted for a quarter of all hospital stays. Over two-thirds of these

admissions were billed to government insurers (e.g., Medicaid/Medicare). Well over half were admitted after entering through emergency departments.

6. A comprehensive study of all hospitalizations of school-aged children/youth in Washington State in the 1990s showed that mental illness surpassed injury as the leading cause of hospitalization for Washington youth by the end of the decade, with mental illness accounting for one-third of all hospital days.

E. Summary Findings: Homeless Persons

1. The 2006 One Night Count indicated that almost half of the 5,963 homeless individuals counted in shelters or transitional housing had problems with mental illness or substance abuse.

2. The incidence of recent incarceration among homeless adults receiving publicly funded mental health treatment is four times the incidence of those who are not homeless.

3. The incidence of homelessness in adults with co-occurring disorders receiving publicly funded mental health treatment is three to four times the incidence of those without co-occurring disorders.

4. The incidence of co-occurring disorders in homeless adults receiving publicly funded mental health treatment is double that of those who are not homeless.

5. Almost a third of the approximately 8,000 people served by Health Care for the Homeless (HCH) in 2006 had mental health and/or substance abuse problems. Nearly half had no health insurance. HCH estimates that they reach only a third of the homeless population.

F. Summary Findings: Racial Disparity

1. According to the 2006 One Night Count, only 37 percent of homeless individuals are white, while the overall population of King County is approximately 75 percent white.

2. Youth of color are significantly overrepresented in the juvenile justice system. While youth of color represent 34 percent of the youth population ages 10-17 in King County, they make up 49 percent of the referrals to juvenile court and 65 percent of the daily secure detention population.

3. African American adults are significantly overrepresented in the adult criminal justice system, accounting for over 35 percent of the population of the King County Jail compared to 5.4 percent of the population of King County.

G. Summary Findings: Estimates of Unmet Treatment Needs

1. A Needs Assessment completed in 2006 by Washington State Transformation Grant researchers estimated that 263,000 (15 percent) of the 1.7 million low-income residents (below 200% of poverty) have a mental disorder significant enough to have a moderate to severe impact on functioning. For King County, the estimated number of individuals who might need and qualify for publicly funded mental health services would be approximately 65,000. In 2006, just over 28,000 received outpatient mental health services funded through the King County Regional Support Network.

2. According to the 2003 Washington State Department of Alcohol and Substance and Abuse household survey, less than a quarter of the 21,000 King County residents eligible for and needing substance abuse treatment were receiving it.

3. National data indicate that the rate of suicide for older persons is higher than for any other age group, yet over half of older adults who get any mental health treatment receive it from their primary care doctor. Under-treatment of depression in the primary care setting is a recognized public health problem.

4. Between three and four percent of King County 8th and 10th graders reported a suicide attempt in the year before they completed the Healthy Youth Survey 2006.

III. SERVICE IMPROVEMENT RECOMMENDATIONS

A. Process

The final recommendations for service improvements presented in this report were developed by a community work group convened by MHCADSD and consisting of representatives from community mental health and chemical dependency treatment providers, local chapters of the National Alliance on Mental Illness (NAMI), Youth Suicide Prevention Program, parent advocates, mental health consumers, King County Sheriff, King County Office of the Prosecuting Attorney, Seattle City Attorney, Seattle Police Department, Public Health-Seattle & King County, King County Juvenile Court, King County Department of Adult and Juvenile Detention, Seattle Department of Human Services, King County District Mental Health Court, King County Mental Health and Substance Abuse Boards, King County Department of Community and Human Services, King County Office of Management and Budget, and King County Council staff.

B. Principles

The work group adopted the following principles in determining service priorities:

1. Follow intent of enabling legislation and Council Motion 12320
2. Serve all geographic areas of King County
3. Serve all age groups of those most in need
4. Address racial disproportionality
5. Focus on prevention and early intervention
6. Preserve public safety
7. Use best practices and promising practices
8. Maximize cost offsets
9. Continually evaluate programs; change or discontinue what does not work
10. Broaden and strengthen the community safety net.

C. Organizing Model – Sequential Intercepts

Starting with the Phase Two Action Plan, the Sequential Intercept Model was used as a framework for work group members to determine what services need to be provided for which people at what locations, in order to help prevent incarceration, hospitalization, and homelessness. This model has been adopted by a number of communities across the nation as an action blueprint for planning system change in the way that communities address the problem of people with mental illness in their criminal justice systems.

The Community Crisis Alternatives Work Group adapted the organizing principles of this model to include people who may have no mental illness but who are at risk for criminal justice involvement due to substance abuse, and to include diversion from emergency medical services as another priority. The work group also expanded on the model's definition of core services to put more emphasis on youth and on prevention services.

It is worth emphasizing that the greatest opportunities for diversion exist when individuals are still in the community, and that diversion options decrease as individuals move through the criminal justice system. Recognizing the importance of prevention services, early assessment and intervention, and comprehensive and integrated community-based services, the Community Crisis Alternatives Work Group has devoted considerable resources in the service recommendations described below to build and support a community services system that will serve to divert many individuals from the criminal justice and emergency medical systems while also providing the infrastructure needed to help people who have entered these systems rejoin the community in a safe and effective manner.

D. Recommendations for new or expanded services

The follow section details the recommendations of the action plan with regard to improving and enhancing services for the target populations in the event additional resources become available. The section offers twelve core strategies under recommendations for (1) community based care, (2) programs targeted for youth, and (3) jail and hospital diversion programs.

1. Community Based Care

An accessible treatment system must be at the core of any plan to prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems. The following strategies seek to reduce the destructive impact of mental illness and substance abuse and help increase the quality of life for individuals with these conditions by providing prevention, early identification and intervention, and accessible and effective mental health and chemical dependency treatment services. By improving the overall health and stability of the individuals in the community, we anticipate, based on the experience of dozens of other communities across the country, that there will be a decrease in the use of emergency health and criminal justice services, and in the incidence of chronic homelessness.

By the same token, investing in jail diversion programs such as crisis diversion centers, drug and mental courts, and alternative sentencing programs without first establishing an accessible and effective community services system will not achieve the desired outcomes. The whole continuum of community services, housing, and diversion programs must be in place in order to succeed in breaking the cycle of untreated mental illness and addiction, homelessness, and repeated involvement in criminal justice and emergency medical systems.

Strategy #1: Increase Access to Community Mental Health and Substance Abuse Treatment

1a. Funds would be used to provide chemical dependency and mental health treatment to individuals who are poor but not eligible for Medicaid services. As noted earlier, mental health services are severely limited for people who do not have Medicaid coverage. Out of more than 27,000 individuals who receive publicly funded outpatient mental health services in King County, less than 500 are not covered by Medicaid. Priority would be given to youth and adults exiting the justice system and hospitals, immigrants, and others at risk for homelessness, incarceration, or hospitalization. Similarly, there are insufficient funds available to provide chemical dependency treatment for those in need who are not Medicaid eligible. Priority for chemical dependency services would be for those most at risk for incarceration, hospitalization, and homelessness.

1b. The action plan supports outreach and engagement programs to ensure that individuals who are eligible for care receive the treatment they need. Funds would be used to provide outreach, engagement, and case management at shelters, modeled after the services currently provided by Health Care for the Homeless. Services could be expanded to serve individuals who are leaving hospitals, jails, or crisis diversion facilities.

1c. Another priority of the action plan is to broaden the concept of prevention by providing treatment services for people who do not meet current access to treatment criteria, but who will get worse without some intervention. The Washington State Screening, Brief Intervention, Referral and Treatment Program has been a successful model for intervening early in the lives of individuals with substance abuse and preventing more serious addiction. Treatment and grant funds will end in 2008, and the action plan supports continuing this program.

1d. Another program that helps individuals who are in crisis, but who may not meet criteria for outpatient services, is the next day appointment service for individuals having a mental health crisis. Funding is currently able to support only a few visits. Additional funds could support individuals to receive more crisis services, which could serve to prevent problems that are more serious and potential hospitalization.

1e. There is currently a significant shortage of chemical dependency professionals in Washington, and this shortage limits access to treatment. The action plan supports providing stipends to treatment agencies to help support the education and training needed to recruit additional staff to become certified professionals.

1f. Families often have difficulty knowing where to turn for help for their children experiencing emotional difficulties or problems with substance abuse. An effective way to help families is to provide peer support and parent partners to assist families is to navigate through the complex child-serving systems, including juvenile justice, child welfare, and mental health and substance abuse treatment. Funding an expansion of the Parents Partners Program would allow MHCADSD to contract with local family organizations to provide these services throughout King County.

1g. As noted in the prevalence section of this report, the rate of suicide for older adults is higher than for any other age group. Undiagnosed and untreated drug and alcohol abuse and depression among older adults are contributing factors to this suicide rate. The action plan calls for funding for innovative prevention and early intervention mental health and substance abuse services for this at-risk population.

1h. The action plan also calls for expanding the availability of crisis intervention and linkage to ongoing services for older adults.

Strategy #2: Improve Quality of Care

2a. Payment rates for mental health and chemical dependency providers have not kept up with the increased costs of providing those services. Rates for

outpatient chemical dependency treatment are established by the state Division of Alcohol and Substance Abuse. Rates for Medicaid managed care mental health outpatient treatment are established by the state Mental Health Division within an approved actuarial range. King County receives a rate that is at the lower end of the approved range, due to a lack of state funding to provide for a larger match for federal Medicaid funds, and due to the formula the state uses to set rates and distribute funds across the state. Additional local tax funds could be used to increase Medicaid and non-Medicaid rates. Further, each additional local dollar provided for Medicaid services brings in an additional dollar in federal Medicaid match funding. The State Legislature increased vendor rates for mental health providers in 2007, with most of the increase dedicated to wage increases for mental health workers. While this funding is very welcome, it is not enough to address the tremendous growth in caseload size that has occurred as a result of years of insufficient funds. The action plan proposes increases to augment state funding and help to reduce caseloads. It is expected that lower caseloads would result in case managers being better able to respond when their clients are in crisis, to see clients more often in order to prevent crises from occurring, and will result in a more stable case management system.

2b. The action plan calls for an expansion of employment services for individuals with mental illness and chemical dependency. Employment is an essential element in recovery-based systems of care. The plan calls for providing vocational specialists in mental health and chemical dependency provider agencies, and for providing training and consultation in vocational services.

Strategy #3: Increase Access to Housing

3a. Housing was identified by stakeholders as one of the most critical unmet needs in the community. Unfortunately, sales tax funds cannot be used for capital construction or rent payments. The action plan proposes using funds to support case management and other treatment services within supportive housing projects. This strategy includes joining with the funders of housing to support the development of housing units for individuals who have mental health and chemical dependency treatment needs and who are homeless, exiting jails and hospitals, or who have been seen at a crisis diversion facility. A range of housing units from transitional to permanent, and from drug and alcohol-free housing to units that are tolerant of some use, is essential for the success of this plan.

2. Programs Targeted at Helping Youth

The action plan supports programs targeted at youth who are at risk for future involvement in the criminal justice system. By intervening early, the Plan seeks

to prevent or reduce future substance abuse, mental health problems, and criminal justice involvement.

Strategy #4: Invest in Prevention and Early Intervention

4a. Children of chemically dependent parents are at higher risk of developing problems with alcohol and drugs. The Plan supports comprehensive services to parents in recovery at adult outpatient treatment programs.

4b. Children of substance abusers are at higher risk of developing problems with alcohol and drugs. The action plan supports prevention services for these youth through community-based youth service agencies and outpatient chemical dependency treatment programs throughout King County.

4c. Funding for school-based mental health and substance abuse services in the 19 school districts in King County varies, but is generally considered a critical need by health care professionals. The 2003 President's New Freedom Commission on Mental Health declared that expanding mental health services in schools is a key step towards overcoming barriers to mental health care. The action plan recommends funding 19 competitive grant awards to schools in partnerships with mental health, chemical dependency treatment, or youth service providers to provide a continuum of mental health and substance abuse services in schools, with a focus on those youth identified as most at risk for dropping out of school and becoming involved in the juvenile justice system.

4d. Suicide is the leading cause of death in 15-24 year-olds. Suicidal behavior (thoughts and attempts) is the major reason for youth hospitalizations. Among 10^{th} grade students who responded to the King County Healthy Youth Survey, 18 percent reported seriously considering suicide and 14 percent made a plan for committing suicide in the previous 12 months. Between three and four percent of responding 8^{th} and 10^{th} graders reported a suicide attempt in the year before they completed the survey. The action plan supports expanding suicide prevention programs in schools.

Strategy #5: Expand Assessments for Youth in the Juvenile Justice System

5a. There is need for increased capacity to provide social and psychosocial assessments for both in-custody and out-of-custody youth involved in the juvenile justice system. Improved access to assessments would help youth to move through the justice system more smoothly and facilitate links to appropriate services.

Strategy #6: Expand Wraparound Services for Youth

6a. Wraparound services refers to a team-based approach to working with children and youth with serious emotional disturbances that has been shown to be an effective way to deliver coordinated services to youth and families that are individualized, strength-based, culturally relevant, and maintain the youth within his or her own community whenever possible. Each youth and family are connected with a single care coordinator and a family advocate who help identify and recruit team members, including other system partners such as physicians and state Division of Children and Family Services caseworkers as well as family, friends, and other natural supports. Providing wraparound services to multi-system involved youth improves the collaboration and coordination of services between child-serving systems, thereby improving efficiency and reducing redundancy.

Strategy #7: Expand Services for Youth in Crisis

7a. The action plan proposed the creation of reception centers for youth in crisis. This strategy involves creating two centers, one in south or east King County and one in central Seattle. Police and other responders would be able to take youth in crisis to these facilities, which could be co-located with a youth shelter or at a crisis residential facility, should one be developed. Services would be provided to help link youth to ongoing services and to housing, if needed.

7b. The action plan also proposes expanding the Children's Crisis Outreach Response System. This currently operational and very successful program would expand to provide crisis outreach and stabilization to children and youth in their homes to divert/prevent placement in a juvenile detention facility and to assist families in accessing services, de-escalating the crisis, and maintaining the youth within his or her community. This service would also provide crisis stabilization beds and case aid support to manage some of the most challenging, aggressive youth in the community, in order to prevent incarceration.

Strategy #8: Expand Family Treatment Court

8a. The action plan calls for an expansion of Family Treatment Court (FTC), an alternative to regular dependency court. FTC is designed to improve the safety and well being of children in the dependency system by providing their parents access to drug and alcohol treatment, judicial monitoring of their sobriety, and individualized services to support the entire family. The plan calls for increasing court and family liaison services, oversight capacity, and access to treatment services to enable FTC to double service capacity from 45 to 90 families.

Strategy #9: Expand Juvenile Drug Court

9a. The action plan supports the expansion of Juvenile Drug Court with services to increase capacity from 50 to 100 participants. Participants receive treatment while their progress is monitored by the Court. Charges against participants are dropped if they successfully complete the program.

3. Jail and Hospital Diversion Programs

Diversion programs seek to divert individuals from incarceration and hospitalization into community treatment settings. Individuals can be diverted at various "intercepts" in the criminal justice system (i.e. arrest, case filing, arraignment, etc.) The earlier an individual is diverted in the process, the greater potential for criminal justice savings.

A number of potential diversion opportunities were identified in the Phase Two Action Report, and these opportunities, including changes in policies and procedures and efforts to change laws that present barriers to diversion, should continue to be pursued. Many of these potential diversion strategies, however, are dependent on the availability of comprehensive community-based services in order to be fully implemented.

Pre-booking diversion programs attempt to divert individuals before they are booked into jail. Post-booking diversion programs attempt to divert these individuals after they have been booked into jail. Diversion programs have been shown to reduce jail days and have the potential to produce reductions in criminal justice costs.

Hospital diversion can also occur either prior to a potential hospitalization or at the time when a person is ready for discharge from the hospital. Crisis diversion facilities help divert individuals in crisis from hospital emergency rooms and subsequent hospital admissions. Some individuals stay in hospitals longer than medically necessary due to the lack of supportive housing services in the community. Providing these services is a way to provide post-hospital diversion.

Strategy #10: Pre-Booking Diversion Programs

10a. The Plan recommends creating a crisis intervention training program for the King County Sheriff's Office, other police departments in King County, other first responders, and jail staff. Establishing a plan for training police officers and other first responders about mental illness, chemical dependency, and the ways to interact with individuals with these issues, as well as the resources and options available to assist them, will enable first responders to provide more effective services and increase the use of diversion options.

10b. The action plan recommends establishing a Crisis Diversion Center to which officers and other crisis responders could refer adults in crisis. The

Center would evaluate individuals and refer them to community-based services. An increase in respite beds is included, in order to provide short-term housing for individuals leaving the center. These beds could be co-located with the Crisis Diversion Center or based in other venues. Additionally, the plan recommends exploring the creation of Mobile Crisis Teams of behavioral and chemical dependency specialists who could be called to increase geographic access and to provide on-site evaluation, referrals and linkage to a crisis diversion facility.

Strategy #11: Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency

11a. An additional mental health jail liaison is recommended to handle the increased caseload of referrals expected under these initiatives.

11b. Mental health courts are an essential component of a jail diversion continuum of service, and have been shown to be effective in engaging clients in treatment and reducing future jail booking. The action plan recommends providing funding for which they could apply, in order to increase services available at existing courts or to begin new mental health court programs.

Strategy #12: Expand Re-entry Programs

12a. Each additional jail re-entry liaison could serve an additional 40 clients per month. These re-entry case managers make sure that individuals connect with services and housing upon leaving the jail, thereby increasing the likelihood of treatment engagement and compliance with treatment.

12b. Hospitalized individuals with mental illness or chemical dependency who are medically fragile or homeless often stay in hospitals longer than medically necessary. The Plan calls for hospital re-entry respite beds and associated services to facilitate hospital release and transition to the community.

12c. Hospital emergency rooms are often overwhelmed with individuals whose admissions are related to mental illness and chemical abuse. The action plan recommends providing additional capacity for Harborview Hospital's Psychiatric Emergency Services to link individuals to community-based services upon discharge from the emergency room

12d. The Community Center for Alternative Programs is an effective diversion resource for individuals who no longer need secure detention, but who are

required by courts to complete conditions for release. Currently, chemical dependency treatment staff conducts urinalyses on their clients to assure compliance. It is more cost efficient and clinically appropriate to have designated non-clinical staff perform this service.

IV. COST BENEFIT ANALYSIS

A. Costs of Untreated Mental Illness and Substance Abuse

Mental illness, alcoholism, and chemical dependency impose high costs on society. These costs are borne by individuals, families, health care institutions and governments. Individuals with severe mental illness or substance abuse issues are less likely to be employed and less able to perform household duties. This loss of productivity affects both the individual and their families. Individuals with severe mental illness or substance abuse issues suffer from poor health and have high health care costs. These costs accrue to individuals, family members, local hospitals, and state and federal entitlement programs. Individuals with mental illness or substance abuse are also more likely to be involved with the criminal justice system. The costs associated with crime are primarily borne by the victims of crime and state and local governments.

Several studies have documented the costs of mental illness and substance abuse within the United States:

1. The economic cost of mental illness in the United States is estimated to be $254 billion per year[10]. Approximately 58 percent of these costs were related to productivity losses (e.g. lost earnings); 39 percent of these costs were related to health care; and 2 percent of these costs were related to other costs, including disability insurance and criminal justice costs (Harwood et al, 2000).

2. The cost of drug abuse was estimated to be $293 billion per year[11]. Approximately 71 percent of these costs were related to losses in productivity; 9 percent of these costs were related to health care; and 20 percent were related to other costs, primarily crime (Office of National Drug Control Policy, 2004).

3. The economic cost of alcohol abuse was estimated at $231 billion per year[12]. Approximately 73 percent of these costs were associated with productivity losses; 14 percent were associated with health care costs, including treatment and costs associated with Fetal Alcohol Syndrome; and 13 percent were

[10] The estimates provided in this section have been adjusted for inflation for the purposes of comparison. However, changes in the prevalence of these diseases could impact the current cost per year.

[11] Ibid.

[12] Ibid.

associated with other costs, including crime and automobile accidents (Harwood, 2000).

B. Strategies to Reduce Costs Associated with Mental Illness and Chemical Dependency

The action plan identifies a number of strategies to reduce the incidence of mental illness and substance abuse and prevent unnecessary hospitalization and incarceration. The strategies described in the previous section on needed service improvements include the expansion and improvement of community-based care; programs aimed at prevention, early identification and intervention for youth; and jail diversion programs. The following section provides a discussion of the effectiveness of these strategies and the potential cost offsets of these programs.

For many of the strategies, it was not possible to estimate cost offsets due to the fact that insufficient research has been conducted to produce a reliable prediction of program outcomes. For other strategies, further planning regarding program design and target populations is required before benefits can be estimated. In the absence of solid estimates, a qualitative discussion is provided to summarize the research supporting each strategy and identifies potential cost offsets.

1. Community Based Care

Strategy #1: Increase Access to Community Mental Health and Substance Abuse Treatment

Program Description	Estimated Cost
1a. Increase access to mental health and chemical dependency outpatient services for people not on Medicaid	$11,125,000
1b. Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	$ 550,000
1c. Emergency room substance abuse early intervention program	$ 800,000
1d. Mental health crisis next-day appointments	$ 250,000
1e. Chemical dependency professional education and training	$ 615,000
1f. Peer support and parent partners family assistance	$ 450,000
1g. Prevention and early intervention mental health and substance abuse services for older adults	$ 500,000
1h. Expand availability of crisis intervention and linkages to on-going services for older adults	$ 350,000

Analysis: Appropriate treatment can reduce the overall incidence of mental illness and chemical dependency. In 2006, the Washington State Institute for Public Policy (WSIPP) reviewed 206 studies of evidence-based treatment for individuals with alcohol, drug, or mental disorders. WSIPP estimated that the provision of treatment services could reduce the short-term incidence of mental

illness by 22 percent, alcohol addiction by 15 percent, and chemical dependence by 22 percent (Aos et al, 2006a.).

A reduction in the prevalence or severity of mental illness and substance abuse should lead to a reduction in health care costs. WSIPP estimates that for every dollar spent on treatment, approximately two dollars are realized in taxpayer benefits. These benefits primarily consist of health care savings.

These findings are substantiated by a series of studies conducted by the state on the impact of treatment on medical costs for aged, blind or disabled individuals on Medicaid. People who received mental health outpatient treatment experienced a significant reduction in medical costs, compared to individuals with similar conditions who did not receive treatment. The relative savings equaled $105 per month in the first year and $126 per month in the second year - offsetting between 41 and 50 percent of the cost of treatment (Mancuso and Estee, 2003).

Individuals who received alcohol or chemical dependency treatment experienced a $311 per month reduction in medical costs, a $47 per month net reduction in mental health costs[13], and a $56 per month reduction in nursing home costs. The average savings in medical costs equaled $414 while the average treatment costs equaled $162. The result was a cost offset of $252 per month (Estee and Nordlund, 2003).

Increasing access to services should also have an impact on criminal justice outcomes. Several studies have concluded that substance abuse treatment reduces the risk of recidivism. WSIPP found that when community based drug treatment is provided to ex-offenders, recidivism is reduced by 9.3 percent (Aos, Miller, and Drake, 2006). The link between mental health treatment and recidivism is less clear. While it is logical to expect that the expansion of mental health services will reduce the risk of individuals becoming involved in the criminal justice system, few studies have quantified this effect (Fisher, Silver, and Wolf, 2006).

A review of the literature suggests that increasing access to care will reduce health care costs for the target population. Given the fact that many of these programs target individuals who do not qualify for Medicaid, these savings will most likely accrue to health care providers who serve the uninsured. This includes community health clinics and local hospitals. The impact of community-based services on criminal justice costs is less certain.

[13] The population saw an increase in outpatient costs, which were offset by a decrease in state and community hospitalization costs.

Strategy#2: Improve the Quality of Care

Program Description	Estimated Cost
2a. Caseload reduction for mental health	$4,000,000
2b. Employment services for individuals with mental illness and chemical dependency	$1,500,000

Analysis: Decreasing the caseload of treatment providers will increase the amount of care provided to each individual and should lead to the prevention of some mental health crises and associated criminal justice involvement and hospitalizations. Increased employment services are not expected to have a significant impact on health or criminal justice outcomes, although it is clear that criminal justice involvement is associated with poverty, and, to the degree that employment services result in a reduction in poverty among those who obtain employment, there may be some reduction in criminal justice involvement.

Strategy #3: Increase Access to Housing

Program Description	Estimated Cost
3a. Supportive services for housing projects	$2,000,000

Analysis: Increasing the number of supportive housing units will decrease homelessness and increase access to care. Supportive housing programs have been shown to reduce the use of public services. A large-scale study of a supportive housing program in New York found that placement in supportive housing dramatically decreased the use of shelters, hospitals, jails and prisons. Participants experienced a 39 percent decrease in shelter days, a 51 percent decrease in days in the state inpatient psychiatric hospital, and a 62 percent decrease in jail days. The reductions in services produced cost savings that nearly offset the cost of supportive housing. The average savings per participant equaled $12,146 while the average cost per participant equaled $13,570. The bulk of the savings were brought about by decreases in shelter use and hospitalization (Culhane, Metraux, and Hadley, 2002).

2. Programs Aimed at Helping Youth

Strategy #4: Invest in Prevention and Early Intervention

Program Description	Estimated Cost
4a. Comprehensive chemical dependency outpatient services for parents in recovery	$ 500,000
4b. Prevention services for children of substance abusers	$ 400,000
4c. School district based mental health and substance abuse services	$1,235,000
4d. School based suicide prevention services	$ 200,000

Analysis: Drug and alcohol prevention programs have the potential to create long-term cost-savings because they target youth prior to the development of substance use problems. In 2004, WSIPP calculated the cost and benefits of prevention and early intervention programs for youth focusing on reducing substance abuse and crime (Aos et al, 2004). Substance abuse prevention programs including Adolescent Transitions Program, Project Northland, and Family Matters produced more than $1,000 in benefits than costs per youth. These benefits were primarily health care savings. Evidence-based prevention programs have the potential to reduce future costs by preventing youth from becoming involved with the criminal justice system.

School-based programs have been shown to improve mental health, substance abuse and educational outcomes (Kutash, Duchnowski, and Lynn, 2006). Schools present one of the earliest opportunities to identify youth with mental health or substance abuse problems. However, limited resources have restricted the capacity of schools to respond to these problems. Over time, funding cuts have eroded the number of social workers, counselors and programs that were potential resources for helping students with treatment needs. Resources should be targeted toward those schools at highest risk for youth involved in the mental health, juvenile justice, and other systems.

Strategy #5: Improve Assessments for Youth in the Justice System

Program Description	Estimated Cost
5a. Increase capacity for social and psychological assessments for juvenile justice involved youth	$360,000

Analysis***:*** Increasing the availability of mental health and chemical dependency assessments for youth who enter the juvenile justice system should increase access to appropriate care for these youth. As discussed in Strategy #1, increasing access to care should produce reductions in health care use and criminal justice involvement.

Strategy #6: Expand Wraparound Services for Youth

Program Description	Estimated Cost
6a. Wraparound family, professional and natural support services for emotionally disturbed youth	$4,695,000

Analysis: Wraparound services for youth have been shown to improve child and adolescent functioning at home, at school and within the community, as well as decrease the amount of stress on a family (Annual Report to Congress, 1998). A longitudinal evaluation of the King County Wraparound Project called Project

TEAM showed significant improvements in the overall clinical functioning of youth involved in the project. For example, the percentage of youth exhibiting severe clinical impairment decreased by 35 percent after one year in service. In addition, the number of youth failing all or most of their classes decreased by 25 percent and the number of children receiving average or above average grades increased by 34 percent. Contacts with the law decreased by approximately 20 percent after one year for those youth involved in Project TEAM.

Other programs across the country have found similar improvements in clinical functioning, school performance and delinquency involvement. Wraparound Milwaukee was able to decrease the use of residential treatment for youth by approximately 60 percent and inpatient psychiatric hospitalization dropped by nearly 80 percent (Kamradt, 2000) through the use of coordinated wraparound services. They also demonstrated significant reductions in recidivism rates for a variety of offenses for the youth enrolled in the Wraparound Milwaukee project (see Kamradt 2000 for more detail).

Strategy #7: Expand Services for Youth in Crisis

Program Description	Estimated Cost
7a. Reception centers for youth in crisis	$ 500,000
7b. Expand crisis outreach and stabilization for children and youth	$1,000,000

Analysis: Creating a reception center will provide police officers with more options when interacting with runaways and minor offenders. The Children's Crisis Outreach Response System provides 24-hour crisis intervention services for King County children, youth and families designed to fit individual strengths and natural support systems. The focus is on safely containing the crisis and maximizing choices. These strategies are not expected to produce significant cost offsets.

Strategy #8: Expand Family Treatment Court

Program Description	Estimated Cost
8a. Expand family treatment court services and supports to parents	$ 700,000

Analysis: Family Treatment Court (FTC) is a relatively new model being employed by jurisdictions that aims to improve child outcomes in the dependency system. Little research has been performed on the cost effectiveness of these programs. However, preliminary evaluations of FTC outcomes are encouraging. A national study of four FTCs found that court participants had positive outcomes

relative to participants in the regular dependency system (Young, 2003). FTC participants were more likely to enroll in treatment and received more intensive levels of treatment than the comparison group. FTC participants were less likely to be investigated by child protective services and less likely to be arrested than those in the comparison group. Children in FTC were placed in permanent situations three months sooner than those in the standard dependency system.

King County's Family Treatment Court is currently being evaluated. A process evaluation has demonstrated that stakeholders feel that the Court is meeting its objectives (Bruns et al, 2006). A long-term outcome evaluation, including a cost-benefit analysis has also been designed and is currently underway.

Strategy #9: Expand Juvenile Drug Court

Program Description	Estimated Cost
9a. Expand Juvenile Drug Court treatment	$ 510,000

Analysis: Drug Courts have been shown to be effective at reducing recidivism. WSIPP reviewed 15 rigorous studies of juvenile drug court programs and found that these programs reduce recidivism by 3.5 percent on average (Aos, Miller, and Drake, 2006). The reduction in recidivism is associated with taxpayer savings as fewer court and incarceration resources are required.

WSIPP estimated that the long-term taxpayer benefits fully offset the marginal costs of the program. Long-term benefits equaled $3,167 while the marginal program costs equaled $2,777 per participant. However, the estimate of program costs was based upon drug courts operating in Maine and may not be relevant to the King County Juvenile Drug Court. A more thorough study of case processing costs including differential uses of detention should be conducted before any conclusions can be reached.

3. Jail Diversion Programs

Strategy #10: Pre-Booking Diversion Programs

Program Description	Estimated Cost
10a. Crisis intervention training program for King County Sheriff, police, jail staff and other first responders	$1,700,000
10b. Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	$6,060,000

Analysis: Pre-booking diversion programs have the potential to reduce the number of arrests and jail days. Police officers receive specialized crisis intervention training to recognize behavior related to psychiatric disorders,

respond to individuals in crisis, and provide referrals to treatment services. Potential benefits of crisis intervention training include lower rates of arrest, increased capacity to resolve crises, and increased access to care.

The success of pre-booking diversion programs is dependent on the strength of the relationship between the police and the mental health system. Several other jurisdictions in the country have established crisis diversion centers where police can drop off individuals in crisis 24-hours a day. Steadman et al. (2000) compared three pre-booking diversion programs, and found that the program with a crisis diversion center had lower rates of arrest and increased rates of treatment placement. Pre-booking diversion programs also have the potential to reduce criminal justice expenditures by avoiding jail and trial costs.

Strategy #11: Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services Provided to Individuals with Mental Illness and Chemical Dependency

Program Description	Estimated Cost
11a. Increase capacity for jail liaison program	$ 80,000
11b. Increase services available for new or existing mental health court programs	$1,300,000

Analysis: Mental health courts have been shown to increase access to treatment and reduce criminal activity. An evaluation of the King County Mental Health Court found that program participants were three times more likely to access treatment than individuals who "opted out" of Mental Health Court (Trupin et al, 2001a). Participants in the Seattle Municipal Court's Mental Health Court increased their treatment visits by 10 percent after enrolling in the court. This linkage to treatment is considered a critical factor in the success of these programs. An evaluation of the Seattle Municipal Court's Mental Health Court found that participation in the court was associated with reduced jail bookings. The average number of bookings per client fell from 2.3 in the year before court involvement to 0.95 in the year following court involvement (Trupin et al, 2001a). Similarly, an evaluation of the Clark County Mental Health Court found that the average number of arrests was reduced from 1.99 pre-enrollment to 0.48 post-enrollment. Additionally, court participants experienced a 62 percent decrease in parole violations (Herinckx et al, 2005).

An expansion of misdemeanant courts to other jurisdictions could improve mental health outcomes for people engaged in the criminal justice system. The felony drop down program could create taxpayer savings through reduced sentencing practices. The cost offsets that accrue from these cases have not yet been thoroughly studied. It is assumed the bulk of the offset would accrue to the state.

Strategy #12: Expand and Improve Re-entry Programs

Program Description	Estimated Cost
12a. Increase jail re-entry program capacity	$ 320,000
12b. Hospital re-entry respite beds	$ 565,000
12c. Increase capacity for Harborview Psychiatric Emergency Services to link individuals to community-based services upon discharge from the emergency room	$ 200,000
12d. Urinalysis supervision for Community Center for Alternative Programs clients	$ 75,000

Analysis: The addition of re-entry staff combined with an increase in non-Medicaid treatment services could have an impact on recidivism. The addition of re-entry staff increases the likelihood that individuals will be engaged in services. Successful engagement in services has been linked to improved criminal justice outcomes. Evidence based substance abuse treatment has been shown to reduce recidivism by 9.3 percent (Aos et al, 2006).

Individuals who are homeless or who are medically fragile and unable to care for their medical needs at their own homes often have longer hospital stays than are medically necessary due to lack of housing that meets their needs. Providing a facility near the hospital in which individuals can receive short-term housing and services should result in considerable savings over the costs of hospitalization.

V. PROPOSALS FOR FINANCING

A. Fund Sources

In addition to the sales tax option, there are a number of funding sources currently available or becoming available, that will help to meet some of the needs identified by the Community Crisis Alternatives Work Group. All of these fund sources, working together, will help address the continuum of treatment, housing, and case management services that will prevent and reduce unnecessary involvement in the criminal justice and emergency medical systems. These initiatives are in addition to those identified as service improvement needs in this Phase III Action Plan.

1. **King County Criminal Justice Initiatives:** The existing King County Criminal Justice Initiatives Project began in 2003 with $2.2 million in funding from King County. State Mental Health Division funds dedicated to serving individuals with mental illness leaving jails have since been added to the program, allowing for expansion of services. The initiatives project provides enhanced screening and assessment in the jail, jail liaisons to link individuals to services upon discharge, assessments for eligibility for public assistance and chemical dependency treatment, housing vouchers and case management, co-

occurring disorder treatment and housing, methadone treatment, and alcohol and drug treatment and community re-entry services at the Community Center for Alternative Programs and at the Regional Justice Center.

2. **Washington State Legislative Actions 2007-09:** The 2007 Washington State Legislative Budget provided funding for a number of the priority services identified in this report. All state budget amounts shown below are statewide amounts for the 2007-2009 biennium; King County amounts are not yet available. In addition to the budget, several bills passed during the session that will also provide support to address mental health and substance abuse needs.

   - $16.8 million for outpatient treatment rate increases for alcohol and substance abuse treatment providers. This is equivalent to a 15 percent increase in fiscal 2008 and a 2 percent increase in fiscal 2009. While this is a substantial increase over current rates, it still only covers 60 percent of treatment providers' costs, according to a recent state study on rates. Since rates are set by the state Division of Alcohol and Substance Abuse, other local funds may not be used to increase treatment rates.

   - $24.4 million for wage increases for mental health workers. All funds must be used for wage increases and may not be used to reduce caseload size or for any other purposes.

   - $11.8 million for vendor rate increase of approximately 2 percent in fiscal 2008 and 2 percent in fiscal 2009.

   - $9.3 million for children's mental health services, with $2.2 million of that amount provided in the State Mental Health Division budget. Much of this funding is dedicated for expanded benefits for children covered by Healthy Options, and for a new center for evidence-based practices at the University of Washington. Very little funding will be available for wraparound services, which the work group identified as a priority.

   - $3.3 million to add a mental health component to the General Assistance-Unemployable (GA-U) medical care services care management project in King and Pierce counties. There are currently 3,900 GA-U clients in King and Pierce counties (most in King County), about 45 percent of whom have a diagnosis of mental illness. This pilot program, which will be developed by Community Health Plan in cooperation with King County Regional Support Network, will provide integrated mental health and primary health services for over 1,700 individuals who would not otherwise have been able to access mental health care.

   - $1.4 million to continue the Reinvesting in Youth pilot program in King and two other counties. This program provides research-based programs to serve youth involved in the juvenile justice system.

- $30 million increase in the Housing Trust Fund, of which an estimated $12 million will be targeted to projects in the Seattle-King County region that can come up with the local match. This increase will allow increased capital investments to help end homelessness in King County, and faster completion of projects as the "bottleneck" for state matching funds eases.

- $10 million was appropriated per year to public health statewide, with an estimated $2.1 million to come to King County to help support core public health functions such as public health emergencies, communicable disease management, healthy families and children health assessments, and environmental health.

- E2SHB 1359 increased the document recording fee collection to help address homelessness. The fee increase will generate around $3.5 million per year, with 90 percent of this amount coming to King County and 10 percent going to the state. This augments E2SHB 2163 passed during the 2006 legislative session, adopted to dedicate revenue to support state and local plans to end homelessness, which generates about $3 million per year distributed to King County. The combined Homeless Housing and Services Fund will provide almost $7 million per year to address homeless housing, operational and supportive services needs in King County.

- 2SHB 1201 extends Medicaid eligibility to age 21 for youth aging out of the state's foster care system, which helps address the physical and mental health care needs for these youth; and 2SHB 1922 creates a $1 million housing voucher system for youth aging out of foster care.

- ESSB 6157 is a comprehensive re-entry program for offenders, that includes housing funding for $4 million for up to twelve months of housing. However, no treatment dollars are provided.

3. **Other State Funding:** King County is receiving state funding for two major projects that will serve people who are high-utilizers of jail and hospitals, known under the umbrella name of Supportive Housing Intervention for Transition to Stability (SHIFTS), which includes funding to establish Program for Assertive Community Treatment (PACT) teams. Two PACT teams will serve a total of 180 adults with severe mental illness who have had frequent or prolonged psychiatric hospitalizations. The state Mental Health Division is providing over $2.3 million per year for services for this program. Housing assistance is being provided by the King County and Seattle housing authorities and philanthropic contributions. One team will serve the central Seattle area, and one team will serve south and east King County providing services that will include integrated mental health and chemical dependency treatment, vocational services, and housing. The balance of the SHIFTS program will identify the 50 highest utilizers of jails in King County and offer housing and integrated treatment services. In addition, funds will be provided to prevent individuals

who are in jail from losing their housing while incarcerated. Funding for this program is being provided by a three-year state grant of over $3.1 million, King County and Seattle housing authority vouchers, Veterans and Human Services Levy funds, and philanthropic funds.

4. **Committee to End Homelessness Activities**: An increase in affordable housing accessible to people with criminal records, histories of homelessness, and with mental illness and chemical dependency was recognized by the work group as a major priority. Since sales tax funds may not be used to fund housing development or pay for housing, other sources of revenue are needed to provide this critical resource. The Committee to End Homelessness in King County is coordinating the regional effort to develop new housing dedicated to individuals who are homeless or at risk for homelessness. There are many partners in this effort, including local governments and housing authorities, United Way of King County, philanthropic organizations, businesses, religious organizations, community non-profit organizations, and homeless individuals.

   Hundreds of new units of housing devoted to homeless individuals have already been developed, and hundreds more are being developed now. A major development in the manner in which housing development is now being managed is that numerous housing and human services funding sources have joined together to ensure that all of the needed resources are provided to make projects successful. Public funding participants in this partnership include King County Department of Community and Human Services, City of Seattle Human Services Department and Office of Housing, United Way of King County, A Regional Coalition for Housing, Sound Families Initiative, and King County and Seattle Housing Authorities. This coordinated effort helps make it easier for housing developers to obtain all the various funds needed to provide permanent supported housing to individuals with high needs, and ensures that the housing being funded meets the priorities identified for ending homelessness in King County.

5. **Veterans and Human Services Levy:** The Veterans and Human Services Levy will provide funding for a number of priority services for persons most in need. Veterans comprise a large percentage of the population of individuals who are homeless and who enter the criminal justice system, and half of the funding provided through the levy is designated for veterans and their families.

6. **MacArthur Foundation's Models for Change Initiative:** King County is one of six counties in the State of Washington that has been asked to participate in a five-year grant initiative called Models for Change. Focused on juvenile justice reforms, this initiative has identified "Mental Health" as one of the priorities for King County. While the amount of the award has not been decided, the funding will support better identification of offender youth with mental health needs and linking them to services.

VI. PROPOSAL FOR USE OF SALES TAX OPTION

Despite the number of initiatives underway to better respond to the problems of homelessness, mental illness, chemical dependency, and the enormous social costs associated with these problems, significant unmet needs remain and other than the sales tax option, no known short or long-term strategy is in sight, including availability of county discretionary funds.

A. Sales Tax Option

The estimate for the funds that would be raised through the one tenth of one percent sales tax allowable under the Omnibus Mental Health and Substance Abuse Act is $48 million for calendar year 2007. The budget summary table found in Attachment 2 shows a summary of the amounts budgeted for the services and programs that are outlined in the service improvement recommendations section of this report. In addition to the services, funds are also set aside for the administration and evaluation of the programs, data systems and technology support, and for a revenue stabilization reserve fund, since the amount collected by a sales tax may be subject to fluctuations according to economic conditions. The budget also provides for a small ongoing amount of funds that can be used in a flexible manner in order to contribute match for special grants, to fund promising pilot programs, and to sustain grant-funded programs that are losing their funding. This budget was prepared with the assumption that further planning would be required if the sales tax were approved and that revisions could be made to meet unanticipated or emerging needs.

B. Administration

King County's Department of Community and Human Services (DCHS) would be charged with responsibility for oversight of activities related to the implementation of the Community Crisis Alternatives Action Plan and administration of the Omnibus Mental Health and Substance Abuse Act sales tax proceeds, if executed by the county council. The department would be responsible for ensuring coordination with other government agencies and entities, county departments, and external partners, as well as alignment with other relevant regional efforts to maximize resources and efficiencies. The department would be responsible for reporting progress and results to the King County Council and its committees.

The action plan has identified a number of best and promising practices that could reduce the costs associated with untreated mental health and substance abuse. DCHS will be responsible for developing, in concert with key stakeholders, specific program designs for implementing Community Crisis Alternatives Action Plan services. It is expected that the majority of new programs and services would be created through a competitive Request for Proposal (RFP) process. Service plans will be developed collaboratively and posted publicly for stakeholder input prior to issuing RFPs. Resulting contracts will be managed and monitored by DCHS.

It is important to ensure an effective evaluation tool is developed and put into place to measure the degree to which the benefits offset the costs. Among the outcomes that should be emphasized are reductions in homelessness, arrests, bookings, days in jail or juvenile detention, and hospital emergency room visits; increases in community tenure, employment, and school attendance; and reductions in racial disproportionality in these systems. Implementation of the plan should allow sufficient time, at least six months, for the recruitment of staff and the planning time necessary to develop RFPs and the information system infrastructure necessary to monitor and evaluate programs and services.

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Mental Illness and Drug Dependency Action Plan: Phase III

PREVALENCE OF MENTAL ILLNESS, CHEMICAL ABUSE AND HOMELESSNESS: Individuals in jails, emergency services and mental health/chemical dependency treatment

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PURPOSE OF THE STUDY

Metropolitan King County Council Motion 12320 called for a study of the individuals with mental illness and chemical dependency involved in the justice, emergency services and homeless services systems. The Veterans and Human Services Levy Service Improvement Plan called for a prevalence study of individuals involved in the criminal justice and emergency services systems who had problems with mental illness, chemical abuse and homelessness. This focus and exploration of behavioral health issues also runs through other studies and planning efforts of the executive and council in recent years, including the Juvenile Justice Operational Master Plan, Adult Justice Operational Master Plan, Criminal Justice Initiatives, King County Consolidated Housing and Community Development Plan, Ten-Year Plan to End Homelessness, Mental Health Recovery Plan, Children's Mental Health Plan, and the Public Health Operational Master Plan.

METHOD

The Department of Community and Human Services, Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) drew from a number of rich and credible sources of data and information from national, state and local sources to arrive at estimates of prevalence in King County. These sources help to provide a much clearer understanding of the nature of the population of individuals who have mental illness and chemical dependency and are homeless and/or involved in the criminal justice and emergency medical systems. The MHCADSD team included a PhD epidemiologist who completed the King County prevalence study in 1998, two PhD psychologists with expertise in program evaluation and research, data analysts and program managers.

SUMMARY FINDINGS

<u>Users of the justice systems</u>

1. Approximately five percent (~1,500) of adults released from King County jails in 2006 had some indication of serious mental illness. This five percent comprised two thirds of the jails' highest users, and:
   - Almost a fifth had some indication of substance abuse.
   - Estimates suggest that half were homeless prior to entering jail.

2. A six-year study conducted by University of North Carolina (UNC) researchers revealed that of the 20,200 King County individuals with serious mental illness receiving publicly

funded mental health care:

- 7,000 were jailed at least once; two-thirds were detained for 'minor' crimes (misdemeanors and non-violent felonies); a third was detained for violent felonies.

- Those committing minor crimes were predominately Caucasian males (73%) and a quarter of them were African Americans. Average age at first detention was 35.
- A third of those committing violent felonies were African American. Again, the majority were Caucasian males (64%). Average age at first detention was 32.

3. According to the UNC researchers, of the chronic, most severely, and persistently mentally ill clients (~7,200) receiving mental health care in King County during that six year study, almost half had a co-occurring substance abuse disorder.
   - One-fifth was homeless at some point.
   - Of the 940 that were homeless and had co-occurring disorders, three quarters of these were users of psychiatric hospitals (with an average stay of 30 days) and had been jailed at least once (with an average of six bookings).

4. On any given day in city jails throughout King County, an estimated 15 percent of inmates have serious mental illness, 80 percent have substance abuse problems, and five percent have co-occurring disorders (average daily census ~ 400).

5. About half of the 1,113 youth using the King County Juvenile Detention Center during 2006 had some symptoms of a mental disorder.

6. Of the 328 at-risk youth served in a King County grant-funded project from 1999-2004, nearly half were not eligible for Medicaid. Yet:
   - The majority had a history of outpatient mental health treatment.
   - Approximately half had a history of substance abuse, special education involvement, or school failure.
   - Nearly a quarter had a history of psychiatric hospitalization.

Users of emergency services

1. The 600 highest users of Harborview Medical Center's Emergency Department (ED) in 2005 accounted for ten percent of all emergency cases, making almost 8,000 emergency room visits. Over a third of these high users were homeless. While approximately ten percent had a primary diagnosis of mental illness or substance use, many more had these issues secondary to the primary medical concerns that prompted them to seek care.

2. Half of the 3,487 people served in 2006 by Harborview's specialty psychiatric emergency department had co-occurring mental illness and substance abuse problems; a third were homeless—mirroring the 2005 percentages noted above for the entire ED.

3. In recent years, other hospital emergency departments in King County have experienced an increase in numbers of persons presenting with mental illness and chemical dependency

problems. Although precise data are not available, one indicator of the magnitude of the problem is the persistent 'boarding' of involuntarily detained mentally ill individuals in EDs due to a lack of psychiatric inpatient beds. Approximately 30-40 individuals per month spend several days in emergency rooms and medical units waiting for a psychiatric bed to become available.

4. The vast majority of people admitted to the King County Sobering Center (~2,100) and Detox services (~3,000) in 2006 were homeless.

5. A 2004 national study of community hospital utilization by persons with mental health and/or substance abuse disorders indicated that adults with these problems accounted for a quarter of all hospital stays. Over two-thirds of these admissions were billed to government insurers (e.g., Medicaid/Medicare). Well over half were admitted after entering through emergency departments.

6. A comprehensive study of all hospitalizations of school-aged children/youth in Washington State in the 1990's showed that mental illness surpassed injury as the leading cause of hospitalization for Washington youth by the end of the decade, with mental illness accounting for one-third of all hospital days.

Homeless persons

1. The incidence of recent incarceration among homeless adults receiving publicly funded mental health treatment is four times the incidence of those who are not homeless.

2. The incidence of homelessness in adults with co-occurring disorders receiving publicly funded mental health treatment is three to four times the incidence of those without co-occurring disorders.

3. The incidence of co-occurring disorders in homeless adults receiving publicly mental health treatment is double that of those who are not homeless.

4. The 2006 One Night Count indicated that almost half of the 5,963 homeless individuals counted in shelters or transitional housing had problems with mental illness or substance abuse.

5. Almost a third of the approximately 8,000 people served by Health Care for the Homeless (HCH) in 2006 had mental health and/or substance abuse problems. Nearly half had no health insurance. HCH estimates that they reach only a third of the homeless population.

Racial disparity

1. According to the 2006 One Night Count, only 37 percent of homeless individuals are white, while the overall population of King County is approximately 75 percent white.

2. Youth of color are significantly overrepresented in the juvenile justice system. While youth of color represent 34 percent of the youth population ages 10-17 in King County, they make up 49 percent of the referrals to juvenile court and 65 percent of the daily secure detention population.

3. African American adults are significantly overrepresented in the adult criminal justice center, accounting for over 25 percent of the population of the King County Jail compared to 5.4 percent of the population of King County.

Estimates of unmet treatment needs

1. A Needs Assessment completed in 2006 by Washington State Transformation Grant researchers estimated that 263,000 (15 %) of the 1.7 million low income residents (below 200% of poverty) in Washington State have a mental disorder significant enough to have a moderate to severe impact on functioning. For King County the estimated number of individuals who might need and qualify for publicly funded services would be approximately 65,000. In 2006, King County's Regional Support Network provided outpatient mental health services for just over 27,000 individuals.

2. According to the 2003 Washington State Department of Alcohol and Substance and Abuse household survey, less than a quarter of the 21,000 King County residents eligible for and needing substance abuse treatment were receiving it.

3. National data indicate that the rate of suicide for older persons is higher than for any other age group, yet over half of older adults who get any mental health treatment receive it from their primary care doctor. Under-treatment of depression in the primary care setting is a recognized public health problem.

4. Between three percent and four percent of King County 8th and 10th graders reported a suicide attempt in the year before they completed the *Healthy Youth Survey 2006.*

5. In 2003, behavioral health encounters became the number one reason nationwide for a primary health care center visit. Yet, only three of 25 public health clinics in King County have funds dedicated for behavioral health services. Public Health – Seattle & King County estimates that of the 127,258 individuals using clinics in King County in 2006, 18,000 to 38,000 are in need of mental health/chemical dependency services. Approximately 40 percent are not eligible for public insurance and therefore can not access services through the publicly funded mental health and substance abuse programs.

RESULTS

Users of the justice systems

1. During 2003-2005, approximately five percent (~1,500/yr) of unduplicated people released from King County jails had at least one indicator of mental illness: either housing on the mental health unit of the jail or a "psych status" flag indicating some question about the

person's mental competency. These individuals accounted for ~3,500 bookings. During 2004-06, a report of jail high-utilizers indicated that misdemeanants with either of these mental illness indicators accounted for 64 percent of the 794 people with five or more bookings within 12 months ("rapid-cyclers") and 59 percent of the 957 people with either two or more 30-day+ bookings or a booking of longer than 180-days during an 18-month period ("long-stayers").

2. During 2003-05, approximately 18 percent (~5,500/yr) of unduplicated people released from King County jails had some indication of substance abuse: either a drug or alcohol flag entered by classification staff or assignment to the King County Drug Diversion Court. These individuals accounted for ~11,000 bookings.

3. While systematic data regarding homeless status at time of King County jail booking is not available, of the 1,584 people seen by the King County jail health services during December 2005, 798 (50%) were identified as being homeless prior to entering the jail[1].

4. King County jail data compare closely to data from national sources:
   - In 2001, the National GAINS Center compiled findings from several studies and found that six percent of males in jail had a serious mental illness and 29 percent had a substance abuse problem. They also found that 12 percent of females in jail had a serious mental illness and 53 percent had a substance abuse problem. Of those in jail with a diagnosis of substance abuse, 72 percent also had a mental disorder[2].
   - In a 2000 study of jail inmates in San Francisco County, 18 percent had a mental disorder and 16 percent were homeless prior to incarceration. For those who were both in jail and previously homeless, 30 percent had a mental disorder. For those who were in jail, previously homeless and had a mental disorder, 78 percent had a co-occurring substance abuse disorder[3].

5. The city of Auburn just completed a study of their jail population and estimated that 15 percent had serious mental illness, 83 percent had chemical dependency/abuse problems, and five percent had both mental illness and chemical dependency/abuse. Given that the population characteristics of those served in other city jails throughout King County is much like that of Auburn, it is estimated that of the approximately 400 inmates served on any given day, 60 would have a serious mental illness, 332 would have substance abuse problems and 20 would have co-occurring disorders[4].

6. In 2006, 2,301 unduplicated youth were admitted to King County secure detention for criminal, Becca, or juvenile detention related matters. Of those youth admitted, 49 percent (1,134) were referred to the mental health clinic after obtaining warning scores on the Massachusetts Youth Screening Instrument (MAYSI) for depression/anxiety (27%); suicidal ideation (28%), thought disturbances (17%) and substance use (10%)[5].

   - Note: Youth of color are significantly overrepresented in the juvenile justice system. While youth of color represent 34 percent of the youth population ages 10-17 in King County, they make up 49 percent of the referrals to juvenile court and 65 percent of

the daily secure detention population.

7. Project TEAM provided services to families and youth with serious emotional problems going through the *At Risk Youth* and *Child in Need of Services* process from September 1999 through March 2004. Of the 328 youth served through this project, nearly half (40%) were not eligible for Medicaid. Yet, the majority had a history of outpatient mental health treatment. Approximately half had a history of substance abuse, special education involvement and school failure. Twenty-one percent had a history of psychiatric hospitalization[6].

8. Of the approximately 1,113 King County youth within the offender system that were given the Washington State Risk Assessment prescreen, 24 percent had a history of mental health problems. For those youth who screened moderate to high risk and were then administered the full Washington State Risk Assessment (n=954), 22 percent had current mental health problems. Of these, only 40 percent were currently receiving treatment[7]. These figures are likely to be underestimates as they are considerably lower than national studies that indicate 65-70 percent of youth involved in the juvenile system have a mental illness and of those, 60 percent have a co-occurring substance abuse disorder[8].

Users of emergency services

1. Data from some King County emergency services revealed:
   - The 300 highest utilizers of Harborview's Emergency Department had 8,016 admissions in 2005. (There were about 78,000 total Emergency Department admissions.) For 36 percent (n= 2,894) of high utilizer admissions, the person was homeless; and for approximately nine percent (n=721) the primary diagnosis was mental illness or substance use, although many more had these issues secondary to primary medical diagnoses[9].
   - Of the 5,104 admissions to Harborview's Psychiatric Emergency Services (a unit within the broader ED) in 2006, 89 percent (n=4,336) had a mental illness, 55 percent (n=2,680) had substance abuse, 45 percent had both, and 29 percent (n=1,501) were homeless.
   - In 2006, of the 2,100 people admitted to the King County Sobering Center, 89 percent were homeless on at least one admission.
   - In 2005, 3,083 people were admitted to King County Detox services. In 2006, 2,496 people were admitted. Approximately 95 percent each year were homeless.
   - Seattle Police Department 2006 records show police response to 6,277 (1.3% of all responses) incidents where the officers determined mental illness was a factor[10].
   - Between 2004 and 2006 the King County Sheriff found[11] a 51 percent increase in juvenile drug offenses and a five percent increase in juvenile liquor violations; a 49 percent increase in adult drug offenses and a 40 percent decrease in adult liquor violations.

2. A 2004 national study of community hospital utilization by persons with mental health and/or substance abuse disorders indicated that adults with these problems accounted for 1

in 4 of all hospital stays. Over two-thirds of these admissions were billed to Medicaid or Medicare. Well over half were admitted after entering through emergency departments[12].

3. A comprehensive retrospective study of hospitalizations of children/youth ages 5-14 years in Washington State in the 1990's showed that the rate of hospitalization for mental illness increased by 22 percent. Mental illness surpassed injury as the leading cause of hospitalization for Washington youth by the end of the decade; mental illness accounted for one-third of all hospital days in 1999[13].

Users of mental health and chemical dependency services

1. One of the most detailed and relevant studies of the population of interest to the current prevalence study was conducted by University of North Carolina (UNC) researchers in King County over a 5½-year period (1993-1998)[14]. Of 30,037 adult individuals served in the mental health system who also used the jail, chemical dependency treatment, and/or medical health services at any point during that time:
   - 24 percent (7,200) were diagnosed as 'severely and persistently mentally ill.' Of these, 49 percent (3,375) had co-occurring substance abuse disorders and 20 percent (1,403) were homeless at least once during the period.
   - 13 percent (939) were homeless and had co-occurring substance abuse disorders. Of these, 76 percent (712) had a least one jail detention (average of six bookings), and 74 percent (693) had at least one hospitalization (average of four admissions).
   - The study also revealed that of the 20,200 King County individuals with less chronic, but still serious mental illness who were receiving publicly funded mental health care 7,000 were jailed at least once (representing 35 percent of the seriously mentally ill but just six percent of the total jail population). Two-thirds were detained for 'minor' crimes (misdemeanors and non-violent felonies); a third was detained for violent felonies.
   - Of the 20,200 noted above, those committing minor crimes were predominately Caucasian males (73%). A quarter of them were African Americans. Average age at first detention was 35.
   - A third of those committing violent felonies were African American. Again, the majority were Caucasian males (64%). Average age at first detention was 32.

2. Information from the 2006 King County mental health database indicates that a total of 25,853 adults received mental health treatment.
   - Of the 19,661 served in outpatient treatment, 36 percent had co-occurring substance abuse disorders, nine percent were homeless, 13 percent had at least one jail booking.
   - Of the 6,192 served who only received inpatient, crisis or other specialty service, 52 percent had co-occurring substance abuse, 33 percent were homeless, 29 percent had at least one jail booking.
   - Of homeless adults who received any mental health treatment, 69 percent had co-occurring substance abuse disorders and 47 percent were jailed at least once in 2005 or 2006.

3. Information from the 2006 King County mental health database indicates that a total of 9,226 children/youth received mental health treatment.
   - Of the 8,447 served in outpatient treatment, ten percent had co-occurring substance abuse disorders, one percent were homeless and five percent had at least one stay in juvenile detention.
   - Of the 779 served who only received inpatient, crisis or other specialty services, 24 percent had co-occurring substance abuse disorders, two percent were homeless and nine percent had at least one stay in juvenile detention.
   - Of homeless youth who received any mental health treatment, 18 percent had co-occurring substance abuse disorders.

4. A Needs Assessment completed in 2006 by Washington State Transformation Grant researchers estimated that 263,000 (15%) of the 1.7 million low income residents (below 200% of poverty) have a mental disorder significant enough to have a moderate to severe impact on functioning. For King County, the estimated number of individuals who need services would be approximately 65,000. In fiscal year 2003 the Department of Social and Health Services/Mental Health Division budget funded services statewide for less than half of those in need[15].

5. National data compiled by the American Association for Geriatric Psychiatry indicate that the rate of suicide for older persons is higher than for any other age group, yet over half of older adults who get any mental health treatment receive it from their primary care doctor. Under-treatment of depression in the primary care setting is a recognized public health problem[16].

6. King County information from the state's 2006 alcohol and substance abuse database indicates that:
   - Of the 5,101 adults served, 45 percent had at least 'moderate mental health needs', 17 percent were homeless, and 61 percent had current legal involvement.
   - Of the 750 youth served, 30 percent had at least 'moderate mental health needs', one percent were homeless, and 50 percent had current legal involvement.

7. The GAIN assessment is administered to all youth referred to and evaluated for substance abuse in King County. Cumulative results from November 2005 through 2006 indicated that[17]:
   - 33 percent reported being homeless/runaway at some time in their life
   - 42 percent had involvement with juvenile justice within the last 90 days
   - 31 percent had a mental health 'internalizing disorder' (problems with depression, thought disorders, etc.) within the past 12 months
   - 51 percent had an 'externalizing disorder' (problems with anger, disruptive behaviors, etc.) within the past 12 months.

8. The 2003 Washington State Department of Alcohol and Substance Abuse (DASA) survey of King County households indicated that[18]:
   - Of 20,911 persons identified as needing treatment and meeting DASA eligibility

criteria, only 21.2 percent (4,441) were being served.

9. The Kessler Cross-National Comparisons of Co-morbidities Study[19] estimated that 20 percent of all adult males and nine percent of all adult females were alcohol dependent; and that nine percent of males and six percent of females were drug dependent at some time during their life. This study also found that:
   - Males with lifetime alcohol dependence, 61 percent had a serious mental illness
   - Females with lifetime alcohol dependence, 77 percent had a serious mental illness
   - Males with lifetime drug dependence, 77 percent had a serious mental illness
   - Females with lifetime drug dependence, 84 percent had a serious mental illness.

Homeless persons

1. The 2006 One Night Count data indicates that of the 5,963 homeless individuals counted in shelters and transitional housing, 1,228 (21%) met a broad definition of mental illness, 585 (10%) were considered to have a serious mental illness and 95 (2%) had been released from a psychiatric hospital in the last year. In addition, 1,262 (21%) were considered to be abusing substances, with 760 (13%) considered to be seriously abusing substances. In addition, 139 (2%) had been released from inpatient chemical dependency treatment in the past year. Only 37 percent of homeless individuals were white, while the overall population of King County is approximately 75 white white. The needs of an additional 1,946 unsheltered individuals were unknown[20].

2. Of the 7,987 of the people served by King County's Health Care for the Homeless Network (HCHN) in 2006 almost a third had mental health and/or substance abuse problems. Nearly half had no health insurance. HCH estimates that they reach only a third of the homeless population[21].

3. A study sampled 364 Seattle youth (ages 13-21) who were homeless between 1991-1994[22].
   - 68 percent met criteria for at least one mental disorder.
   - 45 percent reported a previous suicide attempt.
   - 31 percent of youth had spent time in an emergency room or hospital in the last three months.
   - Almost all youth reported use of alcohol and marijuana in the past year; 77 percent met criteria for substance abuse/dependence.

Other pertinent data

1. Compelling data demonstrates risk factors associated with incarceration and homelessness:
   - A study published in 2007 noted the high risk of death for former prison inmates in the Washington State Department of Corrections (DOC) prisons[23]. Of over 30,000 released inmates (1999-2003), 443 died within 1.9 years. The adjusted death risk was 3.5 times that of other state residents. During the two weeks after release, the risk was 12.7 times that of other residents. Drug overdose was the leading cause of death, with cardiovascular disease, homicide and suicide as other leading causes. Each year

the DOC releases approximately 150 prisoners diagnosed with mental illness to King County. About 60 percent of these have co-occurring substance abuse diagnoses[24].

- The homeless youth study[25] noted that 41 percent of youth were not in school and 83 percent were exposed to at least one form of physical or sexual victimization while homeless.

2. Between three percent and four percent of King County 8th & 10th graders reported a suicide attempt in the year before they completed the *Healthy Youth Survey 2006.*

3. Nationwide in 2003, behavioral health encounters became the number one reason for a primary health care center visit. Yet, only three of 25 public health clinics in King County have funds dedicated for behavioral health services. Public Health – Seattle & King County estimates that of the 127,258 individuals using clinics in King County in 2006, 18,000 to 38,000 are in need of mental health/chemical dependency services. Of individuals using clinics in King County, approximately 40 percent are not eligible for public insurance and therefore can not access services through the publicly funded mental health and substance abuse service systems[26].

Definitions

The definition of Serious Mental Illness (SMI) is stipulated in PL 102-321 as "Adults with SMI are persons 18 years and older who, at any time during a given year, had a diagnosable mental health, behavioral or emotional disorder that met the criteria for DSM III-R and has resulted in functional impairment which substantially interferes with or limits one or more major life activities"[27].

Severe and Persistent Mental Illness (SPMI) was operationalized by the National Advisory Mental Health Council of the National Institute of Mental Health[28]. SPMI is a subset of SMI and generally includes schizophrenia, schizoaffective disorder, manic-depressive disorder, autism and severe forms of major depression, panic disorder and obsessive-compulsive disorder. Evidence of severity includes patient psychiatric hospitalization, psychotic symptoms, use of antipsychotic medication or a GAF scale rating of 50 or less.

Notes

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Mental Illness and Drug Dependency Action Plan: Phase III
Budget Summary Table

Strategy	Recommendations for New or Expanded Services	Cost
1a.	Increased access to mental health and chemical dependency outpatient services for people not on Medicaid	$11,125,000
1b.	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	$ 550,000
1c.	Emergency room substance abuse early intervention program	$ 800,000
1d.	Mental health crisis next day appointments	$ 250,000
1e.	Chemical dependency professional education and training	$ 615,000
1f.	Peer support and parent partners family assistance	$ 450,000
1g.	Prevention and early intervention mental health and substance abuse services for older adults	$ 500,000
1h.	Expand the availability of crisis intervention and linkage to on-going services for older adults	$ 350,000
2a.	Caseload reduction for mental health	$ 4,000,000
2b.	Employment services for individuals with mental illness and chemical dependency	$ 1,500,000
3a.	Supportive services for housing projects	$ 2,000,000
4a.	Comprehensive chemical dependency outpatient services to parents in recovery	$ 500,000
4b.	Prevention services to children of substance abusers	$ 400,000
4c.	School district based mental health and substance abuse services	$ 1,235,000
4d.	School based suicide prevention	$ 200,000
5a.	Increase capacity for social and psychological assessments for juvenile justice youth	$ 360,000
6a.	Wraparound family, professional and natural support services for emotionally disturbed youth	$ 4,695,000
7a.	Reception centers for youth in crisis	$ 500,000
7b.	Expanded crisis outreach and stabilization for children and youth	$ 1,000,000
8a.	Expand family treatment court services and support to parents	$ 700,000
9a.	Expand juvenile drug court treatment	$ 510,000
10a.	Crisis intervention training program for King County Sheriff, police, jail staff and other first responders	$ 1,700,000
10b.	Adult crisis diversion center, respite beds and mobile behavioral health crisis team	$ 6,060,000
11a.	Increase capacity for jail liaison program	$ 80,000
11b.	Increase services available for new or existing mental health court programs	$ 1,300,000
12a.	Increase jail re-entry program capacity	$ 320,000
12b.	Hospital re-entry respite beds	$ 565,000
12c.	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community–based services upon discharge from the emergency room	$ 200,000
12d.	Urinalysis supervision for Community Center for Alternative Programs clients	$ 75,000
	Administration/Evaluation[1]	$ 2,400,000
	Revenue Stabilization Reserve[2]	$ 2,000,000
	Data Systems[3]	$ 500,000
	Flex funds for sustaining grants, providing match, pilot programs	$ 500,000
	GRAND TOTAL	**$47,940,000**

[1] Goal of 5%
[2] Sales tax revenues may be variable depending on the economy. $2 million will be reserved each year until a $10 million reserve fund is reached in order to create stable funding for committed services.
[3] Programming and ongoing technical support for program monitoring and evaluation functions