King County

Metropolitan King County Council

Regional Policy Committee

Staff Report

AGENDA ITEM No.:	**6**	**DATE:**	**September 10, 2008**
Proposed No.:	**2008-0489**	**PREPARED BY:**	**Kelli Carroll**

STAFF REPORT

SUBJECT

An Ordinance related to the Mental Illness and Drug Dependency Implementation Plan.

SUMMARY

Ordinance 15949 authorized a one tenth of one percent sales and use tax for the delivery of mental health, chemical dependency and therapeutic court services in King County. It required the Executive to submit oversight, implementation and evaluation plans for the programs funded with the tax revenue. The 2008 budget ordinance included a proviso with the same requirements. The Mental Illness and Drug Dependency (MIDD) Implementation Plan and motion were transmitted to the King County Council on July 3, 2008.

On September 8, 2008, an Ordinance to adopt a revised Mental Illness and Drug Dependency Implementation Plan was referred to the Regional Policy and Operating Budget Committees. The Regional Policy Committee received a briefing on the MIDD Implementation Plan on August 6.

There will be at least one additional Operating Budget, Fiscal Management and Select Issues Committee meeting on the proposed legislation in order for the Committee to review and discuss the Implementation Plan. It is anticipated that the proposed legislation will come before the Council on either September 29th or October 6th.

Proposed Ordinance 2008-0489 adopts the MIDD Implementation Plan. The proposed ordinance also:

1. Asks the Oversight Committee to prose a process for reviewing and considering new programs and strategies
2. Establishes a new strategies reserve to fund new strategies
3. Outlines the new strategies reserve's policies

BACKGROUND

Motion 12320 directed the Executive to complete a plan that would address the issues noted above, with the intent of building on previous Council directed steps to reduce growth of the criminal justice costs such as Adult Justice Operational Master Plan (AJOMP), Juvenile Justice Operational Master Plan. The Executive's plan was also to include a proposal for funding the activities. The subsequent MIDD Action Plan was accepted by the Council in October of 2007.

In 2005, the Washington State Legislature authorized counties to levy one tenth of one percent sales tax to be used solely for new or expanded mental health and chemical dependency treatment services and therapeutic courts. This law was amended in 2008 to state that moneys collected under the county-authorized sales and use tax for mental health and chemical dependency services and therapeutic courts could also be used for housing that is a component of a coordinated chemical dependency or mental health treatment program or service.

On November 15, 2007, the council authorized the one-tenth of one percent sales and use tax for the delivery of mental health and chemical dependency services and therapeutic court services, creating a dedicated fund source for the services and system improvements identified in the MIDD Action Plan. Ordinance 15949 detailed the required steps to be completed in advance of expenditure of the revenues.

With the adoption of Ordinance 15949 authorizing the sales tax, the Council also established a policy framework to ensure that the five following policy goals are met by the sales tax funded programs:

1. A reduction of the number of mentally ill and chemically dependent individuals using costly interventions like jail, emergency rooms and hospitals;
2. A reduction of the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency;
3. A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults;
4. Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement; and
5. Explicit linkage with, and furthering the work of, other council directed efforts including, the adult and juvenile justice operational master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Services Improvement Plan and the county Recovery Plan

Key MIDD Facts

1. Current estimates suggest that the tax will generate $50 million annually.
2. The tax became effective on April 1, 2008.
3. The tax expires on January 1, 2017. State statute does not establish an expiration date for this tax; it was established by the Council via Ordinance 15949.
4. The MIDD Oversight Committee was established by Ordinance 16077 on April 28, 2008.

Purpose and Summary of the MIDD Implementation Plan

The Council intended for the Implementation Plan to expand on the initial MIDD Action Plan by providing additional important details on the services and programs of the MIDD strategies. Ordinance 15949 provided specific direction on the creation of, and elements to be included in the MIDD Implementation Plan. The Implementation Plan was to be developed in collaboration with the oversight group and was to include or address the following specific areas:

- A discussion of needed resources, including staff, information and provider contracts
- A schedule of the implementation of programs and services outlined in the Mental Illness and Drug Dependency Action Plan
- A revised 2008 spending plan
- A revised 2008 financial plan
- Milestones for implementation of the programs
- Proposals for MIDD funding for adult drug diversion court and how to integrate programs that support specialized mental health or substance abuse counseling, therapy and support groups for victims of sexual assault, victims of domestic violence

and children exposed to domestic violence, provided by or in collaboration with recognized sexual assault and domestic violence services providers

In order for spending to commence on any one of the MIDD programs in 2008, the Council must approve the Implementation Plan and Evaluation Plan. As established in Ordinance 15949, the Council set aside this review period for analysis and consideration of the MIDD strategies

Housing and Financial Planning
At the July 23, 2008 Operating Budget, Fiscal Management and Select Issues Committee, a number of questions were raised pertaining to the housing and financial planning elements of the Implementation Plan. At the August 27, 2008 Operating Budget, Fiscal Management and Select Issues Committee meeting, information in response to those questions was provided. **Attachment 3** contains the information provided to the committee on August 27. **Attachments 4 and 5** were provided as attachments to the August 27 staff report.

ANALYSIS

1. Why an Ordinance?

Ordinance 15949 calls for the Executive to transmit an oversight, implementation and evaluation plans to the Council for approval by motion. The Executive submitted the MIDD Implementation Plan and motion to adopt the Plan on July 3, 2008.

The MIDD tax and the programs and strategies it funds will have far reaching impacts throughout the county. Accordingly, there is a need to assure policymakers and stakeholders that the programs and strategies are implemented as described and planned.
The three key factors driving the need for a greater level of assurance and accountability that an ordinance would provide are:

A. The MIDD sales tax will bring the largest infusion of new human service funds into King County in decades.
B. Thousands of county residents could receive critical mental health, substance abuse and therapeutic court services through dozens of new or expanded programs funded by the MIDD revenue.
C. Stakeholders and community partners have worked with the County for over two years to develop the programs and strategies of the Implementation Plan; and the MIDD strategies are intended to work together for maximum system-wide benefit.

A motion is a statement by the Council that does not carry the force of law[1], where as an ordinance does have the force of law. Adopting the Plan by ordinance provides for a greater level of accountability for the MIDD programs than a motion could. It also responds to a high degree of interest in the MIDD tax and its programs and strategies on the part of the Council and its community partners.

By way of comparison, the Veterans and Human Services Service Improvement Plan and its allocation plan were also adopted by ordinance (15632) in 2006.

2. What Does the Ordinance Do?

Proposed Ordinance 2008-0489 adopts the revised Implementation Plan. The ordinance also proposes changes to certain elements of the MIDD. The changes affected by the proposed ordinance are outlined in Table 1.

TABLE 1

[1] King County Charter, Article 2, Section 240

Proposed Ordinance 2008-0489	Effect
A. **Adopts Revised Implementation Plan; Specifies expenditures to be made according to Implementation/Spending Plan:** Expenditures from the mental illness and drug dependency fund shall occur as specified by the Implementation Plan/Spending plan	1. Assures stakeholders and policymakers that programs and strategies will move forward as budgeted and scheduled 2. Prevents reallocation of funds between programs or reserves
B. **Asks the Oversight Committee to develop and propose a new strategies process:** The Oversight Committee shall propose a process and a schedule for new programs and strategies to be considered for funding by the sales tax revenue. The process and schedule shall: 1. Be easily accessible and transparent to the potential proposers of new programs and strategies ; 2. Provide clear and simple directions for the potential proposers of new programs and strategies ; 3. Specify the key elements required in any proposal or request for funding; 4. Include a schedule and timeline for the proposal process; and 5. Provide at least two dates during the calendar year when new strategies and any necessary supplemental appropriation ordinances would be sent to the council for consideration. 6. Until council action on the oversight committee's recommendation for a new strategy process, persons or organizations seeking consideration of new strategies funded by the sales tax revenue shall submit such requests to the oversight committee co-chairs. These requests shall then be forwarded by the co-chairs to executive and council staff.	1. Acknowledges that the programs and strategies in the Implementation Plan are not fixed 2. Enables new MIDD programs and strategies to be considered and included 3. Provides for the creation of process whereby new strategies may be brought forward for consideration and funding 4. Engages Oversight Committee in designing the proposed process, utilizing the group's expertise and knowledge 5. Identifies the key elements that the new strategies process must contain, emphasizing "user friendly" aspects for the future process 6. Specifies that there are two points during the calendar year when new strategies may be brought forward to the Council for consideration/funding. 7. Establishes the Oversight Committee Co-Chairs as the interim point of contact for persons or organizations interested in receiving MIDD funds for a new strategy or program until the new strategy process has been acted on by the Council
C. **Establishes a New Strategy Reserve for the MIDD fund.** In order to reserve funds for new strategies not currently specified in the implementation plan, a new strategy reserve is hereby created in the mental illness and drug dependency fund. The purpose of this reserve is to fund new programs and strategies that meet the county's policy goals established in Ordinance 15949.	Creates a reserve to fund future new strategies.

D. **Outlines policies for using New Strategy Reserve:** Mental Illness and Drug Dependency programs or strategies that are funded from the new strategy reserve shall receive funding from the reserve for two full years, during which time, these programs and strategies shall be reviewed as part of the annual evaluation cycles. After the initial two year period, the new programs and strategies shall be subject to expansion, revision or elimination. 1. The new strategy reserve shall be limited to five million dollars. 2. The new strategy reserve shall be initially funded in 2008 by: a. allocating one million eight hundred thousand dollars of the Mental Illness and Drug Dependency fund's revenue stabilization reserve to the new strategy reserve; and b. allocating seven hundred thousand dollars of the Mental Illness and Drug Dependency fund's 2008 revenue. 3. In 2009 by allocating up to two million seven hundred thousand dollars of the Mental Illness and Drug Dependency fund's 2008 ending undesignated fund balance to the new strategy reserve at the end of the 2008 fiscal year. 4. In 2010 and beyond, the new strategy reserve will be replenished on an annual basis by allocating up to one half of the Mental Illness and Drug Dependency fund's previous ending year's undesignated fund balance at to the reserve until the five million dollars limit is reached.	1. Provides for new programs and strategies to be funded for an initial two years 2. Specifies that new programs and strategies will be reviewed during their first two years per the evaluation cycles 3. States that after the first two years of funds and evaluations, the new programs and strategies may be expanded, revised or eliminated 4. Sets a $ 5.0 million cap of the new strategies reserve 5. Finances new strategy reserve with additional and reprogrammed revenue

3. What the Ordinance Doesn't Do

Ordinance 2008-0489 does not propose changes in the individual implementation plans or schedules to any of the 35 specific strategies initially proposed in the July 3, 2008 Implementation Plan.

The initial Implementation Plan proposed by the Executive recommends utilizing $18 million of unspent 2008 MIDD funds for a new housing strategy. This strategy would include housing development capital and rental assistance/subsidies. It is initially estimated that about $13 million would be used for housing development and $5 million would be allocated to rental assistance/subsidies. Proposed Ordinance 2008-0489 does not recommend changes to the housing strategy as proposed by the Executive.

4. The New Strategies Reserve
Proposed Ordinance 2008-0489 proposes the establishment of a new strategies reserve. This reserve would be used to fund new MIDD initiatives. The proposed ordinance recommends financing the new strategies reserve by a) utilizing additional revenue; b) by reallocating portions of other reserves and; c) by applying undesignated fund balance.

The recommended budget and funding levels of the 35 individual strategies are not affected by the establishment of the new strategies reserve.

The MIDD fund was established during the 2008 county budget process. The 2008 adopted MIDD fund financial plan created a revenue stabilization reserve for the fund. The purpose of the reserve is to offset fluctuations in revenue collection during economic swings, protecting MIDD programs from potential reductions in years when revenue might fall below projected levels. The Executive proposed that a minimum of $2.0 million would be set aside annually until the $10.0 million level of the stabilization reserve had been reached.

Due to higher than expected revenue collections in 2008, the Office of Management and Budget projects that $1.8 million more could be added to the revenue stabilization reserve in 2008 (**Attachment 4**). Adding $1.8 million of "extra" revenue to the planned $2.0 million has the effect of building up the revenue stabilization reserves to the $10 million cap sooner.

5. Potential Changes to MIDD Ordinances 15949 and 16077
Ordinance 15949 imposed the sales tax and established requirements for quarterly and annual reporting. It also gave direction to the Executive on the submission of the annual spending plans. Ordinance 16077 established the Oversight Committee and its powers and duties. Some provisions of proposed Ordinance 2008-0489 may require amendments to these two ordinances.

For example, Proposed Ordinance 2008-0489 would add elements to the quarterly and annual reports that are not specified in Ordinance 15949. In another example, Proposed Ordinance 2008-0489 would require the Oversight Committee to propose a process for considering new strategies. This creates an additional duty for the committee that is not specified in Ordinance 16077. In addition, amendments may be appropriate to specify the timing and process for transmitting subsequent year's spending plans.

Legal review of these drafting issues is underway by the Office of the Prosecuting Attorney and the Council's legal counsel. If it is determined that the provisions of Proposed Ordinance 2008-0489 should include amendments to these existing ordinances, such amendments could be offered at the September 24, 2008 Operating Budget, Fiscal Management and Select Issues Committee meeting.

REASONABLENESS
The MIDD Implementation Plan fulfills the requirements of the 2008 budget proviso and of Ordinance 15949. Proposed Ordinance 2008-0489 is ready for committee action at this time.

INVITED
- Amnon Shoenfeld, Division Director, Mental Health, Chemical Abuse and Dependency Services Division, Department of Community and Human Services

ATTACHMENTS
1. Proposed Ordinance 2008-0489 and Revised Mental Illness and Drug Dependency Implementation Plan, September 2, 2008

2. Housing Information Sheet, excerpt from August 27, 2008 Operating Budget, Fiscal Management and Select Issues Committee staff report on the MIDD Implementation Plan
3. MIDD Oversight Group Housing Strategy Information Sheet, dated July 24, 2008
4. Revised Mental Illness and Drug Dependency Fund Financial Plan, September 5, 2008
5. "A Gravely Disabled Mental Health Care System" by Carol Smith, Seattle Post Intelligencer, September 8, 2008

King County

KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 5, 2008

Ordinance

Proposed No. 2008-0489.1 **Sponsors** Ferguson

AN ORDINANCE relating to the mental illness and drug dependency implementation plan.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. **Findings:**

A. In 2005, the Washington state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services.

B. In 2007, the King County council adopted Ordinance 15949 authorizing the levy and collection of, and legislative policies for the expenditure of revenues from, an additional sales and use tax of one-tenth of one percent for the delivery of mental health and chemical dependency services and therapeutic courts. The ordinance also established a policy framework for measuring the effectiveness of the public's investment, requiring the King County executive to submit oversight, implementation and evaluation plans for the programs funded with the tax revenue.

C. In 2008, the Washington state Legislature amended RCW 82.14.460 in Chapter 157, Laws of Washington 2008, which defines those programs and services that are authorized for funding by the sales tax. The amendment added housing that is a component of a coordinated mental health or chemical dependency treatment program or service to the list of programs and services that are authorized for funding by the sales tax. The statute also amended the nonsupplanting provision to allow the sales tax funds to be used for replacement of lapsed federal funding previously provided for mental health, substance abuse and therapeutic court services and programs.

D In April 2008, the King County council adopted Ordinance 16077, establishing the King County mental illness and drug dependency oversight committee. The oversight committee is an advisory body to the King County executive and the council. The purpose of the oversight committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable, and collaborative. The committee reviews and comments on quarterly, annual and evaluation reports as required in Ordinance 15949. It also reviews and comments on emerging and evolving priorities for the use of the mental illness and drug dependency sales tax revenue. The oversight committee members bring knowledge, expertise and the perspective necessary to successfully review and provide input on the development, implementation, and evaluation of the tax funded programs.

E. Ordinance 15949 directed the development of an implementation plan to be developed in collaboration with an oversight group. The oversight group, under the guidance of the department of community and human services, provided input on development of the implementation plan, which was attached to the transmitted motion.

F. The implementation plan describes the implementation of the programs and services outlined in the mental illness and drug dependency action plan. It includes: a schedule for the implementation of programs and services outlined in the mental illness and drug dependency action plan; a discussion of needed resources, including staff, information and provider contracts; and milestones for implementation of the programs. In addition, the implementation plan addresses how adult drug diversion court, one of the county's therapeutic courts, may utilize sales tax revenue for program expansion. Finally, it includes strategies and programs that support specialized mental health or substance abuse counseling, therapy and support groups for victims of sexual assault, victims of domestic violence and children exposed to domestic violence, provided by or in collaboration with recognized sexual assault and domestic violence services providers.

G. Funds for housing development and rental subsidies that are part of a coordinated mental health or chemical dependency treatment program or service are included in the implementation plan.

H. The services identified in the implementation plan will help to address the unmet needs of thousands of vulnerable King County residents. Improved access to mental health and chemical dependency treatment and support is expected to improve the quality of life for those in need of services and yield significant cost savings to the region through the reduced usage of the criminal justice system and more expensive alternatives to treatment.

I. The strategies outlined in the 2008 implementation plan represent a continuum of initial mental health, therapeutic court and substance abuse services. The strategies contained in the implementation plan attached to this ordinance or any future

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implementation plans may be expanded, revised or eliminated by ordinance based on, but not limited to, the following reasons: changes to state law or county policy; performance data from the evaluation of sales-tax funded programs and strategies; recommendation from the county executive or the oversight committee; or county budgetary constraints.

J. The council recognizes that the needs of the county's residents may change over time and that new and innovative mental health, substance abuse and therapeutic court programs and services are continually being developed and implemented across the country. Therefore, it is the policy of the county that the county's mental illness and drug dependency shall maintain flexibility to respond to the changing needs of the county's population as well as to accommodate new mental health, substance abuse and therapeutic court strategies and programs.

K. The county's mental illness and drug dependency strategies and programs shall be responsive to the changing needs of the county's population. They shall maintain the flexibility to accommodate new, revised or improved mental health, substance abuse and therapeutic court strategies and programs.

SECTION 1.

The implementation plan for the mental illness and drug dependency action plan, Attachment A to this ordinance, is hereby adopted. Expenditures from the mental illness and drug dependency fund shall only occur as provided by the implementation plan, which is Attachment A to this ordinance, and the spending plan, which is appendix D to Attachment A to this ordinance.

SECTION 2.

A. The mental illness and drug dependency oversight committee, with input from the council and the executive, shall propose a process and a schedule for new strategies and programs to be considered for funding by the sales tax revenue. The process and schedule shall:

1. Be easily accessible and transparent to the potential proposers of new strategies and programs;

2. Provide clear and simple directions for the potential proposers of new strategies and programs;

3. Specify the key elements required in any proposal or request for funding;

4. Include a schedule and timeline for the proposal process; and

5. Provide at least two dates during the calendar year when new strategies and any necessary supplemental appropriation ordinances would be sent to the council for consideration. One of those dates shall be April 1, when the annual report is due.

B. The oversight committee's recommendation for a new strategy process will be submitted to the council along with the mental illness and drug dependency annual report that is due April 1, 2009.

C. Until council action on the oversight committee's recommendation for a new strategy process, persons or organizations seeking consideration of new strategies funded by the sales tax revenue shall submit such requests to the oversight committee co-chairs. These requests shall then be forwarded by the co-chairs to executive and council staff.

SECTION 3.

A. In order to reserve funds for new strategies not currently specified in the implementation plan, a new strategy reserve is hereby created in the mental illness and

drug dependency fund. The purpose of this reserve is to fund new strategies and programs that meet the county's policy goals established in Ordinance 15949.

B. Mental illness and drug dependency programs or strategies that are funded from the new strategy reserve shall receive funding from the reserve for two full years, during which time, these programs and strategies shall be reviewed as part of the annual evaluation cycles. After the initial two year period, the new strategies and programs shall be subject to expansion, revision or elimination.

C. The new strategy reserve shall be limited to five million dollars.

D. The new strategy reserve shall be initially funded:

1. In 2008 by:

a. allocating one million eight hundred thousand dollars of the mental illness and drug dependency fund's revenue stabilization reserve to the new strategy reserve; and

b. allocating seven hundred thousand dollars of the mental illness and drug dependency fund's 2008 revenue.

2. In 2009 by allocating up to two million seven hundred thousand dollars of the mental illness and drug dependency fund's 2008 ending undesignated fund balance to the new strategy reserve at the end of the 2008 fiscal year.

E. In 2010 and beyond, the new strategy reserve will be replenished on an annual basis by allocating up to one half of the mental illness and drug dependency fund's previous ending year's undesignated fund balance at to the reserve until the five million dollars limit is reached.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

ATTEST:

APPROVED this _____ day of _____, _____.

Attachments A. Mental Illness and Drug Dependancy Implementation Plan Version 2 - REVISED 9-2-08

ATTACHMENT A

King County Mental Health, Chemical Abuse and Dependency Services

King County

Mental Illness and Drug Dependency Implementation Plan

VERSION 2

REVISED September 2, 2008

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King County

Mental Illness and Drug Dependency Action Plan

Table of Contents

Introduction

1. Overview

In July 2006 the King County Council, recognizing the unmet needs of people disabled by mental illness and chemical dependency and the ongoing public costs of serving them in hospitals and jails, passed 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".*

The three-phase action that was developed, called "The Mental Illness and Drug Dependency (MIDD) Plan", was accepted by Council in October 2007. In November 2007 Council passed Ordinance 15949, authorizing the collection of a one-tenth of one-percent sales and use tax to provide funding for the programs outlined in the MIDD, and requiring the submission of a three-part Oversight, Implementation, and Evaluation Plan for Council approval prior to funds being spent on the MIDD. The Oversight Plan, describing the representation, roles and responsibilities of the Oversight Committee, was approved by Council on April 28, 2008. The attached Implementation Plan describes in detail the services that will be provided, the resources needed for implementation, the timeline and milestones for implementation, how drug diversion court and programs that support victims of domestic violence and sexual assault, and how housing will be included in the MIDD continuum of mental health and substance abuse services, and the revised spending plan for the MIDD fund. This Implementation Plan provides a detailed framework for a comprehensive system of programs and strategies that will fulfill the Council mandate to create a full continuum of treatment, housing, and case management services that will lead to a significant reduction in the human and public costs of mental illness and chemical dependency in King County.

The MIDD Implementation Plan will provide an integrated system of:

- Prevention and early intervention services
- Community-based treatment
- Expanded therapeutic court programs
- Jail and hospital diversion programs
- Housing and housing supportive services.

The plan includes new programs as well as expansion of existing programs and services. These new and expanded services will address the unmet needs of approximately 33,000 individuals in King County each year.

2. Development of the MIDD Implementation Plan

The MIDD Implementation Plan represents the collaborative efforts over a two-year period of a wide range of community and governmental stakeholders, including representatives of mental health and substance abuse treatment agencies, courts, law enforcement, public health, the prosecuting attorney, public defense, juvenile and adult justice systems, children's services, juvenile rehabilitation, and many others. The product of this work is a comprehensive, multi-jurisdictional plan to help youth and adults who are at risk for or suffer from mental illness and/or substance abuse.

The strategies that make up the MIDD Plan were first developed by several community workgroups that met from the spring of 2006 through the spring of 2007. These groups used the Sequential Intercept Model as a framework 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.

King County has 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.

The workgroups that developed the strategies for the MIDD recognized 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. Understanding the importance of prevention services, early assessment and intervention, and comprehensive and integrated community-based services, the MIDD plan has devoted considerable resources 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.

Following the acceptance by the King County Council of the MIDD plan and the passage of Ordinance 15949 authorizing the collection of the one-tenth of one-percent sales and use tax, additional work was done to refine the original strategies, and to add new strategies to the Plan to serve individuals in adult drug court as well as victims of domestic violence and sexual assault. This new work was done by in collaboration with a number of community and government stakeholders, and with the newly formed Interim Oversight Committee.

The MIDD Oversight Committee was convened first as an interim group in April, 2008 while legislation adopting the Oversight Plan was being processed, and subsequently seated as a formal committee in May 2008 after members were appointed by the King County Executive and confirmed by the King County Council. The Committee is comprised of representatives from a broad spectrum of county, community and city entities (a list of committee members is provided in Appendix A). Committee members and their staff generously contributed their time, insight and knowledge to review and provide input on the draft Implementation Plan.

Members attended and participated in multiple committee meetings as well as in workgroup meetings at which each strategy in the plan was discussed in detail. Public comment was also received by the committee through testimony at meetings, written comments, website comments, and presentations by members of their own stakeholder groups. In addition, the members of the Oversight Committee reviewed and provided input on the revised 2008 spending plan. Completion of the MIDD Implementation Plan would not have been possible without the thoughtful collaboration of the Oversight Committee members.

Through the MIDD programs, individuals with mental illness and chemical dependency will be linked to effective services designed to help them to become stable and productive, and prevent unnecessary incarceration and hospitalization. These services include:

- Prevention and early intervention strategies for high-risk youth that will reduce substance abuse and youth suicide, help more youth to stay in school, and prevent their involvement in the juvenile justice system.
- Community-based treatment will provide mental health and chemical dependency services for people who have not previously been able to access them.
- Crisis intervention training for police and other first responders, a crisis diversion facility for adults, and a reception center for youth that will provide effective alternatives to jails and hospitals for individuals in crisis.
- Therapeutic court program that will divert juveniles and adults from detention and jail.
- Early intervention and prevention services for adult and child survivors of domestic violence and sexual assault that will help prevent the onset of more severe mental illness and substance abuse, and help to interrupt the intergenerational cycle of violence.
- Housing with supportive services that will ensure that individuals who are homeless will be able to receive the maximum benefit from treatment services.

Together, all of these strategies will result in an improved quality of life for people with mental illness and chemical dependency and their families throughout King County.

3. The MIDD Implementation Plan Strategies

The MIDD Implementation Plan strategies are grouped into five service areas. The first three were included in the MIDD Action Plan that was accepted by the King County Council in October 2007. The fourth service area includes new programs incorporated into the MIDD plan in response to King County Ordinance 15949 and a change in State law which clarified the use of sales tax collections for housing. The Council, recognizing the unmet mental health and substance abuse treatment needs of individuals involved in adult drug diversion court and of victims of domestic violence and sexual assault, directed the Implementation Plan to include services for these individuals. The final service area addresses the housing needs of individuals with serious mental illness and chemical dependency.

1. Community-Based Care includes strategies to:
   - Increase access to community mental health and substance abuse treatment for uninsured children, adults, and older adults

- Improve the quality of care by decreasing mental health caseloads and providing specialized employment services
- Provide supportive services for housing projects serving people with mental illness and chemical dependency treatment needs.

2. Programs Targeted to Help Youth includes strategies to:
   - Expand prevention and early intervention programs
   - Expand assessments for youth in the juvenile justice system
   - Provide comprehensive team-based, intensive "wraparound" services
   - Expand services for youth in crisis
   - Maintain and expand Family Treatment Court and Juvenile Drug Court.

3. Jail and Hospital Diversion includes strategies to:
   - Divert people who do not need to be in jail or hospital through crisis intervention training for police and other first responders and by creating a crisis diversion facility
   - Expand mental health courts and other post-booking services to get people out of jail and into services faster
   - Expand programs that help individuals re-enter the community from jails and hospitals.

4. Domestic Violence and Sexual Assault Intervention and Prevention and Adult Drug Court includes strategies to:
   - Address the mental health needs of children who have been exposed to domestic violence
   - Increase access to coordinated, early intervention mental health and substance abuse services for survivors of domestic violence
   - Increase access to treatment services for victims of sexual assault
   - Enhance services available through the King County Adult Drug Diversion Court.

5. Housing Development includes strategies to:
   - Support capital projects and rental subsidies for people with mental illness and chemical dependency.

   (Note: This strategy was enabled by legislation passed into law in March 2008 (SSB 6791) that clarified that moneys collected under the county-authorized sales and use tax for mental health and chemical dependency services and therapeutic courts could be used for housing that is a component of a coordinated chemical dependency or mental health treatment program or service. This new housing development strategy will use unspent funds resulting from the delayed start-up of programs in 2008, and will not take away funding that could be used for the service strategies listed above.)

Each individual strategy contains:

- A needs statement
- A description of services
- A discussion of needed resources, including staff, information and provider contracts
- Milestones for implementation of the programs.

A table showing what type of services will be provided (mental health, substance abuse, or both), age groups served, whether the service is an expansion of an existing service or a new service, whether a request for proposal process is required, and estimated service start dates is provided in Appendix B.

A schedule for the implementation of programs is included in Appendix C. A revised 2008 spending plan and financial plan for the mental illness and drug dependency fund is included in Appendix D and discussed below. In addition, each of the strategies includes a list of linkages to other programs and planning and coordinating efforts, highlighting the fact that collaboration and coordination are critical to the successful implementation of the MIDD Plan.

4. MIDD Management and Implementation

The King County Department of Community and Human Services' (DCHS) Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has overall responsibility for the management of the implementation of the MIDD, including managing the budget, program development, issuing requests for proposals (RFPs), writing and monitoring contracts, quality management, and program evaluation.

The MIDD Oversight Committee is an advisory body to the Executive and Council, whose purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the MIDD tax revenue are transparent, accountable, collaborative and effective. The Oversight Committee will review, make recommendations, and provide comments to the Executive and Council on emerging and evolving priorities for the use of the MIDD revenue, and on the implementation and evaluation components of the MIDD Plan. The Oversight Committee is staffed collaboratively by MHCADSD and the King County Office of Management and Budget (OMB).

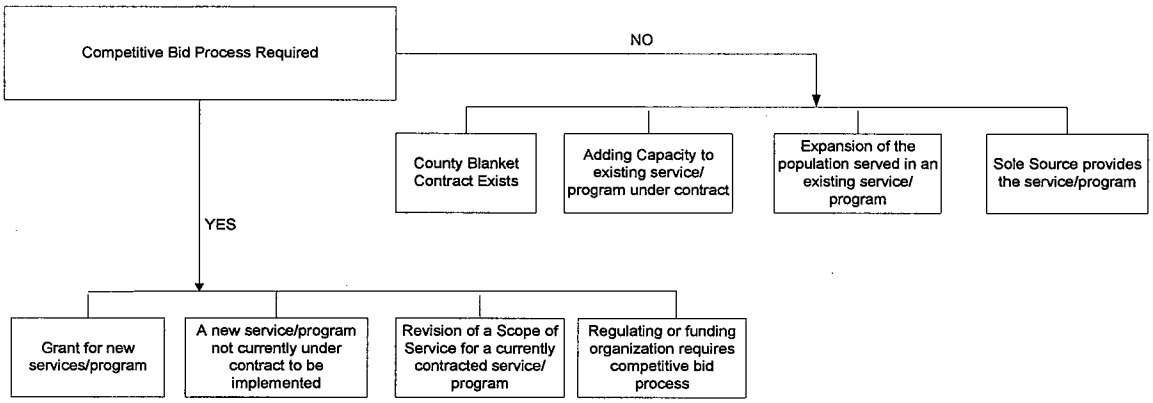
A. Timeline for implementation

The timeline for implementation of the strategies was determined by MHCADSD staff in consultation with stakeholders and partners identified for each strategy. Variables considered in developing timelines included whether or not the plan was complete or needed additional development, whether an RFP was required or not, and the time needed for staff recruitment and training. In addition, MHCADSD considered the work required by community providers to respond to RFPs, and, when possible, spread out the RFP response dates so that providers would not have to respond to multiple RFPs at the same time.

B. Procurement for services

King County policies regarding procurements were followed in determining whether a competitive RFP was required for each strategy. See Appendix E for the King County procurement requirements. The decision tree below shows how decisions were made regarding the need for RFPs.

DECISION TREE
FOR
PROCUREMENT OF SERVICES



There have also been differences in perspective among Oversight Committee members regarding whether Strategy 11b, to increase services available for new or existing mental health courts, requires an RFP process.

C. Provision of services

The great majority of services that will be provided through the MIDD will be contracted out to community agencies. When fully implemented, an estimated 438 full-time equivalent staff must be hired to provide the services and administrative responsibilities of the MIDD Plan.

D. Fiscal management

The .1% sales tax to support Mental Illness and Drug Dependency (MIDD) is collected by the State and transmitted to King County within two to three months of its receipt. King County then deposits the proceeds into the MIDD fund which is managed by the MHCADSD. Once the funds are available, and all other necessary conditions have been met, contracts of memoranda of agreement with providers for MIDD services will be written and negotiated and services can begin. Providers will be paid in the same manner as for other services contracted by MHCADSD: by either check or wire transfer.

MHCADSD has the infrastructure in place to contract with providers and to manage and measure the services they provide before releasing payments. All of the current funding sources for MHCADSD, including the State Mental Health Division and the Division of Alcoholism and Substance Abuse, the City of Seattle and others, require evidence that services are being performed in conformance with their contracts or agreements as a condition of payment. The same infrastructure and fiscal management methodology will be used to manage MIDD funds and services, as are

used to manage MHCADSD's other books of business. No lump sum payments will be issued prospectively in anticipation of services.

E. Revised spending plan

The original 2008 spending plan for the MIDD was first developed in mid-2007. This 2008 spending plan was revised recently to incorporate information that became available this year regarding when funds would be available for spending. Because we now know that MIDD services can not start until late September/early October of 2008, the spending plan reflects spending on provider services that start no earlier than when funds become available. Other factors have also been taken into account as appropriate in developing the spending plan including the ability to hire staff, ramp up services, and accommodate organizational and facility growth needs. The revised 2008 spending plan is included in Appendix D.

6. Challenges

A. Need for Additional Planning

Several of the strategies in the MIDD plan can be implemented immediately after approval of the Implementation and Evaluation Plans by the King County Council. Some of the new strategies involve multiple systems and will require additional planning. These include:

- Adult Crisis Diversion Facility (10b)
- Youth Reception Center (7a)
- Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities (1b)
- School District-Based Mental Health and Substance Abuse Services (4c)
- Increased Capacity for Harborview Psychiatric Emergency Services to provide linkage to community services (12c).

B. Staffing

The MIDD strategies will require over 400 new staff at community-based agencies, including mental health professionals, chemical dependency professionals, case managers, administrative staff and others. To address the complex and urgent needs of the people who will be served through the MIDD programs, staff for these programs should be highly qualified, experienced, and trained in the policies and procedures of the relevant agency. Agencies implementing MIDD programs may be challenged to find qualified staff to fill all the new positions in a timely fashion. To increase the number of qualified professionals available in King County, the MIDD Implementation Plan includes a strategy for training chemical dependency professionals in King County, resulting in up to 125 new certified chemical dependency professionals annually.

C. Stability of King County Funding to Foundation Programs

In the current climate of King County budget reductions, questions have been raised at the MIDD Oversight Committee and in public comments as to the potential impact of budget cuts on existing programs that will be expanded or enhanced with MIDD

funding. It is the intent of MHCADSD to move forward with implementation and planning in accordance with the timelines outlined in the MIDD Plan, and in Appendix C. If necessary, these questions will be revisited after the adoption of the 2009 budget in November, 2008.

D. MIDD Housing Development Strategy

MIDD Oversight Committee members expressed unanimous support for use of unspent 2008 funds for housing development and rental subsidies. However, there is a difference in perspective among committee members and stakeholders who have submitted public comments regarding the use of funds for housing development in subsequent years. One perspective is that services must be prioritized because the MIDD as originally presented to and approved by the King County Council was intended to fill large gaps in the mental health and chemical dependency treatment systems, and did not include housing. A counter view is that housing needs to be a higher funding priority in order for services to be successful. There is agreement that a balance is needed and this topic will be an area for continued discussion by the Oversight Committee.

E. Use of MIDD Funds for Medication

In the process of reviewing the individual strategies in the MIDD Implementation Plan, some members of the Oversight Committee identified the need for funding for medication for many individuals receiving services through the MIDD programs. MHCADSD recognizes this need, but has determined that medications are the responsibility of the State of Washington, and that service provision is the priority for MIDD funds. Community providers have worked with pharmaceutical companies and used other funding sources to provide for the medication needs of clients who are not able to access state funding to pay for medications.

F. Supplantation issues

The state legislation (E2SSB 5763) that allowed counties to impose the sales and use tax that will provide the funding for the MIDD required that funds from the sales tax be used for new or expanded services and not be used to supplant existing funding for these services, with the exception of lapsed Federal funding previously used for the operation or delivery of services and programs as defined by the legislation. Any services that were funded by King County at the time the County enacted the one-tenth of one-percent sales and use tax may not be subsequently funded by the sales tax in the event that county funding is lost. This plan reflects adherence to the non-supplantation intent.

7. Conclusion

As noted above, this Implementation Plan is the second part of a three-part plan required by Council as part of Ordinance 15949. The third and final part, the Evaluation Plan, will be submitted to Council by August 1, 2008. Once Council has approved all three plans, many of the programs in the Implementation Plan will begin to receive funds and provide services. Other programs will be phased in as program

designs and procurements for services are completed and as staff are hired and trained by providers. By the end of 2008, hundreds of children adults and older adults across King County will have begun to receive the services and supports needed to stabilize and improve their lives. All the citizens of King County will benefit in the coming years as the public and human costs of mental illness and substance abuse are reduced.

Community Based Care Strategies 1a – 3a

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

Strategy No: 1a (1) – Increased Access to Mental Health Outpatient Services for People Not on Medicaid

County Policy Goals Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

The public mental health system has long been driven by Medicaid funding. Medicaid regulations require that funds be expended only for persons on Medicaid. These regulations and funding restrictions prevent King County from serving a large population of individuals who need mental health treatment but are not on Medicaid and are financially unable to pay for services. Individuals with severe mental illness may not be covered by Medicaid due to their citizenship status, their inability to provide documentation needed for eligibility, their income intermittently exceeding the income limit for Medicaid eligibility, or other technical barriers to eligibility. When they don't receive needed outpatient services, they often end up in psychiatric hospitals and jails. Over half the individuals with mental illness who are admitted to psychiatric hospitals do not have Medicaid coverage. This strategy will serve people of all ages and who reside in all parts of King County.

◊ *B. Reason for Inclusion of the Strategy*

Currently, when individuals lose their Medicaid coverage they also lose their mental health services, or are intermittently eligible. This disrupts continuity of care and threatens the individual's clinical stability. Additionally, there is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose mental health needs are only addressed when their need reaches crisis proportions - either in hospital emergency departments, inpatient care, or jails. Expanded access to services could be put into place immediately upon receipt of expenditure authority, and would immediately open up access to services for individuals who are leaving hospitals and jails, and who previously would not have been able to receive services.

◊ *C. Service Components/Design*

Provide expanded access to outpatient mental health services for individuals who do not qualify for, or lose their Medicaid coverage, yet meet the income and clinical eligibility standards (medical necessity) for public mental health services. Services offered will include assistance to individuals to establish Medicaid eligibility.

◊ *D. Target Population*

Children, youth, adults, and older adults who have been served by the mental health system under Medicaid but have lost their eligibility; and individuals who have a mental illness, do not receive or do not qualify for Medicaid, or are waiting for approval for Medicaid, but meet clinical and financial eligibility criteria. The priority will be for those who are most in need of services, particularly individuals exiting the justice system, being discharged from hospitals, court-ordered to treatment, and those at risk for homelessness, incarceration, or hospitalization.

◊ *E. Program Goals*

Increase access to services and service provision for individuals who are currently ineligible; decrease the number who are re-incarcerated or re-hospitalized, and reduce jail and inpatient utilization, and homelessness.

◊ *F. Outputs/Outcomes*

An additional 2400 non-Medicaid clients served per year.
A reduction in use of jail, hospital, and emergency services.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
September 2008	Implement revised policies for non-Medicaid back fill and access	
Sept - December	Ramp up of non-Medicaid clients served	$2,130,000
	Total Funds 2008	**$2,130,000**
Jan – Dec 2009	Target of 2400 non-Medicaid clients served annually	$8,520,000
	Total Funds 2009	**$8,520, 000**
Ongoing Annual	**Total Funds**	**$8,520, 000**

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

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

Current Regional Support Network (RSN) outpatient providers will be able to provide service as soon as funding is available and access is opened up. Current work force capacity will need to be expanded to meet projected target. It is estimated that necessary recruitment and training would occur over approximately 16 months following the receipt of expenditure authority on or around September 15, 2008.

Approximately 70 - 75 additional FTEs may be required to deliver additional non-Medicaid services across the 16-member outpatient provider network. This network

also includes youth-serving agencies that provide services under subcontracts with RSN providers.

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

Dates:	Activity:
Sept 2008	• Training for provider network on new policies and access criteria
Sept – Dec 2008	• Training for inpatient units, civil commitment and mental health courts, and jail liaison

◊ *C. Partnership/Linkages*

King County Mental Health, Chemical Abuse and Dependency Services Division will continue to maintain close partnerships with its outpatient provider network, hospital inpatient units, jails, and community health clinics for referral of appropriate persons from the identified target populations who are not on Medicaid and in need of services.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Development of revised policies and procedures:	June 1 - July 15, 2008
Policies released for review and comment:	July 15
End of review and comment period:	August 6
Final policies released for implementation in 30 days:	August 15
Providers implement new policies and increase access for non-Medicaid population:	September 15, 2008

◊ *B. Procurement of Providers*

The mental health providers are currently under contract with the County. No RFP is required.

◊ *C. Contracting of Services*

Increases can be accommodated within current contract structure.

◊ *D. Services Start Date(s)*

Services to consumers will begin September 15, 2008, or as soon as spending authority is approved by King County Council.

Strategy Title: Increased Access to Community Mental Health and Substance Abuse Treatment

Strategy No: 1a(2) – Increased Access to Substance Abuse Outpatient Services for People Not On Medicaid

County Policy Goals Addressed:

- A reduction of the incidence and severity of substance abuse and mental and emotional disorders in youth and adults.
- A reduction of the number of people with mental illness and substance abuse using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

The present substance abuse treatment system provides treatment based on financial eligibility. Many individuals are unable pay for treatment because they do not qualify for Medicaid or other public funding. As of March 31, 2008 there are 219 unduplicated individuals on the waiting list to receive treatment that fall into this category. Wait lists for substance abuse services for this population can be as long as 8 months. This strategy will provide access to treatment for individuals not eligible for or covered by Medicaid, the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), or General Assistance Unemployable (GAU) benefits, or waiting for acceptance into a medical benefits program.

◊ *B. Reason for Inclusion of the Strategy*

Providing opiate substitution treatment[1] and non-opiate substitution substance abuse treatment[2] lowers health care costs and reduces arrests and convictions. Current funding for non-Medicaid clients is insufficient to meet the need. Funds will be used to provide opiate substitution treatment (OST) and outpatient treatment for individuals who do not meet the financial eligibility requirements of the substance abuse treatment system in Washington State.

◊ *C. Service Components/Design*

Funding will be increased to County contracted outpatient treatment agencies and OST programs to provide treatment services for low-income individuals from King

[1] Department of Social and Health Services - Research and Data Analysis Division - Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions, June 2004 (Fact Sheet - PDF)

[2] Department of Social and Health Services - Research and Data Analysis Division – Non Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions, June 2004 (Fact Sheet - PDF)

County. Low-income individuals are defined as having income of 80% of the state median income or less, adjusted for family size. Specific service components include intensive outpatient treatment and outpatient treatment as well as daily doses of methadone or an alternate OST such as suboxone.

◊ *D. Target Population*

Individuals who abuse substances or are chemically dependent leaving jails and inpatient treatment, undocumented residents, individuals on current wait lists, individuals who are not able to continue treatment due to loss of funding, individuals living with HIV/AIDS, intravenous drug users, and older adults and youth will be prioritized.

◊ *E. Program Goals*

Increase the number of individuals with substance abuse problems admitted to substance abuse treatment and OST. Numerous studies have shown that individuals who receive substance abuse treatment have reduced medical and criminal justice costs.

◊ *F. Outputs/Outcomes*

An additional 461 individuals needing OST and 400 individuals needing outpatient substance abuse disorder treatment will receive services annually. Providing access to needed substance abuse treatment will reduce the severity of chemical dependency as well as the medical and criminal justice costs for the individuals served.

2. Funding Resources Needed and Spending Plan

The project needs $2,623,225 to increase substance abuse treatment services capacity within the provider community.

Dates	Activity	Funding
Sept – Dec 2008	Start-up: • OST • Outpatient Treatment	 $435,806 $220,000
	Total Funds 2008	**$635,806**
2009 and onward	Ongoing Treatment Services • OST • Outpatient Treatment	 $1,743,225 $880,000
Ongoing Annual	**Total Funds**	**$2,623,225**

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

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

This funding level provides for additional treatment at two OST providers; and

this funding level provides for additional treatment capacity at 30 outpatient substance abuse treatment providers.

At the direction of the County, OST providers have begun to increase admissions and staff. The agencies will hire a mix of Chemical Dependency Counselors and Trainees. Trainees will receive training funds under MIDD strategy 1e. Caseloads for OST average 75 clients per clinician. An additional 6.5 FTE's will be necessary.

Non-OST outpatient providers will need to increase staff capacity to take on new clients. Agencies will hire a mix of Chemical Dependency Counselors and Trainees. Trainees will receive training funds under MIDD strategy 1e. Caseloads for non-OST outpatient counselors vary widely depending on the specific population that agency is targeting. An additional 10.0 FTE's will be necessary.

Because of recent treatment expansion in the area of Medicaid clients in recent years – provider agencies have been in a process of growth for over two years. They are experienced in recruiting counseling staff. In addition, new resources dedicated to workforce development will assist agencies in recruiting for these positions.

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

Dates:	Activity:
Sept – Dec 2008	• Treatment providers hire additional staff as needed;
Sept 2008	• Services start in those Agencies where capacity is developed and ready.
March 2009	• Assess capacity of treatment programs.

◊ *C. Partnership/Linkages*

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and the providers will need to continue to maintain significant partnerships with the local Community Services Organizations (CSO) that manage financial benefits and entitlements. Although treatment services are available, other needed services such as housing, medical needs and cross system collaboration between mental health and substance abuse will need to continue.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Program design planning will be substantially completed by April 30, 2008.
2. Draft contract exhibits for mental health and chemical dependency agencies will be developed by May 31, 2008 and routed internally for review.
3. Contract amendment language for the chemical dependency agencies will be developed and transmitted to the providers by July 31, 2008.

4. Treatment programs will start-up during the 4th calendar quarter of 2008.

◊ *B. Procurement of Providers*

The chemical dependency providers are currently under contract with the County and no RFP is required for this expansion of services.

◊ *C. Contracting of Services*

Contracts with the additional eligibility categories for chemical dependency providers will start on September 15, 2008

◊ *D. Services Start date(s)*

Services to consumers will begin September 15, 2008 and increase throughout the first quarter and each subsequent year until reaching full capacity.

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

Strategy No: 1b – Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

The One Night Count, conducted on January 25, 2007, estimated that there are 6000 individuals using emergency shelter and transitional housing on any given night in King County. This strategy was proposed during the original development of the Mental Illness and Drug Dependency Action Plan (MIDD) as a way of addressing the needs for ongoing case management for homeless individuals being discharged to shelters from jails and hospitals, as well as for those who would be discharged from the new crisis diversion facility that is being planned as part of the MIDD. The original concept was to build upon the success of Healthcare for the Homeless in engaging and assisting individuals at several shelters in King County with mental health, chemical dependency, and primary health needs.

◊ *B. Reason for Inclusion of the Strategy*

Shelters do not have the resources to provide the mental health and chemical dependency assessments and case management needed to help individuals access treatment and permanent supported housing. Providing these services will help individuals access housing and escape the cycle of chronic homelessness and repeated involvement in the criminal justice and emergency medical systems.

◊ *C. Service Components/Design*

There are several strategies being considered, but a final service design is not being proposed at this time. There are a number of programs targeting this homeless population that are being developed in the next year, and it is critical that these efforts be well-coordinated in order to reduce duplication of effort and to achieve the most efficient and effective results. A major effort that is underway to serve homeless individuals who are frequently involved with the criminal justice and hospital emergency systems is the High Utilizer Referral System, with funding provided by the Veterans and Human Services Levy and the United Way Campaign to End Chronic Homelessness. The Service Improvement Plan that is being developed this year includes a redesign of the Emergency Services Patrol and Dutch Shisler Sobering Center, increased outreach and service engagement for individuals with chemical dependency and improved coordination among key stakeholders to identify high utilizers of criminal justice and emergency medical services in order to facilitate placement into dedicated supported housing. Below is an excerpt from the Veterans & Human Services Levy Service Improvement Plan 2.1 (a-2) that describes the intent of the plan:

"This procurement plan is the third in a series of three that address this objective. The first, a procurement plan to enhance outreach and engagement of homeless people in South King County was approved in 2007 (SIP 2.1(b)). The second procurement plan, approved in March 2008, calls for development of a county-wide database that will identify high utilizers of public safety and emergency medical systems. The database will ultimately facilitate coordinated entry into existing and new housing, services and supports, and is a tool that will be used by the staff and programs to implement the strategies described in this procurement plan.

This third plan describes a set of proposed investments that will improve coordination of homeless outreach, engagement, and entry into treatment and housing for a subset of homeless single adults in Seattle, as described on page 19 of the Service Improvement Plan.

In this Procurement Plan, we first describe a group of current services that target homeless people with substance abuse problems – the *King County Emergency Service Patrol or ESP*, which picks up intoxicated people off the streets; the *Dutch Shisler Sobering Support Center*, which provides a safe place to sleep off the effects of intoxication; *REACH Case Management*, an intensive case management service provided to the most frequent users of the Sobering service; and the *High Utilizer Group or HUG*, that meets to conduct individual case planning for the most challenging clients.

While this redesign is somewhat complex, the Levy's SIP called for strategies to "challenge existing fragmentation," to "fill existing gaps in services and continuums of care" and to "build on existing successful programs or structures." This redesign meets all of these criteria."

Since the final design for the high utilizer system has not yet been fully developed, we propose to use the funding dedicated to this strategy to fill any gaps identified in the high utilizer service system, once other programs dedicated to this target population are implemented.

◊ *D. Target Population*

Homeless adults being discharged from jails, hospital emergency departments, crisis facilities and in-patient psychiatric and chemical dependency facilities.

◊ *E. Program Goal*

Increase availability of outreach, engagement, and case management services for homeless individuals.

◊ *F. Outputs/Outcomes*

1. Linkage of individuals to needed community treatment and housing.
2. Expected outcomes include reduced use of emergency medical services, reduced jail bookings, and increased number of people in shelters being placed in services and permanent supported housing.

2. Funding Resources Needed and Spending Plan

To be determined

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

◊ *A. Number and type of Providers*

To be determined

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

Stakeholders include The Committee to End Homelessness in King County, The Veterans and Human Services Levy Boards, United Way of King County, shelter providers, jails, and hospitals throughout King County, the King County Department of Community and Human Services, and Public Health – Seattle and King County.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined

◊ *B. Procurement of Providers*

Exact timeline to be determined

◊ *C. Contracting of Services*

Exact timeline to be determined

◊ *D. Services Start Date(s)*

To be determined

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

Strategy Title: 1c - Emergency Room Substance Abuse and Early Intervention Program

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Individuals who have abused alcohol and/or other drugs have an increased risk of being involved in automobile and other accidents, as well as a heightened risk for other health problems, which may lead to emergency room admissions. Admissions to hospital emergency services may provide an opportunity to engage individuals who have abused substances into accepting the need for intervention and brief treatment, and prevent future alcohol and drug-related hospitalizations. This strategy provides delivery of early intervention and treatment services to hospital emergency room patients who have substance use disorders or are at risk of developing these disorders.

◊ *B. Reason for Inclusion of the Strategy*

The existing substance abuse intervention program at Harborview Medical Center already has a record of success and has demonstrated cost effectiveness with regard to reducing substance abuse and other health problems associated with drug use and reducing utilization of medical services. Patients who received services in this program at Harborview have altered their substance use patterns significantly. Among substance abuses who received at lease a brief intervention, use reported in the six month follow-up interview declined significantly compared to use reported at screening.[3] The current program is funded by a federal grant which began in 2003 and will end in September 2008. Implementation of this strategy will allow the continuation of the program at Harborview and expansion of the service to additional hospitals in south King County. The program will reduce the number of individuals with substance abuse and dependency issues in hospital emergency rooms and increase access and referral to treatment.

[3] Department of Social and Health Services - Research and Data Analysis Division, (May 2, 2007) *Harborview Medical Center Substance Use Outcomes,* http://www1.dshs.wa.gov/pdf/ms/rda/research/4/60/HMC.2007.1.pdf

◊ *C. Service Components/Design*

The program is delivered by integrating chemical dependency professionals into the multidisciplinary team within emergency rooms. Service design includes the following:

- Maximize the number of emergency room patients who are identified through screening to have substance abuse problems.
- Deliver brief counseling, or "brief interventions," to patients who screen positive for substance use disorders.
- Increase referrals of chemically dependent people from the generalist medical setting to CD community treatment agencies.
- Reduce subsequent emergency room use rates, medical costs, criminal behavior, disability, and death for patients with alcohol and drug problems of all severity levels.
- Improve the links between the medical and chemical dependency treatment communities so that providing screenings and interventions for substance use disorders become routine.

◊ *D. Target Population*

The program provides early intervention for at-risk substance users before more severe consequences occur, as well as intervention and referral for high utilizers of hospital emergecy room services.

Expansion to south King County hospital emergency departments was made at the request of the Washington State Hospital Association and as a result of an increase in low income and indigent clients in south King County.

◊ *E. Program Goals*

Provide early intervention and referral to treatment for those with less severe addiction issues who are admitted to hospital emergency rooms in order to reduce the risk of more serious chemical dependency.

◊ *F. Outputs/Outcomes*

3,488 new clients would be served each year in addition to the current number of clients served for a total capacity of 7,680 served annually.

Expected outcomes include reductions in emergency room visits, other medical costs, accidents, criminal behavior, and death.

2. Funding Resources Needed and Spending Plan

The emergency room substance abuse and early intervention program will have an annual cost of $796,500.

Dates	Activity	Funding
Sept – Dec 2008	Continue Harborview contract	$120,000
	Total Funds 2008	**$120,000**
Jan – Dec 2009	Harborview	$442,500
Jan – Dec 2009	Expansion to south King County	$354,000
	Total Funds 2009	**$796,500**
2010 and onward	Ongoing program cost	$796,500
Ongoing Annual	**Total Funds**	**$796,500**

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

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

This strategy will provide support for nine FTE Chemical Dependency Professionals (CDPs); five at Harborview Medical Center (existing staff) and four new FTE CDPs in south King County.

Although there is a statewide shortage of substance abuse professionals and recruiting can be a challenge, selected provider will have access to *Chemical Dependency Professional Education and Training* under MIDD strategy 1e.

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

Dates:	Activity:
Oct 1 – Dec 31,2008	Funding to Harborview for existing program staff.
Oct 1– Dec 31, 2008	Recruitment for south King County positions
January 1, 2009	Services start in south King County
January 1, 2009	Fully operating programs at all facilities

◊ *C. Partnership/Linkages*

MHCADSD will partner with Harborview Medical Center and south King County hospitals on this project. South King County hospital locations will be identified in collaboration with the Washington State Association of Hospitals.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

The current contract with Harborview will be extended without interruption, pending final approval for spending authority by the King County Council prior to the end of federal funding on September 30, 2008.

Services in south King County will begin in January 2009.

◊ *B. Procurement of Providers*

There is a current contract with Harborview for services, so an RFP is not required to continue services. State law allows sales tax funds to be used to replace lost federal funding.

Procurement of providers for south King County will be determined in collaboration with the Washington State Association of Hospitals. Procurement will occur Oct-Dec 2008.

◊ *C. Contracting of Services*

Contract with Harborview will be amended effective October 1, 2008.

Contracts for south King County will be effective January 1, 2008.

◊ *D. Service Start Date(s)*

Services at Harborview will start October 1, 2008.

Services at south King County hospitals will start January 2, 2009.

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

Strategy Title: 1d – Mental Health Crisis Next Day Appointments

County Policy Goal Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms, and hospitals.

1. Program/Service Description

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

Next day appointment (NDA) services are an existing service that provides follow up to a face-to-face crisis service with timely direct crisis intervention, resolution, referral, and follow-up services. This help is available for individuals who are in crisis but may not be eligible for or need ongoing services. For those who do need ongoing services this can be a point of entry as long as the outpatient system has capacity [see strategy 1a (1)]. This service is used to divert costly inappropriate inpatient admissions. Current funding provides only a limited amount of follow up stabilization service.

◊ *B. Reason for Inclusion of the Strategy*

Expanded services will provide for increased stabilization and decreased inpatient utilization. Services that reduce emergency room visits and inpatient admissions constitute better care and will result in savings to the system. Access to ongoing mental health services following a crisis can result in more effective intervention with a person's illness, more successful stabilizaton, and prevention of further deterioration of the person's condition. Crisis services contracts are already in place and expanded services could be provided immediately without a Request for Proposal (RFP) process.

◊ *C. Service Components/Design*

Consumers in crisis will be seen for additional treatment and stabilization beyond the next day appointment. Potential additional services could include:

- Linkage to ongoing services as access is made more available through MIDD funding.
- Completion of Medicaid application process.
- Medication plan developed and linkage to primary care provider for those who are not enrolled for ongoing services.
- Referrals to chemical dependency treatment.

The specific service components will be developed as part of a stakeholder process.

◊ *D. Target Population*

Adults aged 18 years or older who are at risk for voluntary or involuntary inpatient psychiatric admission, are not enrolled in RSN outpatient services, and who are referred by the Crisis Clinic or the Designated Mental Health Professionals (DMHPs). Crisis Clinic referrals include those persons seen in local emergency departments and it is determined that they can be safely stabilized in the community with appropriate and timely services, thereby averting an inpatient admission.

◊ *E. Program Goals*

1. Increase access to crisis stabilization services in order to reduce inpatient admissions.
2. Provide early and timely intervention into a person's mental illness in order to prevent further deterioration in the person's condition.

◊ *F. Outputs/Outcomes*

1. 750 persons will receive expanded crisis stabilization services.
2. An expected outcome is reduced admissions to hospital emergency rooms and inpatient units.

2. Funding Resources Needed and Spending Plan

Detailed spending plan to be determined based on review of data submitted by current providers.

Dates	Activity	Funding
Sept - Dec 2008	Implement expanded crisis services	$73,000
	Total Funds 2008	**$73,000**
Jan – Dec 2009	Target of 750 NDA referrals to receive expanded services	$250,000
	Total Funds 2009	**$250,000**
Ongoing Annual	**Total Funds**	**$250,000**

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

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

Five existing Adult Crisis Services providers serving all regions of King County.

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

Dates:	Activity:
September – December 2008	Staff retrained to new model
September 2008 – December 2009	Increased prescriber capacity
September – December 2008	Training for Crisis Clinic, Hospital ED Staff, DMHPs

◊ *C. Partnership/Linkages*

- Stakeholders to develop service model details: Crisis and Commitment Services, Crisis Clinic/ hospital authorization staff, Harborview Psychiatric Emergency Services staff, mental health crisis providers, chemical dependency providers, Mental Health, Chemical Abuse and Dependency (MHCADSD) staff.
- Partnerships with the five adult crisis services providers.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Stakeholder process to develop program details:	May-July 2008
Development of contract amendments:	August 2008
Contract amendments in place:	September 15, 2008

◊ *B. Procurement of Providers*

The mental health providers are currently under contract with the County, and no RFP is required under this expansion of services.

◊ *C. Contracting of Services*

Contracts with current providers will be amended effective September 15, 2008.

◊ *D. Services Start date(s)*

Services will begin September 15, 2008 or as soon as spending authority is approved by King County Council.

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

Strategy No: 1e – Chemical Dependency Professional Education and Training

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

There is a significant shortage of chemical dependency professionals.[4] By 2010, the demand for addiction professionals and licensed treatment staff with graduate-level degrees is projected to increase by 35 percent.[5] This shortage limits access to treatment. The lack of certified chemical dependency professionals (CDPs) makes it challenging for King County substance abuse providers to meet their treatment expansion goals and to increase the number of clients admitted to and receiving needed substance abuse services.

◊ *B. Reason for Inclusion of the Strategy*

A well trained and sufficient supply of substance abuse counselors means better access to and higher quality substance abuse treatment. This funding will provide stipends to treatment agencies and additional workforce development activities to help support staff with the education and training needed to become CDPs. Increasing the supply of CDPs will ensure that we have a sufficient and properly trained workforce in King County to increase the number of clients served.

◊ *C. Service Components/Design*

Treatment agencies will be able to offer chemical dependency professional trainees (CDPTs) reimbursement for tuition and books for course work meeting the educational requirements to become a chemical dependency professional. The requirements are 45 quarter hours or semester hours of course work specific to the assessment, treatment and case management of individuals with substance use disorders. Courses may be taken at accredited community colleges, universities,

[4] Abt Associates. (2007). *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce*, Rockville: Substance Abuse and Mental Health Services Administration (SAMHSA)/DHHS. http://www.samhsa.gov/Workforce/WorkforceReportFinal.pdf

[5] National Association of State Alcohol and Drug Abuse Directors (NASADAD). (2003). *Recommendations related to closing the treatment gap, NASADAD policy position paper, 2003.* www.nasadad.org/resource.php?base_id=37.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and/or at all Association for Addiction Professionals approved education providers. Individuals taking advantage of the tuition and books reimbursement will be asked to commit to staying at the treatment agency for one year post graduation. Funds will also be used to pay for training needs of the workforce, cultural competency consultation, clinical supervision and additional workforce development activities. Reimbursement for staff time to attend trainings and/or classes is not included in phase one implementation. Reimbursement for this time may be considered in future workforce development strategies funded through this initiative.

◊ *D. Target Population*

Individuals working at any King County contracted treatment agency who are in the process of becoming certified CDPs.

◊ *E. Program Goal*

Increase the number of Chemical Dependency Professionals in King County, and increase their access to professional development and cultural competence consultation.

◊ *F. Outputs/Outcomes*

1. 45 CDPTs testing at each test cycle offered by the Washington State Department of Health;
2. Up to 125 new certified chemical dependency professionals annually.
3. An expected outcome of increasing the number of CDPs is that individuals will be able to access treatment sooner and more readily, and this will, in turn, reduce criminal justice involvement and admissions to emergency rooms and inpatient units.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
July – Dec 2008	Start-up (initial tuition reimbursement will begin after completion of first courses)	$160,000
	Total Funds 2008	**$160,000**
Jan – Dec 2009	Continuing Tuition Reimbursement	$615,625
	Total Funds 2009	$615,625
2010 and onward	Ongoing Continuing Tuition Reimbursement and additional workforce development activities	
Ongoing Annual	**Total Funds**	$615,625

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

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

Dates:	Number of Treatment Providers:	Activity/Number of CDPTs enrolled:
September 1 – December 31, 2008	32	• Tuition and books reimbursement begins/125 CPDTs enrolled for tuition reimbursement
2009 and continuing	32	• Tuition and books reimbursement continues/150 CPDTs enrolled for tuition reimbursement/ tests and CDP status awarded for 45 CDPTs

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

Current County contracted outpatient providers would be able access funding immediately and increase their pool of qualified CDPs.

◊ *C. Partnership/Linkages*

Linkage with local community colleges, interested universities, and other appropriate entities, including Seattle Central Community College, Edmonds Community College, Highline Community College, Bellevue Community College, Tacoma Community College, University of Washington Extension, and National Association of Alcoholism and Drug Abuse Counselors (NAADAC) The Association of Addiction Professionals Approved Education Providers.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Dates:	Activity:
April – June 2008	• Meeting with local community colleges, universities and development of a list of other approved education providers who are able to meet the educational requirements to become a CDP.
May – June 2008	• Development of Contract Exhibit outlining tuition and books reimbursement for agencies. List of education resources provided to the agencies.
July – Sept 30 2008	• Contract Exhibits are signed by all parties and agencies are aware of how to bill for tuition and books reimbursement for staff who qualify.
August 1, 2008	• Training for Agencies related to contractual expectations for tuition and books reimbursement.

Oct – Dec 31, 2008	• Tuition and books reimbursement is made available for all CDPTs at King County contracted agencies.
2009 and continuing	• Contract Exhibit included in all contracts. Portions of the funds will be carved out for a Request for Proposals to interested community colleges, universities, and other appropriate entities to develop an institute of condensed classes for advanced degree clinicians. Additional workforce development activities will be added.

◊ *B. Procurement of Providers*

Providers are currently under contract with King County and contracts are managed by the Mental Health, Chemical Abuse and Dependency Services Division. No additional procurement or recruitment of providers is planned.

◊ *C. Contracting of Services*

May 2008 -- Contract Exhibit developed, reviewed and made available to review by contracted treatment agencies

June 2008 -- Contract Exhibit amended into current contracts

September 2008 – December 2008 -- Tuition reimbursement begins prior to the end of 2008.

January 1, 2009 -- Contract Exhibit included in all 2009 agency treatment agency contracts.

◊ *D. Services Start Date(s)*

September 2008

Strategy Title: Increased Access to Community Mental Health and Substance Abuse Treatment

Strategy No: 1f - Peer Support and Parent Partner Family Assistance

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering the work of, other council directed efforts (the Recovery Plan for Mental Health Services).

1. Program/Service Description

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

Parents, family members and youth consumers of the public mental health, substance abuse and other service systems benefit from the unique mentoring, guidance and expertise offered by someone who has had similar experiences. Navigating complex service systems can be a frustrating, confusing and challenging experience for consumers. Traditionally, systems fail to help consumers mitigate against these experiences. Parent partners/peers help families and youth to identify their needs, focus on strengths, develop and implement services and supports, and successfully partner with system professionals. This type of support is currently only available to a limited number of families in King County; the vast majority of families who would benefit do not have access.

◊ *B. Reason for Inclusion of the Strategy*

Parent partners/peers are an essential component of any progressive public system. National research suggests that this approach is highly effective—both for the consumer and for the system. Capacity to provide these supports is extremely limited in King County. Although the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) developed some capacity to offer this type of assistance as a result of a federal System of Care grant, the grant funding ended in 2005, curtailing further growth and development. MIDD funds will help to significantly expand the availability of this critical resource to consumers throughout the county.

◊ *C. Service Components/Design*

MHCADSD will employ a full time Parent Partner Specialist to provide leadership in the development and coordination of a network of parent partner/youth peer support organizations. In coordination with MHCADS, the organizations will provide peer support, technical assistance, mentoring, training, networking opportunities and resources to families and youth in the target population.

◊ *D. Target Population*

1. Families whose children and/or youth currently receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system and/or special education programs, and who have requested assistance to successfully access services and supports for their children/youth.
2. Youth who currently receive services from the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system and/or special education programs, and who have requested assistance to successfully access services and supports.

◊ *E. Program Goals*

To empower families and youth by assisting them to:

1. Increase their knowledge and expertise.
2. Utilize effective coping skills and strategies to support children/youth.
3. Effectively navigate complex service system(s).

◊ *F. Outputs/Outcomes*

1. Parent Partner Specialist is hired; permanent fulltime staff resource is available at MHCADSD.
2. Increase in the number of families and youth receiving parent partner/peer support services (up to 4000/year).
3. Increase in the number of parent partner/peer support services provided.
4. Increase in the number of parent/youth engaged in networks of support.
5. Increase in the number of training/education services available annually.

2. Funding Resources Needed and Spending Plan

This program needs $450,000 per year to develop and sustain the MHCADS leadership position and to contract with and sustain a network of parent and youth peer organizations to serve all of King County.

Dates	Activity	Funding
July – Dec 2008	Start-up (Hire and train MHCADS staff; development of program design, including recruitment strategies; RFP development)	$75,000
	Total Funds 2008	**$75,000**
Jan – Dec 2009	Phased in procurement, selection, contracting, recruitment and training of parent partner and youth peer organizations	$450,000
	Total Funds 2009	**$450,000**
2010 and onward	County-wide network of parent partner and youth peer organizations is in place; ongoing training, support and program evaluation	$450,000
Ongoing Annual	**Total Funds**	**$450,000**

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

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

This funding level supports a full-time Parent Partner Specialist at MHCADS ($50,000 at 2008 county rates) and up to 40 part-time parent partners/youth peers in several organizations at a total projected cost of $400,000 per year. Parent partners/youth peer support services may be provided by free standing parent/peer run organizations and/or by community mental health centers. The number of parent partners and youth peers ultimately needed to fully implement this program county-wide is not currently available, therefore a phased-in implementation plan is required. Potential providers may be new or existing family organizations; including freestanding organizations or those attached to community mental health agencies.

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

Dates:	Activity:
Sept 1– Dec 30, 2008	• Hire and train MHCADS Parent Partner Specialist. • Research & evaluate existing program models and best practices in King County, Washington State and nationally to inform program design.
Jan – Dec 2009	• Development and implementation of training and technical assistance plan to support parent partner and youth peer organizational development and sustainability. • Services will be initiated in a phased manner as capacity is developed and ready.
2010 and ongoing	• Program evaluation and modifications will help determine ongoing training and technical assistance needs. • Ongoing training and technical assistance is implemented to assure program achieves goal(s). •

◊ *C. Partnership/Linkages*

MHCADS and its contracted parent partner and youth peer organizations will maintain close partnerships with national and state parent and youth peer organizations, and with local systems, including mental health and substance abuse treatment providers, child welfare, juvenile justice, schools and other stakeholders.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. MHCADS staff person recruited and hired by September 1, 2008.
2. Program design planning will be substantially completed by December 31, 2008.
3. The Request for Proposals (RFP) for the procurement of parent and youth organizations will be developed by January 30, 2009.
4. First organizations will start-up no later than July 1, 2009.

◊ *B. Procurement of Providers*

1. The RFP for parent and youth organizations will be released by February 15, 2009.
2. The response date will be March 31, 2009.
3. The awards for accepted bids will be made April 15, 2009.

◊ *C. Contracting of Services*

Contracts for parent and youth organizations will start on May 15, 2009.

◊ *D. Services Start date(s)*

Services to families and youth will begin July 1, 2009.

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

Strategy No: 1g – Prevention and Early Intervention Mental Health and Substance Abuse Services for Older Adults

County Policy Goals Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals.

1. Program/Service Description

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

Undiagnosed and untreated depression and drug and alcohol abuse are contributing factors to high suicide rates for older men and women. A recent report of the Surgeon General cites depression symptom prevalence estimates of 17% to 35% in older adult primary care patients.

◊ *B. Reason for Inclusion of the Strategy*

In 2007, King County Health Centers served an estimated 20,000 low income adults over 55 years of age. In recent studies among those 55 years and older who have completed suicide, 77% had contact with a primary care provider within a year of their suicide and 58% had contact with the primary care provider within a month of their suicide. These studies suggest that identifying and treating high risk older adults in health centers is an effective strategy.

◊ *C. Service Components/Design*

Mental health/chemical dependency staff will be integrated into the staffing of primary care teams in the safety net clinics. (Safety net clinics include community health centers, public health centers, and Harborview primary care clinics. These clinics work closely with community centers and senior centers in many suburban communities, and a number of clinics are piloting new outreach and integrated service strategies to serve older adults under a state grant to King County Care Partners through Senior Services.)

Mental health/chemical dependency staff will screen older adults for depression and/or drug or alcohol abuse. Brief interventions and treatment will be initiated in primary care. Adults with more severe or complex needs that cannot be adequately treated in primary care will be referred to mental health and chemical dependency treatment agencies already under contract with Mental Health, Chemical Abuse and Dependency Services Division.

Mental health and chemical dependency providers integrated in primary care will also be responsible for coordinating referrals to MHCADSD contracting agencies, facilitating communication between primary care teams and mental health/chemical dependency treatment providers, and assuring that treatment plans are coordinated.

◊ *D. Target Population*

Adults age 55 years and older seen in primary care clinics who are low income and/or otherwise have no medical health insurance.

◊ *E. Program Goal*

Provide screening and treatment for depression and for prescription or illegal drug or alcohol abuse in older adults who are seen in primary care clinics.

◊ *F. Outputs/Outcomes*

A reduction of the number of people with mental illness and chemical dependency using costly interventions such as jail, emergency rooms and hospitals. Screening and appropriate interventions will occur for 2,500 to 4,000 individuals annually.

Expected outcomes include reductions in suicides, alcohol and drug abuse among older low income adults in King County. Additionally reductions are expected in health care costs because older adult patients with depression visit doctors and emergency rooms more often, use more medications, and incur higher inpatient charges than those who are not depressed.

2. Funding Resources Needed and Spending Plan

The mental health and substance abuse service enhancement for safety net primary care clinics will have an annual cost of $500,000.

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training)	$150,000
	Total Funds 2008	**$150,000**
Jan – Mar 2009	Continued start-up	$250,000
Jan – Dec 2009	Phasing in ongoing services	$250,000
	Total Funds 2009	**$500,000**
2010 and onward	Ongoing safety net clinic Services with enhanced mental health and substance abuse services	$500,000
Ongoing Annual	**Total Funds**	**$500,000**

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

◊ *A. Number Type of Providers*

Mental health providers in safety net clinics include psychologists, MSWs, and RNs or ARNPs with specialized psychiatric training. Many clinics would like to include chemical dependency providers on their primary care team, but the shortage in trained chemical dependency providers has generally not made that feasible. The equivalent of 10.0 FTE mental health providers will be added to clinic staff. Resources will be spread among 15 or more clinics so as to include those clinics that serve significant populations of older low income adults.

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

Dates:	Activity:
Sept 15 – Nov 30, 2008	• Treatment providers hire staff
Sept 15, 2008 – Mar 30, 2009	• Start up activities
Oct 1, 2008	• Training for primary care related to ongoing services
Nov 1, 2008	• Services start in those clinics where capacity is developed and ready
June 1, 2009	• Fully operating programs

◊ *C. Partnership/Linkages*

The clinics will need to develop and maintain referral relationships with mental health and drug and alcohol treatment providers to assure appropriate treatment for those individuals whose treatment needs cannot be managed in primary care.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

As this is an addition to existing programs the planning is substantially complete; refinements to the plan will be completed by July 2008.

◊ *B. Procurement of Providers*

The providers are currently under contract with the County.

◊ *C. Contracting of Services*

Contracts amendments will be in place by August 30, 2008.

◊ *D. Services Start date(s)*

Services will begin no later than November 1, 2008.

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

Strategy No: 1h – Expand the Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults

County Policy Goal Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

Home-based age-appropriate outreach and intervention services for older adults with mental health and/or substance abuse issues are insufficient to meet the need. Older adults are under represented in the mental health and substance abuse treatment systems in King County. While the number of those 55 and older is 22% of the King County population, only 7% of clients in substance abuse treatment and 15% of those in mental health programs receive services. The Geriatric Crisis Services program currently has three FTE that serve 200 clients per year. The program turns away at least three referrals a week. Additionally, the Seattle Police indicated that they would likely refer 1-3 individuals per week to this program from the Crisis and Hostage Negotiation team.

◊ *B. Reason for Inclusion of the Strategy*

As our population ages, the number of older adults who experience a crisis in which mental health and/or alcohol and other drugs is a contributing factor is increasing. Family members, unsure of who to contact, resort to calling the police or other first responders. This team will provide relief to police and other emergency responders and divert unnecessary jail bookings and hospitalizations.

◊ *C. Service Components/Design*

Geriatric Crisis Services is a specialized outreach crisis intervention and stabilization service available to older adults in King County. A multidisciplinary team of geriatric specialists will respond to police and other first responders, professionals, relatives and others in the community for outreach and assessments of older adults who are experiencing crises related to mental illness and substance abuse. Services provided include comprehensive assessments at the client's residence as well as crisis intervention and stabilization with prompt referral and linkage to mental health, chemical dependency, aging, and health care providers in the community. The team also provides consultation, care planning, and education for professionals, families, and other care providers.

The program is not designed as a 24 hour per day service. The team works during typical business hours and the Crisis Clinic provides after hours telephone coverage. The crisis team staff doesn't carry caseloads because they are specialty crisis workers. They assess and link people to follow-up services. The average length of stay in the program is 23 days. The staff's job is to perform a comprehensive assessment (mental health, substance use, physical assessment, social, environmental, etc.) of the client, stabilize the client and link the client to mental health, substance abuse, aging, and health care providers. The amount of time spent in each episode of intervention can be quite variable depending on the client's situation and level of cooperation. The clinicians intensely work on stabilizing multiple clients at one time.

Currently the team's response time is up to three working days. The MIDD funding will allow the program to decrease the response time and expand the services for first responders (police, fire, EMTs) and the Designated Mental Health Professionals (DMHP). The program will be able to respond within 24 working hours. In addition the program will be available to provide on demand telephone consultation.

One of the primary tasks of the program is the linkage of clients to medical care. It is not uncommon for a client to not have seen a physician in many years. In addition, there is a psychiatrist on the team who consults in person with the staff weekly, is available for phone for consultation and is also available to perform weekly home visits. Our proposal also adds a .6 RN to perform medical assessments.

◊ *D. Target Population*

Individuals age 55+ residing in King County at risk of or experiencing a crisis in which mental health or alcohol and/or other drugs are a likely contributing factor and/or exacerbating the situation.

◊ *E. Program Goal*

Build capacity in the community to provide prevention and treatment services to the older adult population, establish a solid evidenced-based crisis team, and increase the number of older adults accessing treatment services.

◊ *F. Outputs/Outcomes*

The program currently serves 200 people per year. With the additional staff resources the program will serve an additional 340 new clients served each year for a total of 540 people per year served. Expected outcomes will include an increase in engagement of older adults in ongoing mental health and chemical dependency treatment and a reduction in the use of emergency medical services by these individuals.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept-Dec 2008	Start-up (hire and train staff)	$87,500
Jan-Dec 2009	Full implementation	$350,000
2010 Onward	Ongoing program cost	$350,000

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

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

1 FTE Master's level social worker/mental health therapist
1 FTE Chemical Dependency Professional
1 FTE Chemical Dependency Professional Trainee
.6 FTE Nurse

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

Two-day agency orientation and six weeks of team orientation. Team orientation includes policy and procedure manual orientation, office procedures, developing knowledge of the services of other teams. New team members function independently after six weeks.

Timeline:

Dates:	Activity:
Sept – Oct 2008	• Provider hires program staff.
Sept 2008 – Dec. 15, 2008	• Training of new staff. Training takes about six weeks.
Oct 1, 2008 – Dec 1, 2008	• Training and networking with community stakeholders such as the police department and community emergency rooms and other first responders.
Dec 1, 2008	• Services start.
Feb 1, 2009	• Agency has reached full operating capacity.

◊ *C. Partnership/Linkages*

Ongoing partnerships with the substance abuse and mental health provider network. Partnership with jails, police, Crisis Clinic, 24-Hour Helpline, National Alliance on Mental Illness (NAMI), and others who refer and/or work with the target population.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Program planning will be completed by June 2008.

2. Contract amendment language will be completed for Evergreen Health Services by July 30, 2008.
3. Program will start on December 1, 2008.

◊ *B. Procurement of Providers*

Evergreen Community Health Care will provide the service, no Requests For Proposals will be issued. Services will be amended as an exhibit to the provider's existing contract.

◊ *C. Contracting of Services*

The contract will start September 2008.

◊ *D. Services Start date(s)*

Services to consumers will start December 1, 2008

Strategy Title: Improve Quality of Care

Strategy No: 2a - Caseload Reduction for Mental Health

County Policy Goal Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

As a result of state mental health funding allocation decisions, the funding King County Regional Support Network (RSNs are counties and groups of counties that manage publicly funded mental health services through contracts with the state) receives for mental health services have not kept up with the increased costs of providing those services. This has led to increases in the size of community mental health center case loads over the years, compromising quality of care and negatively impacting the system's ability to hire and retain staff.

Large case load sizes negatively impact a case manager's ability to maintain regular contact with consumers. Regular contact allows the case manager to: assist consumers in developing their own illness management strategies; provide psycho-education; provide motivational interviewing for pursuing supported employment services; monitor fluctuations in symptoms so that medication adjustments can be recommended; and provide other treatment services that contribute to consumers' stability and recovery. With very large case loads, case managers are limited in their ability to provide routine rehabilitation services and instead primarily respond to crises.

◊ *B. Reason for Inclusion of the Strategy*

Dedicated funding to enable agencies to add additional staff and reduce case load sizes would have a substantial benefit for those being being served as well as for those providing the services. Decreased case loads would enable case managers to respond more quickly when their clients are in crisis. Clients could be seen sooner after being discharged from jails or hospitals. More time could be spent with clients to meet their goals and to provide the supports they need. This strategy is consistent with the goal of reducing the number of people with mental illness who use more costly interventions such as jails, emergency rooms, and inpatient care.

◊ *C. Service Components/Design*

Case management services may be provided in different ways and by varied staff across the network of RSN contracted mental health providers. Services such as money management, helping individuals shop for food or take care of their

apartments, medication management, vocational services, and education may be provided by mental health case managers, peer counselors, vocational specialists, or financial workers, depending on the agency. Additional funding will be provided to decrease outpatient caseloads at community mental health agencies, across the system. Planning is still taking place to determine how to take into account the variation across the system in how, and by whom, case management services are provided. Among the variables are the following:

- Variation in case load sizes that are reported to be from 20 or 25 to as large as 80 clients per case load
- Case mix-- the relative severity of consumers' illnesses within and across caseloads
- Different models for providing services (for example, if one agency has a vocational specialist providing vocational services and another has the case manager provide that service, the responsibilities and workloads for the case managers are different, and case load size could be adjusted accordingly)
- Some agencies pay higher salaries and may have higher caseloads, while others have kept lower caseloads, but pay lower salaries.

There will need to be ongoing discussions with stakeholders to determine the best way to achieve the goals of this strategy, including determining how case management caseloads will be measured, and which staff providing which services should be considered in determining case loads.

◊ *D. Target Population*

Children, youth, adults, and older adults receiving outpatient services through the King County Regional Support Network.

◊ *E. Program Goals*

- Lower outpatient mental health case loads to allow case managers to see consumers more regularly to assist them to achieve greater stability and recovery, and to be more responsive to consumers who are in crisis, particularly those who are in, and exiting from, jails and hospitals.
- Decreased case manager turnover due to high caseloads, which will lead to a more stable and effective work force as well as savings related to training and orientation of new staff.

◊ *F. Outputs/ Outcomes*

- Addition of up to 110 new staff, including peer counselors, mental health professionals, and supervisors.
- Reduction of system-average case loads by a percentage yet to be determined. (Original calculations on the estimated percentage decrease did not include some variables identified in discussions with mental health providers, such as supervisory positions needed to support new case managers and additional space requirements).

- The expected outcomes of lower caseloads are reductions in emergency room utilization, hospital admissions, criminal and juvenile justice involvement, and prevention of out of home placement for children.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept- Dec 2008	Provide funds to contracted mental health agencies to begin hiring additional case managers.	$1,750,000
	Total Funds 2008	**$1,750,000**
Jan – Dec 2009	Continue ramp-up of staff, complete by end of year. $3,500,000 will be MIDD funds and $1,500,000 will be additional federal matching funds.	$5,000,000
	Total Funds 2009	**$5,000,000**
Ongoing Annual	**Total Funds**	**$7,000,000**

Ongoing total funding assumes additional federal matching funds. MIDD Action Plan funds will be $4 million, and federal match will be $3 million.

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

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

- 16 RSN mental health outpatient providers and subcontracted youth service providers.
- As many as 110 new case managers and supervisors added.

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

Supervisor training for staff moving into new role: Ongoing while staffing increases are underway.

◊ *C. Partnership/Linkages*

RSN Mental Health Provider agencies and subcontracted agencies.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

- Stakeholder Process to develop implementation strategy: May-July 2008
- Contracts amended: August 2008
- Agencies begin hiring process: September 2008
- Case load reduction completed: December 2009

◊ *B. Procurement of Providers*

Proposed timelines Not Applicable

◊ *C. Contracting of Services*

Existing contracts amended: August, 2008

◊ *D. Services State Date(s)* September 15, 2008

Strategy Title: Improve Quality of Care

Strategy No: 2b – Employment Services for Individuals with Mental Illness and Chemical Dependency

County Policy Goal Addressed:

- Explicit linkage with, and furthering the work of, other council directed efforts including the Adult and Juvenile Operational Master Plans, the Ten Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.

1. Program/Service Description

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

Employment is an essential element in recovery-based systems of care and moving individuals towards self-sufficiency. Currently less than ten percent of individuals enrolled in outpatient mental health services are employed. In the chemical dependency treatment system only 25% of the individuals in statewide treatment programs are employed. For the individuals in King County treatment programs only 16% are employed.

◊ *B. Reason for Inclusion of the Strategy*

Currently there are no specialized vocational resources in the chemical dependency treatment provider community and very limited resources in the mental health treatment community to address the needs of individuals receiving treatment services who need assistance and support to find and retain a competitive job.

◊ *C. Service Components/Design*

The mental health and chemical dependency treatment provider community will provide fidelity-based (adheres to an evidenced-based service model) supported employment services including: trial work experiences, job placement, on the job intensive training supports, and job retention services for individuals who are receiving treatment services for mental health and/or chemical dependency. Additionally, consumers will receive benefits counseling and extended supports to foster long-term job retention. Outreach and education to participants concerned about how getting a job will affect eligibility for public resources will also occur.

◊ *D. Target Population*

Persons who are currently receiving services under the public mental health or the public chemical dependency treatment system in King County who need supported employment services to obtain competitive employment.

◊ *E. Program Goal*

Provide evidence-based supported employment services to individuals in King County who are in mental health and/or chemical dependency treatment programs in order to help individuals obtain jobs and further their recovery and self-sufficiency.

◊ *F. Outputs/Outcomes*

1. The program is projected to serve 920 individuals annually.
2. Individuals will receive, on average, six months of ongoing employment placement and retention services.
3. The expected outcomes of providing employment services include an increase in the employment rates, improved housing stability, and decreased reliance on public assistance for those individuals receiving services.

2. Funding Resources Needed and Spending Plan

The original proposal for the project indicated a need $1.5 million to increase the employment services staffing capacity within the treatment provider community. There is a need for an additional $600,000 to support the existing employment programs in the mental health system due to a budget cut in federal Medicaid related directly to employment services that is occurring in July 2008. The total funds needed for this strategy are $2.1 million.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training) All FTEs will be contracted out to providers	$350,000
	Total Funds 2008	**$350,000**
Jan – Mar 2009	Continued Start-up	$250,000
Jan – Dec 2009	Phasing in Ongoing Supported Employment Services	$1,350,000
	Total Funds 2009	**$1,600,000**
2010 and onward	Ongoing Supported Employment Services	$2,100,000
Ongoing Annual	**Total Funds**	**$2,100,000**

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

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

This funding level provides for the addition of up to 23 vocational specialists within the contracted King County mental health and substance abuse treatment provider community.

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

Dates:	Activity:
Sept 15 – Nov 30, 2008	• Treatment providers begin to hire vocational staff. It may take over one year for providers to recruit and train the full complement of vocational staff called for in this strategy.
Sept 15, 2008 – Mar 30, 2009	• Vocational specialists require training that occurs both on the job and through university based programs. The training can take from 3 – 6 months.
Oct 1, 2008	• Training for Agencies related to contractual expectations for ongoing services and any expectations for the partnership with the Division of Vocational Rehabilitation.
Nov 1, 2008	• Services start in those Agencies where capacity is developed and ready.
June 1, 2009	• Fidelity measurement of the fully operating Supported Employment Programs.

◊ *C. Partnership/Linkages*

King County MHCADSD and the providers will need to continue to maintain significant partnerships with the Division of Vocational Rehabilitation (DVR) and the local Community Service Offices (CSO) that manage financial benefits and entitlements.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Program design planning will be substantially completed by June 30, 2008.

The mental health treatment system already has a cadre of treatment providers that provide employment services. Therefore the County is able to amend existing contracts to expand service capacity in existing employment services programs. Currently the chemical dependency treatment system does not have employment services operating in any of its treatment programs. The County will develop a Request for Proposal process to recruit for treatment providers who are willing and able to add employment services to their treatment programs.

The Request for Proposals (RFP) for the procurement of the Chemical Dependency providers will be developed by July 2008.

Contract amendment language for the mental health vocational provider agencies will be developed and transmitted to the providers by July 31, 2008.

Vocational programs will start-up during the 4th calendar quarter of 2008.

◊ *B. Procurement of Providers*

The RFP for CD providers will be released August 2008.

The response date will be September 2008.

The awards for accepted bids will be in September 2008.

◊ *C. Contracting of Services*

Contracts for MH providers and CD providers will start in October 2008.

◊ *D. Services Start date(s)*

Limited services to consumers will begin November 1, 2008.

Strategy Title: Increase Access to Housing

Strategy No: 3a - Supportive Services for Housing Projects

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts, including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

Housing providers often do not have adequate on-site staff resources to provide hands on assistance to homeless persons to help them transition to housing stability. Many housing projects are under funded for supportive housing services. Persons who are homeless need to relearn the skills needed to maintain a residence and meet the obligations of tenancy.

◊ *B. Reason for Inclusion of the Strategy*

With on-site supportive housing services, individuals will receive the assistance they need to be successful in their housing environment and will be less likely to return to homelessness. Housing providers will be able to accept homeless individuals that they had previously turned down due to inadequate available housing supports/services. Lack of on-site services and responsiveness by case management staff when a tenant has a crisis are often cited by landlords as the primary reasons for not dedicating housing to persons who are homeless and have a disability.

◊ *C. Service Components/Design*

The treatment provider community will provide supportive housing services to assist individuals to transition from homelessness to housing stability. Services will be provided primarily at the individual's housing site and in the surrounding community by housing support specialists.

Services will include assistance to help the individual meet the obligations of his/her tenancy, i.e. rent payments, abide by landlord rules, cooperate with neighbors, keep

apartment clean and safe; assistance with learning the daily living skills to live independently, i.e. shopping, cooking, budgeting, cleaning; coordination with mental health and/or chemical dependency treatment providers and healthcare providers; and helping individuals get to medical appointments.

◊ *D. Target Population*

Persons in the public mental health treatment system and chemical dependency treatment system who are homeless; have not been able to attain housing stability; are exiting jails and hospitals; or have been seen at a crisis diversion facility.

◊ *E. Program Goals*

Increase the number of housed individuals with mental illness and chemical dependency who are receiving supportive housing services, leading to increased housing tenure and housing stability. Housing stability has been shown to be a key determinant in increasing treatment participation and in reduced use of criminal justice and emergency medical systems.

◊ *F. Outputs/Outcomes*

An estimated 400 individuals will be served. The number of housing providers is yet to be determined. Expected outcomes include increased housing stability and reduced use of criminal justice and emergency medical services.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
July 2008	Request For Proposal (RFP) issued	
Aug 2008	RFP selection process completed	
Sept 2008	Funds awarded to providers	
Sept – Oct 2008	Start-up (staff hiring and training)	$2,000,000
Nov 2008	Begin services to target population	
	Total Funds 2008	**$2,000,000**
Ongoing Annual	**Total Funds**	**$2,000,000**

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

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

The number of providers is yet to be determined. Those selected will be mental health treatment providers, chemical dependency treatment providers and affordable housing providers that currently serve the target population.

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

Current providers serving the target population and housing providers that will be applying for new capital projects will be identified through an RFP procurement process.

- Housing support specialists will be added to mental health treatment providers and chemical dependency treatment providers in the Mental Health Chemical Abuse and Dependency Services Division (MHCADSD) network and to affordable housing providers (private non-profit) that house the target population.
- A housing support specialist will have a caseload of 15 clients. The specialist will work with individuals primarily at the housing site, teaching daily living skills and helping the client achieve the obligations of tenancy and housing stability. The housing support specialist will also coordinate with the client's treatment team and regularly communicate with the landlord.
- Adding housing support specialists will allow providers to house individuals who have previously been turned down or have been unsuccessful in housing due to lack of stability and/or lack of daily living skills.

◊ *C. Partnership/Linkages*

Mental health treatment providers, chemical dependency treatment providers and affordable housing providers that serve the target population, funders of housing development and services, and the Committee to End Homelessness in King County.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Program design planning will be substantially completed by April 30, 2008

RFPs for the procurement of the MHCADSD providers and affordable housing providers will be developed by June 30, 2008.

New contracts with MHCADSD network providers and affordable housing providers will be developed and transmitted to the providers in September 2008.

Supportive housing teams/ programs will start-up during the 4th calendar quarter of 2008.

◊ *B. Procurement of Providers*

The RFP for providers will be released July 1, 2008.

The response date will be July 30, 2008.

The awards of accepted bids will be in September 2008.

◊ *C. Contracting of Services*

Contracts for MHCADSD providers and affordable housing providers will start in September 2008.

◊ *D. Services Start Date(s)*

Services to consumers will begin in November 2008.

Programs Targeted to Help Youth Strategies 4a – 9a

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4a - Comprehensive Chemical Dependency Outpatient Services to Parents In Recovery (Will be renamed: Services to Parents Participating in Substance Abuse Outpatient Treatment Programs)

County Policy Goal Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Nationally, in 2001, ten percent of children aged five or younger have one or more parents abusing or dependent on alcohol or other drugs. [6] The nature of the addictive process focuses parental attention on the procurement, the use, and the experience of the alcohol/drugs. This involvement interferes with and diminishes their ability to be attentive and appropriately responsive to their children's emotional and physical needs. It also increases family isolation, and there is a tendency for children to assume the vacancy in the position of parent. Because of the lack of appropriate parental behavior, observation and monitoring, children of substance abusers are more likely to exhibit developmental and behavioral challenges and are at higher risk of later developing problems with alcohol and other drugs as well as mental health problems.

While substance abuse treatment addresses the parent's recovery from addiction, it does not directly address the impact of addiction on the children and family, nor deal with parenting as a specific issue with skill building, guided skill practice and targeted support.

◊ *B. Reason for Inclusion of the Strategy*

In King County, in 2007, 25% of adults enrolled in outpatient substance abuse treatment had children under age 18 living with them.[7] By increasing their ability to attend to and care for their children's health and well-being, effectively communicating with and actively structuring their children, and reducing family isolation, recovering parents will decrease risk factors while increasing protective factors and resiliency in their children. Recovering parents who increase their skills and ability in parenting positively affect their children's lives and assist their children in overcoming developmental issues.

[6] *Children Living with Substance-Abusing or Substance-Dependent Parents,* The NHSDA Report, June 2, 2003
[7] DSHS/DASA, TARGET Treatment Analyzer Standard Reports for King County, 2007

◊ *C. Service Components/Design*

These services will be provided to parents participating in county-funded outpatient substance abuse treatment programs that are selected in the Request For Qualifications (RFQ) process to be the contracted providers of this service. The overall services include assessment of individual parent and family functioning and development of a service plan, parent education, parent support and supervised skill practice.

Once the assessment of parent/family functioning review is completed, a service plan is developed specific to this parent and family which includes group and individual parent education and support, and observed skill practice with their children so the parent(s) receives immediate in-the-moment coaching alternatives and affirmation.

The Family Coordinator will actively link parents and children as needed to developmental testing and treatment as well as therapeutic child care and other social services for children and youth of the parents in the treatment program. The children and family will be included in the services and/or events provided in MIDD Strategy 4b Prevention Services to Children of Substance Abusers.

◊ *D. Target Population*

Custodial parents participating in outpatient substance abuse treatment programs selected in the RFQ process.

◊ *E. Program Goal*

Increased family functioning and reduced potential for child neglect; reduced drug use by children of recovering parents.

◊ *F. Outputs/Outcomes*

- 400 parents served annually
  (Current data available does not tell us how many adults admitted to outpatient treatment have children living with them, but extrapolations from other data sets gives us an estimate of 700 parents with children at home who could benefit from this program.)
- Increased parent services at outpatient substance abuse treatment programs
- Increased family communication
- Increased positive family structure
- Increased parent skill in developmentally appropriate interactions with child
- Reduced substance abuse by children of recovering parents

2. Funding Resources Needed and Spending Plan

The program needs $500,000 of MIDD funding per year to sustain.

Dates	Activity	Funding
April – October 2008	Planning	
October – December 2008	Procurement; RFQ	
	Total Funds 2008	**$ 0**
January – March 2009	Contracting	
April – June 2009	Staff hiring and training	$ 375,000
	Total Funds 2009	**$ 375,000**
Ongoing Annual	**Total Funds**	**$ 500,000**

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

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

Opiate substitution treatment providers
Outpatient substance abuse treatment providers

2 FTE Family Coordinators
2 FTE Family Support Workers
3 FTE *Families Facing the Future* staff

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

Training in the Family Support Model
Staff trained in *Facing the Future* curriculum and parent services model

◊ *C. Partnership/Linkages*

Opiate substitution treatment providers
Outpatient substance abuse treatment providers

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Project planning and RFQ development: April – October 2008

◊ *B. Procurement of Providers*

RFA released: by October 1, 2008
RFA awarded: by December 15, 2008

◊ *C. Contracting of Services*

Contract signed by March 30, 2009

◊ *D. Services Start Date(s)*

Services to parents start by June 30, 2009

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4b – Prevention Services to Children of Substance Abusers

County Policy Goals Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Children of substance abusers (COSA) are more likely to exhibit problem behaviors and are at higher risk of later developing problems with alcohol and other drugs.[8] To decrease these risks and increase protective factors for healthy youth development, COSAs need coping skills and support from caring, trusting adults. It is estimated that one in four children under the age of 18 lives in a home where alcoholism or alcohol abuse is prevalent.[9] Countless other children are exposed to illegal drug use in their families.[10] In King County, in 2007, 25% of adults enrolled in outpatient substance abuse treatment had children under age 18 living with them.

◊ *B. Reason for Inclusion of the Strategy*

Evidence-based prevention programs have the potential to reduce future costs by preventing youth from becoming involved with the criminal justice system as well as the substance abuse treatment system. Because they target youth and intervene prior to the development of substance use problems, alcohol and other drug prevention programs have the potential to create long-term cost savings including the prevention of long-term health issues.

◊ *C. Service Components/Design*

This strategy expands upon evidenced based initiatives proven to work with this high risk population. It is based upon principles of effectiveness for substance abuse prevention and is a proactive, family-based approach.

A major service component is the provision of educational/support groups for COSAs, using evidence-based programming such as the *Celebrating Families!™* curriculum. The National Association for Children of Alcoholics (NACoA) recently acquired *Celebrating Families!™* and is disseminating the curriculum. *Celebrating Families!™* is a cognitive behavioral, support group model which has the goal: " to

[8] National Association for Children of Alcoholics (NACoA) website, *Children of Alcoholics: Important Facts, August 1998 compilation*, http://www.nacoa.net/impfacts.htm
[9] Substance Abuse and Mental Health Services Administration (SAMHSA), National Clearinghouse for Alcohol and Drug Information (NCADI) website, *You Can Help: A Guide for Caring Adults Working with Young People Experiencing Addiction in the Family*, NCADI Publication No. PHD878, http://csat.samhsa.gov/publications/youcanhelp.aspx
[10] SAMHSA, Ibid.

foster the development of whole, fulfilled, and addiction-free individuals and families by increasing resiliency factors and decreasing risk factors."[11]

Specifically, each series of the *Celebrating Families!*™ curriculum is comprised of 16 two-hour sessions. A family meal precedes each session and then family members are separated by age group for the main, educational portion of the program. Toward the end of each session, all the family members are brought back together to interact in healthy ways.

The *Celebrating Families!*™ curriculum builds a strong foundation; however, to adapt the program to local needs and to make the services more comprehensive, other components may be added including life-skills training, mentoring services, parent educational/support groups, and special drug prevention awareness events.

Through services contracted to a local provider(s) (which may include school organizations, community-based youth and family service agencies, and outpatient chemical dependency treatment agencies), activities would be presented multiple times in all five geographic regions of King County (east, south, north, central, and Vashon Island).

◊ *D. Target Population*

The target populations are COSAs and their parents/guardians/kinship caregivers. Children will be identified from various referral sources including schools, community-based organizations, recreation and after-school programs, child welfare and the foster care system, juvenile justice as well as self-referrals.

◊ *E. Program Goal*

Provide an evidence-based prevention program to children of substance abusers to reduce the risk of their developing substance abuse problems or chemical dependency.

◊ *F. Outputs/Outcomes*

400 individuals served annually
Reduced substance abuse by COSAs
Improvement in health outcomes
Improvement in school attendance and performance
Reduction in juvenile justice involvement by COSAs
Improvement in individual and family functioning

[11] NACoA, *Celebrating Families!*™ website, http://www.celebratingfamilies.net/

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept- December 2008	Planning, procurement, and contracting	
	Total Funds 2008	**$ 0**
Jan – March 2009	Hiring and training of Project Coordinator and Staff by provider(s) awarded under the RFQ process	$100,000
April – December 2009	Service provision	$300,000
	Total Funds 2009	**$ 400,000**
Ongoing Annual	**Total Funds**	**$ 400,000**

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

◊ *A. Number and Type of Providers*

One 0.75 FTE Contracted Project Coordinator

Five 0.5 FTE Contracted Project Staff

Provider(s) may include school organizations, community-based youth and family service agencies, alcohol and other drug prevention agencies, and outpatient chemical dependency treatment agencies

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

Project staff will need training and support in various curricula/programs, such as *Celebrating Families!™*, parenting, life skills, and mentoring.

Initial training of project staff shall be provided within two months of hire. Ongoing training will be scheduled, as needed.

◊ *C. Partnership/Linkages*

Partnerships and linkages will be between local, county, and state agencies and organizations which have access to COSAs and their families. This may include but not be limited to: King County Alcohol and Other Drug Prevention Program, King County Community Organizing Program, King County Youth and Family Services, King County Superior Court/Juvenile Services, local chemical dependency treatment agencies, alcohol and other drug prevention/intervention programs, Washington State Department of Social and Health Services' Division of Children and Family Services, Treehouse, Casey Family Program, Puget Sound Educational Service District, King County Mentoring Roundtable, mental health treatment agencies.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

March 3, 2008 to May 30, 2008 (three months) -- Project planning

◊ *B. Procurement of Providers*

June 2, 2008 to October 1, 2008 (five months) – Development/approval of competitive bid documents. Request for Proposals (RFP) process

◊ *C. Contracting of Services*

November 3, 2008 to December 31, 2008 (two months) – Contract development and processing

◊ *D. Services Start date(s)*

April 1, 2009 – Services to youth and caregivers start

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4c – School District Based Mental Health and Substance Abuse Services

County Policy Goal Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Mental health and substance abuse problems in children and youth interfere with their ability to learn, progress in school, and progress along a normal developmental course. A 2001 U.S. Surgeon General report stated that mental health is critical to a child's learning and general health, and is as important as immunizations. Approximately 21% of children between the ages 9 and 17 have diagnosable emotional or behavior disorders, but fewer than a third receive help.[12] This group of children have an increased risk for dropping out of school and not becoming fully contributing members of adult society.[13] Their difficulties often are not recognized as mental health and/or substance abuse related. They get left behind educationally and socially and can be labeled as difficult, which leads to further isolation from accurate problem identification and professional assistance.

Substance abuse can be linked to untreated mental illness as 43% of children who use mental health services also have a substance abuse disorder. [14] There is an increased risk for co-occurring disorders with students who smoke, drink or use other illicit drugs; substance abuse is associated with depression, anxiety disorder, attention deficit hyperactivity disorder, conduct disorder and eating disorders. [15] Children with mental disorders, particularly depression, are at a higher risk for suicide; an estimated 90% of children who commit suicide have a mental disorder. [16] Youth who fail at school are much more likely to end up on public assistance and involved in the criminal justice system. According to one study, 66% of boys and almost 75% of girls in juvenile detention have at least one mental disorder. [17] A 2005

[12] *Caring for Kids,* The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University, Summer 2003
[13] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000
[14] Substance Abuse and Mental Health Services Administration, 2002. Report to Congress on the prevention and treatment of co-occuring substance abuse disorders and mental disorders
[15] *Malignant Neglect: Substance Abuse and America's Schools,* National Center on Addition and Substance Abuse, Columbia University, September 2001
[16] U.S. Department of Health and Human Services, *Mental Health: A Report to the Surgeon General,* 1999
[17] President's New Freedom Commission on Mental Health, Final Report to the President, 2003

report from the Civil Rights Project at Harvard University says failure to graduate from high school triples the likelihood of going to jail.

Without proper care their problems and challenges compound so that when professional care is offered the mental illness and substance abuse has progressed to the point that their needs are much more complex.

◊ *B. Reason for Inclusion of the Strategy*

Schools provide an early opportunity to identify children and youth with mental health and substance abuse problems. School based programs have been shown to improve mental health, and improve educational outcomes and school success.[18]

◊ *C. Service Components/Design*

Due to the complex nature of the project, the number of potential partners and the implementation development timeline, the service design work for this strategy has not been completed. Services design will be defined with local partners with services delivery to begin with 2009/2010 school year.

◊ *D. Target Population*

Children and youth enrolled in King County schools who are at risk for future school drop out.

◊ *E. Program Goal*

To reduce the risk of students developing mental or emotional illness, or using drugs/alcohol.

◊ *F. Outputs/Outcomes*

Up to 19 competitive grant awards to schools, school districts, or community-based organizations in partnership 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.

Using an existing model of in-school services in the Seattle school-based health centers, it is estimated that each school-based counselor would provide therapeutic interventions with five students per school day, in addition to providing facilitation of group activities and school-wide initiatives including population-based mental health preventive and mental health promotion strategies. Counselors would coordinate with MIDD Strategy 4d School Based Suicide Prevention activities and programs, therefore counselors may also be deployed to other schools in their district to assist in the event of a significant event or tragedy such as the suicide, death, or serious assault of a student, teacher, or other school staff.

[18] *Outcomes of Expanded Mental Health Programs,* Center for School Mental Health Assistance, 2003

Expected outcomes:

- Reduced risk of students developing mental and emotional illnesses and abusing drugs and alcohol.
- Improved school performance and reduced involvement in juvenile justice and emergency medical systems.

2. Funding Resources Needed and Spending Plan

The program needs $1,235,306 of MIDD fund per year to sustain.

Dates	Activity	Funding
April-December 2008	Stakeholder planning process	$0
	Total Funds 2008	**$0**
January-June 2009	Complete planning, develop and issue Request for Proposals (RFPs)	$0
June-August 2009	Select recipients, complete contracts, staff hired	$125,000
September-December 2009	Services begin	$400,000
	Total Funds 2009	**$ 525,000**
2010	Services fully operational	$1,235,000
Ongoing Annual	**Total Funds**	**$1,235,000**

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

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

To be determined through the planning process.

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

To be determined through the planning process.

Dates:	Activity:
April – December 2008	Planning Process
June – August 2009	Staff Training

◊ *C. Partnership/Linkages*

Public Health; Community Services Division; King County Systems Integration Initiative, school-based health clinics; local schools and school districts, education services districts, mental health providers serving children of active duty military

personnel, and other community providers. Linkage to MIDD strategy 4d School Based Suicide Prevention.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined in the planning process

◊ *B. Procurement of Providers*

May-June 2009

◊ *C. Contracting of Services*

August 2009

◊ *D. Services Start Date(s)*

School year 2009-2010

Strategy Title: Invest in Prevention and Early Intervention

Strategy No: 4d – School Based Suicide Prevention

County Policy Goals Addressed:

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Suicide is the second leading cause of death for Washington youth ages 15-24. Between 2000 - 2004, 117 youth in King County died by suicide. In this same period, there were 1,024 hospitalizations of King County youth because of suicidal attempts. Among 10th grade students in King County who responded to the 2006 Healthy Youth Survey, 13 percent reported seriously considering suicide and almost 10 percent reported making a plan within the past 12 months for committing suicide. Between three and four percent reported attempting suicide in the prior year.

◊ *B. Reason for Inclusion of the Strategy*

Currently there is no integrated suicide prevention strategy countywide. Provision of these services will reduce the number of youth suicides in King County. This strategy will also increase the ability of parents, as well as school staff and administrators, to identify warning signs of potential suicide and develop appropriate prevention and intervention strategies.

◊ *C. Service Components/Design*

There are four main components to this strategy:

1. **Suicide awareness presentations for youth 12-19:** These presentations will raise awareness of suicide and help students understand the warning signs of suicide. They will also explain how to get help for themselves or their friends. These will focus on increasing "help seeking" behavior and "help giving" behavior as it relates to suicide prevention.
2. **Teacher training:** This will provide faculty and other staff with information about depression and suicide, including warning signs; differentiates "normal" adolescent behavior from at risk behavior; identifies basic intervention strategies; and reinforces a school's crisis response policies and procedures.
3. **Parent education:** This will offer presentations to parents and guardians on childhood depression, suicide, and community crisis resources. This will also cover tips on how to talk to young people about depression and suicide, as well as how to assist parents in helping their youth deal with stress and depression.

4. **Assist schools in developing suicide prevention/intervention policies and procedures:** Many schools have no policies or procedures to respond to deal with suicide. This aspect will help school leadership establish a suicide prevention strategy, to assist staff in identifying students at risk for self-destructive/pre suicide behaviors and to respond to a suicide crisis if needed. This includes training front line staff such as teachers, nursing staff, coaches and counselors the skills and appropriate steps for intervening with students at risk, engaging families and outside support systems and community resources.

◊ *D. Target Population*

The target populations are King County school students, including alternative schools students, age 12-19 years, school staff and administrators, and the students' parents and guardians.

◊ *E. Program Goals*

- Support parents and guardians to increase knowledge and skills of suicide prevention and intervention strategies.
- Assist schools in developing suicide prevention, suicide intervention and crisis response strategies.

◊ *F. Outputs/Outcomes*

Individuals to be reached

- 3000 students
- 1500 parents
- 500 school staff

The expected outcomes include increased awareness among youth, school personnel, and parents regarding suicide, and a reduction in youth suicides in King County.

2. Funding Resources Needed and Spending Plan

The program needs $200,000 of MIDD funds per year to be sustainable.

Dates	Activity	Funding
March – July 2008	Develop scope of work and outcomes in conjunction with Crisis Clinic TeenLink and YSPP	0
August 2008	Develop exhibit and written contract	0
October 15, 2008	Contract effective date	0
October – December 2008	New staff hired and trained; services commence	$ 75,000
	Total Funds 2008	**$ 75,000**
January – December 2009		$ 200,000
	Total Funds 2009	**$ 200,000**
Ongoing Annual	**Total Funds**	**$ 200,000**

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

◊ *A. Number and type of providers (and where possible FTE capacity added via this strategy):*

2 FTEs to provide Suicide Awareness training and instruction, 0.75 FTE for parent and teacher training, and 0.25 for school policy development.

This strategy involves one primary provider that will utilize the 3 FTE. We will negotiate with a provider that we already have a contract with to provide this service.

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

Existing provider staff are trained and seen as experts on youth depression and suicide, however all of the newly hired staff will require training. A coordinated effort between these agencies is central to the strategy to ensure there is a systematic approach to the implementation of the suicide prevention strategy in schools, and/or school districts (depending on the local need).

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between schools, school districts, Public Health, mental health providers serving children of active duty military personnel, and other King County youth serving agencies.

4. Implementation/Timelines

◊ A. *Project Planning and Overall Implementation Timeline*

March 2008 through July 2008: develop scope of work and contract.

◊ *B. Procurement of Providers*

August 2008: King County already contracts with the Crisis Clinic for TeenLink services so MHCADSD will amend this contract to add funding and an exhibit for the additional work and outcomes, including the subcontract for the additional work and hiring of FTEs.

◊ *D. Contracting of Services*

September 15, 2008 effective date

◊ *E. Services Start Date*

October 2008 services provided to youth, parents and schools.

Strategy Title: Expand Assessments for Youth in the Juvenile Justice System

Strategy No: 5a – Increase Capacity for Social and Psychological Assessments for Juvenile Justice Youth

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

The juvenile court processes 4,850 youth per year. National estimates suggest that 65-70% of youth in the juvenile justice system have problems with mental illness. Of those, approximately 60% had a co-occurring substance abuse problem. Of the 2300 youth admitted to King County juvenile detention in 2006, approximately half were referred to the mental health clinic due to their response on the Massachusetts Youth Screening Instrument (MAYSI), a standardized screening tool used in justice systems to determine the need for further mental health evaluation. An estimated 80% of the 1300 King County youth annually placed on probation, who are moderate or high risk to re-offend are chemically dependent or substance abusers.

◊ *B. Reason for Inclusion of the Strategy*

To successfully reduce future involvement in the justice system, the behavioral health issues of youth entering the juvenile justice system need to be effectively and assertively assessed and treated.

◊ *C. Service Components/Design*

Under this strategy, the system will add staff capacity to increase the availability at the juvenile court of screening and assessment to determine if juvenile justice and child welfare system involved youth have substance abuse and/or mental health issues. Following screening and assessment, this strategy will help assure treatment service linkage for youth identified with substance abuse and/or mental health treatment needs. The following staffing capacity will be added to the system: one chemical dependency professional, one mental health treatment liaison, one assessment coordinator, one psychologist, and contracted professionals to perform specialty assessments (psychiatric, medication evaluation, forensic psychiatric, neurological, etc.).

◊ *D. Target Population*

Youth age 12 years or older who have become involved with the juvenile justice and/or child welfare system.

◊ *E. Program Goal*

Increase the appropriate response to youth who have become involved with juvenile justice system due to substance abuse or mental health issues.

◊ *F. Outputs/Outcomes*

- Screening and assessment of up to 1,080 youth per year.
- Linkage to treatment services for those youth identified with a treatment need.
- Reduction in future involvement in the juvenile justice system.

2. Funding Resources Needed and Spending Plan

The project needs $361,000 to increase assessment staff capacity to address the needs of youth involved in the juvenile justice system.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training and award of the RFP for specialty professional assessment services)	$60,000
	Total Funds 2008	**$60,000**
Jan – Mar 2009	Continued start-up (training for court staff on how to utilize the specialty assessment services and implementation of CD and MH assessment and linkage services)	$60,000
Jan – Dec 2009	Phasing in ongoing services	$250,000
	Total Funds 2009	**$310,000**
2010 and onward	Ongoing assessment and linkage services	
Ongoing Annual	**Total Funds**	**$361,000**

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

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

- One FTE Chemical Dependency Professional (CDP) (contracted)
- One FTE Mental Health Liaison—Children's Mental Health Professional (contracted)
- One FTE King County Superior Court Assessment Coordinator

- One FTE King County Superior Court Psychologist
- Consultant contracts for professionals who provide specialty assessments

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

The CDP will need to be qualified to administer the Global Assessment of Need (GAIN) assessment instrument. Certification to administer this assessment tool can take up to three months if the individual is not qualified at the time of hire.

All other staff and consultants should be hired with appropriate qualifications to perform required assessments.

◊ *C. Partnership/Linkages*

Partnerships with substance abuse and mental health treatment providers for the purpose of assuring quality linkages to needed treatment and/or evidence based programs specifically designed to reduce juvenile justice recidivism.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Continued planning related to the implementation of this strategy proceeds from May – August 2008.

◊ *B. Procurement of Providers*

The RFP(s) for the specialty assessment professionals will be released no later than August 30, 2008.

◊ *C. Contracting of Services*

Amendments to existing contracts for the CDP and the mental health liaison will be in place by September 1, 2008.

◊ *D. Services Start Date(s)*

CDP Assessments, Assessment Coordinator and MH Liaison services will begin September 15, 2008.

The Psychiatric staffing and specialty assessment services will begin no later than January 1, 2009.

Strategy Title: Expand Wraparound Services for Youth

Strategy No: 6a – Wraparound Family, Professional and Natural Support Services for Emotionally Disturbed Youth

County Policy Goal Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Families with children who have serious emotional and behavioral disturbances face numerous challenges. These children often experience profound difficulties with functioning in school, maintaining relationships with family and peers, coping with their emotions, and controlling their behavior. Sometimes these difficulties strain families to the point that they see no other solution than to place their child outside of their home. When families turn to formal systems for support, they may experience a fragmented process that is driven more by system needs than by the needs of the child/youth and family.

Wraparound is a proven, effective approach to developing and coordinating service plans that build on the strengths of the child/youth and family. Resulting plans are individualized and are based on the family's goals. They address the specific cultural needs of the family, with the goal that services and supports occur in the family's home and community whenever possible. A team of supportive individuals 'wraps' around the family to help them achieve their goals. Often the team is made up of 'natural' supports like relatives, neighbors, coaches, clergy, etc., who continue to be involved for years.

Wraparound reduces reliance on formal systems and increases resilience, self-determination and overall well-being for families. Families who participate in wraparound often describe it as the only approach that truly worked for them. Wraparound helps families to stay together and to avoid use of more costly resources such as inpatient care, foster care and/or juvenile justice.

Wraparound approaches have evolved since the early 1990s. 'High fidelity wraparound' is a 'state of the art,' scientifically supported approach that adheres to the established principles, guidelines and processes which have been shown to produce better outcomes.

◊ *B. Reason for Inclusion of the Strategy*

Capacity to provide high fidelity wraparound is limited in King County. Although the Regional Support Network developed capacity to offer wraparound as a result of federal Child and Adolescent Service System Project (CAASP) and System of Care grants, all grant funding ended in 2005, curtailing further growth and development. The Children's Mental Health Plan developed by MHCADS in 2005 anticipated that high fidelity wraparound would be available in 2006-07 to all children receiving the most intensive level of outpatient services. However, the system has lacked sufficient resources to even begin to reach this goal. MIDD funds will help to significantly expand the availability of wraparound to consumers throughout the county. There is an increasing body of research that demonstrates the effectiveness of high fidelity wraparound. In addition, the principles, methods and goals underlying wraparound align well with those of the MHCADS Recovery Initiative.

◊ *C. Service Components/Design*

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADS) will employ a full time Wraparound Initiative Specialist devoted to the development and coordination of the initiative. The Specialist, other MHCADS staff and partner agencies will design, develop and implement wraparound in King County based upon the 'Ten Principles of Wraparound' and the essential conditions defined as necessary to support high fidelity wraparound by the National Wraparound Initiative (NWI) and Portland State University Research and Training Center.

The King County Wraparound Initiative (KCWI) will assure that training, technical assistance, coaching, flexible funds/resources and capacity for system wide quality improvement and program evaluation is available on an ongoing basis. The KCWI will phase in high fidelity wraparound over several years, building system capacity with a network of providers and assuring linkage to MIDD funded parent organizations (See Strategy 1f).

◊ *D. Target Population*

Emotionally and/or behaviorally disturbed children and/or youth (up to the age of 21) and their families who receive services from two or more of the public mental health and substance abuse treatment systems, the child welfare system, the juvenile justice system, developmental disabilities and/or special education programs, and who would benefit from high fidelity wraparound.

◊ *E. Program Goal*

High fidelity wraparound is available as needed for children/youth and families in the target population throughout King County.

◊ *F. Outputs/Outcomes*

1. High fidelity wraparound provided to 920 youth and families per year
2. Training and technical assistance regularly available to provider organizations, parent organizations and partner agencies
3. Improved school performance for youth served
4. Improved high school graduation rates for youth served
5. Reduced drug and alcohol use for youth served
6. Improvement in functioning at home, school and community for youth served
7. Reduced juvenile justice involvement for youth served
8. Maintained stability of current placement for youth served
9. Increased community connections and utilization of natural supports by youth and families

2. Funding Resources Needed and Spending Plan

This program needs $4,692,000 of MIDD funds per year to develop and sustain the MHCADS staff capacity, provide training and flexible funding and to contract with and sustain a network of organizations to serve all of King County. When allowable, additional resources (including Medicaid and state funds) will be accessed by MHCADS contracted providers and/or our system partners to provide actual services and supports. MHCADS will assure that funds are expended in accordance with contract expectations and standardized protocols (e.g., flexible funds must be used within established parameters).

Dates	Activity	Funding
June – Dec 2008	Start-up (Hire MHCADS staff; development of program design, including training and evaluation plan, consultation needs; RFP development).	$175,000
	Total Funds 2008	**$175,000**
Jan – Dec 2009	Phase in development of readiness capacity. Procurement, selection, contracting, recruitment and training of wraparound provider network.	$3,000,000
	Total Funds 2009	**$3,000,000**
2010 and onward	County-wide network of provider organizations in place; ongoing training, support, quality improvement processes and program evaluation.	$4,692,000
Ongoing Annual	**Total Funds**	**$4,692,000**

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

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

This funding level supports a full-time Wraparound Initiative Specialist at MHCADS ($90,000 at 2008 county rates) and the capacity to provide ongoing training, monitoring, quality improvement and program evaluation. A phased-in

implementation plan is required to develop, train and sustain a network of provider organizations with capacity to offer high fidelity wraparound to the target population (40 facilitators, 5 supervisors to serve 920 families). Potential provider organizations may include both new and existing providers of wraparound.

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

Dates:	Activity:
June– Dec 30, 2008	• Hire and train MHCADS Wraparound Initiative Specialist • Develop and begin implementation of training and technical assistance plan
Jan – Dec 2009	• Orientation/training offered to develop readiness across the county • Services will be initiated in phases as provider network is selected and develops capacity to offer high fidelity wraparound.
2010 and ongoing	• Program evaluation and quality improvement processes will help determine ongoing training and technical assistance needs. • Ongoing training and technical assistance is implemented to assure KCWI achieves goal(s).

◊ *C. Partnership/Linkages*

MHCADS and its contracted wraparound provider network will maintain close partnerships with the NWI, with state and local parent organizations and with local partners, including mental health and substance abuse treatment providers, child welfare and juvenile justice systems, schools and other stakeholders.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. MHCADS staff person recruited and hired by June 1, 2008.
2. Program design and training plan will be substantially completed by December 31, 2008.
3. First services will be offered by September 2009.

◊ *B. Procurement of Providers*

1. The RFP for provider organizations will be released by March 15, 2009.
2. The response date will be April 30, 2009.
3. The awards for accepted bids will be made May 15, 2009.

◊ *C. Contracting of Services*

1. Contracts for provider organizations will start on June 15, 2009.
2. Training for provider organizations will begin by July 1, 2009.

◊ *D. Services Start Dates(s)*

First services to families and youth will begin September 1, 2009.

Strategy Title: Expand Services for Youth in Crisis

Strategy No: 7a – Reception Centers for Youth in Crisis

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.

1. Program/Service Description

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

The King County juvenile justice system struggles to respond adequately to the needs of arrested youth who are not eligible for juvenile detention and who do not have a readily available parent or guardian. Although appropriate services might be available through Harborview's Emergency Department, the Secure Crisis Residential Center, the Children's Crisis Outreach Response Team, shelters, and/or Division of Child and Family Services, each of these services has different criteria, phone numbers and intake procedures. There is no coordinated response system to assist police or other professionals who encounter these youth. In addition, the system may need additional services to meet the needs of these youth.

◊ *B. Reason for Inclusion of the Strategy*

It is a King County priority to minimize the use of detention for youth who are not a serious public safety concern and who do not have readily available parents or guardians. Since King County implemented the juvenile detention intake criteria in the late 1990s, law enforcement has experienced difficulty accessing community alternatives for youth who don't meet those criteria. The Mental Illness and Drug Dependency Action Plan (MIDD) funds will help address these concerns and provide an opportunity to better assess unmet needs, develop additional services and improve coordination. This strategy is consistent with the goals of the King County Systems Integration Initiative.

◊ *C. Service Components/Design*

The recommendation of the original MIDD Action Plan was to meet the needs of the target population through development of a reception center that would provide an

immediate option for law enforcement and serve as a central coordination point. As envisioned, the reception center would help connect youth to their parent/guardian or help them find alternative housing. Reception center staff would assess the youth's needs for treatment and services and link them to those services.

At this juncture, a needs assessment and planning process is an essential next step to help evaluate the feasibility of the original recommendation. In particular, the needs assessment will gather information about the projected use of a reception center. The planning for this strategy will be coordinated with the planning processes for related MIDD strategies (especially Children's Crisis Outreach Response System (7b), and Crisis Intervention Training for first responders (10a)). The goal of this integrated planning process would be to develop a crisis response system that meets the needs of the target population(s) and comprises a full continuum of service options.

◊ *D. Target Population*

Youth who have been arrested, are ineligible for detention, and do not have a readily available parent or guardian. Many of these youth have mental health and/or substance abuse needs. The needs assessment and planning process will help determine if a broader population of youth might also qualify for and benefit from this intervention (e.g., youth in crisis referred by schools or community centers).

◊ *E. Program Goals*

Create a coordinated response/entry system for the target population.

Law enforcement and other first responders will be able to link youth to appropriate services in a timely manner.

An enhanced array of services is available to the target population.

◊ *F. Outputs/Outcomes*

Complete a needs assessment in conjunction with Strategy 7b to determine appropriate strategies to meet goals.

Implement strategies identified through needs assessment (e.g., coordinated response system, reception center, additional services).

Reduce admissions to juvenile detention for youth served.

Reduce admissions to hospital emergency rooms and inpatient units for youth served.

Decrease homelessness for youth served.

2. Funding Resources Needed and Spending Plan

The project needs $75,000 to conduct a needs assessment, design a coordinated response system, and assess the feasibility of and subsequently design a centralized reception center and/or additional services.

Dates	Activity	Funding
May – Dec 2008	Project team (which may include a consultant) conducts needs assessment, evaluates feasibility of reception center, develops program design, budget and RFP if recommended.	$75,000
	Total Funds 2008	**$75,000**
Jan – Mar 2009	♦ Start-up activities for coordinated response system including training and communication plan (e.g., printing of materials) ♦ Project team finalizes recommendation for reception center and additional services. Next steps could include Request for Qualifications (RFQ) or Request for Proposals (RFP).	TBD (Note that one-time funds may be needed for capital improvements)
	Total Funds 2009	**$497,400**
2010 and onward	TBD	TBD
Ongoing Annual	**Total Funds**	**$497,4000**

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

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

If implemented, the reception center would require a community provider, a suitable location, 24/7 capability and staff, including treatment specialists (mental health and substance abuse) and case managers.

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

Needs will be dependent upon the program design.

◊ *C. Partnership/Linkage*

The planning process will occur in partnership with juvenile justice, law enforcement, youth service providers, King County Mental Health Chemical Abuse and Dependency Services Division, families and other involved stakeholders.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Needs assessment/Baseline/Feasibility Study and Concept Development: Conduct a study and planning process; develop recommendations and design for a reception center and coordinated response system. Develop budget estimates. (May – Dec 2008)
2. Implementation of Coordinated Response System: Conduct training of staff, law enforcement, and other professionals. Implement coordinated response system. (January – Mar 2009)
3. Reception Center: Depending on recommendation from the project team, next steps could include the development of an RFQ or RFP. Implementation date to be determined. (2009)

◊ *B. Procurement of Providers*

To be determined, depending on recommendations from the project team.

◊ *C. Contracting of Services*

To be determined, depending on recommendations from the project team.

◊ *D. Services Start Date(s)*

To be determined, depending on recommendations from the project team.

Strategy Title: Expand Services for Youth in Crisis

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

County Policy Goals Addressed:

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

1. Program/Service Description

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

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

◊ *B. Reason for Inclusion of the Strategy*

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

◊ *C. Service Components/Design*

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

coordinated with the planning for related MIDD strategies (especially Reception Center (7a), and Crisis Intervention Training for first responders (10a)).

◊ *D. Target Population*

Children and youth age 3-17 who are currently in King County and who are experiencing a mental health crisis. This includes children, youth, and families where the functioning of the child and/or family is severely impacted due to family conflict and/or severe emotional or behavioral problems, and where the current living situation is at imminent risk of disruption. The program will also target children and youth being discharged from a psychiatric hospital or juvenile detention center without an appropriate living arrangement.

◊ *E. Program Goal*

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

◊ *F. Outputs/Outcomes*

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

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sep – Dec 2008	Stakeholder work group will conduct needs assessment, evaluate alternatives and recommend model for expansion (budget for needs assessment in strategy 7a)	
	Total Funds 2008	**$**
Jan – Dec 2009	• Development of expanded model • Contract amendment and/or RFP as needed; services begin • Training and technical assistance is provided	$1,000,000
	Total Funds 2009	**$1,000,000**
2010 and beyond	• Comprehensive continuum of	$1,000,000

	crisis interventions available to children and youth; • Ongoing training and technical assistance and quality improvement process.	
Ongoing Annual	**Total Funds**	**$1,000,000**

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

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

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

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

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

◊ *C. Partnership/Linkages*

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

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

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

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

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

Program evaluation and modifications as needed -- ongoing

◊ *B. Procurement of Providers*

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

◊ *C. Contracting of Services*

See overall timeline above.

◊ *D. Services Start Dates(s)*

To be determined through needs assessment and stakeholder planning process.

Target date range for service enhancements: September 2009-January 2010.

Strategy Title: Expand Family Treatment Court

Strategy No: 8a – Expand Family Treatment Court Services and Support to Parents

County Policy Goals Addressed:

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

1. Program/Service Description

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

With increasing frequency, children are placed in foster care because their parents are addicted to alcohol or drugs. Many children also are born to mothers who abused alcohol or drugs while pregnant. Equally concerning is the number of children in foster care whose families are torn apart by substance abuse who subsequently abuse alcohol or drugs themselves. Two hundred ninety (290) children, or 43% of the 675 annual dependency petitions filed in King County Superior Court (KCSC), are drug related.

Family Treatment Court (FTC) is a special program designed to ensure that children live in safe and drug free homes. This program is designed to serve individuals who have an abuse or neglect case against them with associated alcohol or substance abuse allegations. Over 50% of the families entering FTC are homeless and in need of transitional and/or permanent housing. Eighty-five percent are unemployed and the majority of female parent participants have been victims of domestic violence. The FTC program will help the parents recover from alcohol or substance abuse and work toward reuniting parents with their children.

◊ *B. Reason for Inclusion of the Strategy*

Keeping families whose lives have been devastated as a result of substance abuse together and/or encouraging early reunification is good for families and the community. The majority of children who enter foster care eventually return to their parents. However, in recent years an increasing number of children leave foster care only to re-enter the system at a later date as a result of parental substance abuse.

◊ *C. Service Components/Design*

FTC is organized around the ten key components that define a drug court: 1) integrated systems (child welfare, substance abuse treatment services and the court); 2) protection and assurance of legal rights, advocacy and confidentiality; 3) early identification and intervention; 4) access to comprehensive services and

individualized case planning; 5) frequent case monitoring and drug testing; 6) graduated responses and rewards; 7) increased judicial supervision; 8) deliberate program evaluation and monitoring; 9) a collaborative, non-adversarial, cross-trained team; and 10) partnerships with public agencies and community-based organizations.

◊ *D. Target Population*

FTC serves King County parents involved in the child welfare system who are identified as being chemically dependent and who have had their children removed due to their substance use.

◊ *E. Program Goals*

FTC's goals are: 1) to ensure that children have safe and permanent homes within permanency planning guidelines or sooner; 2) to ensure that families of color have outcomes from dependency cases similar to families not of color; 3) to ensure that parents are better able to care for themselves and their children and seek resources to do so; and 4) to reduce the societal cost of dependency cases involving parental chemical dependency.

◊ *F. Outputs/Outcomes*

45 new children will be served in the program, doubling the current capacity to a total of 90 children. Expected outcomes include a reduction in the use of substances and in juvenile justice system involvement.

2. Funding Resources Needed and Spending Plan

The continuation and expansion of Family Treatment Court will have an annual cost of $694,300.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Provide ongoing funding of existing services and start-up of program expansion (staff hiring and training)	$522,000
	Total Funds 2008	**$522,000**
Jan – Dec 2009	Continued start-up and program funding	$694,300
	Total Funds 2009	**$694,300**
2010 and onward	Ongoing Family Treatment Court costs	$694,300
Ongoing Annual	**Total Funds**	**$694,300**

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

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

Type of Provider:	Description:
Treatment Liaison (1.0 FTE)	• This position serves as a liaison between FTC and chemical dependency treatment agencies, monitors parent's progress and compliance, and provides therapeutic case coordination services to FTC families.
Recruitment Specialist (1.0 FTE)	• This position actively identifies and recruits new participants, provides orientation, conducts chemical dependency and mental health screenings, makes referrals to treatment agencies, serves as a liaison between the court and treatment agency and provides case coordination services to FTC parents.
Parent-to-Parent Coordinator (.5 FTE)	• Goal of the Parent-to Parent Program is to increase parental engagement in hearings and the dependency process by connecting parents newly involved in the dependency court process with parents who have successfully reunited with their children. Coordinator guides veteran parents in helping new parents, organizes the schedule for shelter care hearings and facilitates "Dependency 101" classes. Will coordinate with FTC Alumni veteran parents to attend court hearings, conduct Dependency 101 classes and identify potential FTC participants.
Wraparound Coordinator (***Contracted*** 1.0 FTE)	• Coordinates on-going wraparound meetings for families in FTC that include both natural and professional supports involved with the parents and/or children. Facilitates wraparound meetings and leads the team in the development of a unified care plan consisting of strengths, normalized needs, measurable goals, and assigned tasks to complete these goals across ten different life domains. Develops a Strength, Need, & Cultural Discovery with the parent to be used in the development & implementation of the care plan. Assists the team in developing family/professional partnerships.

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

Recruitment Specialist and Treatment Liaison positions will be recruited, hired and trained by KCSC 7/1/08 – 9/15/08. Increases in public defense, CASA Supervisor and AG time assigned to FTC will be developed by 12/31/08. The design and implementation of the parent-to-parent program will be conducted in collaboration with DSHS and MIDD Strategy #1f. Ongoing FTC team building and training activities will be conducted.

◊ *C. Partnership/Linkages*

Partnerships and linkages have already been developed with the Department of Children and Family Services, Children's' Administration, treatment providers and the court system. Linkages to the Wraparound initiative 6a will occur as well.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Phase:	Timeline:	Strategies:	Target # of children:
Build to current capacity levels	09/15/08 - 12/31/08	• Referral at 72-hour hearing to observe FTC by judicial officer (started 2/08) • Hire **Treatment Liaison** by 9/15/08	45
Phase I	09/15/08 - 12/31/08	• Hire/Contract for **Parent-to-Parent Program Coordinator** to start by January 2009 • Hire **Recruitment Specialist** by 9/15/08 • Contract for additional **Wraparound Coordinators** to meet the need of the existing participants so they are in place by January 2009	60
Phase II	01/01/09 - 06/30/09	• Implement Dependency 101/Parent-to-Parent Program • Contract for an additional **Wraparound Coordinator** so they are in place by July 2009 • Identify potential space needs	75
Phase III	06/30/09 - 12/31/09	• Identify remaining needs to move to full capacity	90

◊ *B. Procurement of Providers*

There is no current plan for procurement of services to accompany program expansion.

◊ *C. Contracting of Services*

Current FTC Wraparound Coordinator contract amended for continuation by 9/1/08. Additional Wraparound Coordinator positions to accommodate program expansion to be procured and contracted through MIDD Strategy 6a.

◊ *D. Services State Date(s)*

Services to clients will begin to increase September 2008.

Strategy Title: Programs Targeted for Youth

Strategy No: 9a – Expand Juvenile Drug Court

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.

1. Program/Service Description

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

The number of juveniles charged with drug-related crimes and referred for substance abuse services continues to increase. An estimated 80% of the 1300 youth annually placed on probation and who are assessed as moderate or high risk to reoffend are chemically dependent or substance abusers. An estimated 325, or 25% of these youth, are eligible for and could benefit from juvenile drug court services. There is currently insufficient capacity to increase the number of youth served annually in the King County Juvenile Drug Court (JDC) program. This strategy strengthens the program and increases the number of youth who have access to the JDC.

◊ *B. Reason for Inclusion of the Strategy*

JDC programs are effective at reducing recidivism and keeping youth engaged in the treatment process. Two outcome studies specific to the King County JDC have documented significant reductions in recidivism among program participants. Juvenile justice has increasingly become the service delivery point for adolescents with substance abuse and co-occurring problems who lack resources for other assistance. The JDC model provides improved, expanded, yet cost-effective adolescent substance abuse in a coordinated system of care. The model of care in King County challenges systemic inequities and facilitates dialogue among justice and treatment professionals, families, and the youth themselves. The implementation of evidence-based practices and the Reclaiming Futures Project have transformed disconnected laws, programs and professionals into an effective, efficient and successful community of responders, helping youth reclaim their lives while improving public health and public safety.

◊ *C. Service Components/Design*

JDC is organized around the ten key components that define a drug court:
1) integrated systems (substance abuse treatment services and the court);

2) protection and assurance of legal rights, advocacy and confidentiality; 3) early identification and intervention; 4) access to comprehensive services and individualized case planning; 5) frequent case monitoring and drug testing; 6) graduated responses and rewards; 7) increased judicial supervision; 8) deliberate program evaluation and monitoring; 9) a collaborative, non-adversarial, cross-trained team; and 10) partnerships with public agencies and community-based organizations.

◊ *D. Target Population*

JDC serves King County youth involved in the juvenile justice system who are identified as having substance abuse issues or are diagnosed as chemically dependent.

◊ *E. Program Goal*

Strengthen the JDC program and increase the number of youth who have access to the Juvenile Drug Court.

◊ *F. Outputs/Outcomes*

An additional 36 youth per year will be served and the current capacity will be maintained for a total capacity of 72 youth served annually.

Expected outcomes include: 1) Reduced substance abuse/dependence and delinquent activity among participants, 2) Improved coordination between the court and community agencies, 3) Increased familial involvement in youth's legal and treatment process, and 4) Increased protective factors and decreased risk factors among youth and their families. Long term outcomes include a reduction in recidivism and a decreased use of secure detention and/or state juvenile rehabilitation institutions.

2. Funding Resources Needed and Spending Plan

The expansion of JDC will have an annual cost of $588,000.

Dates	Activity	Funding
Sept – Dec 2008	Start-up (staff hiring and training)	$250,000
	Total Funds 2008	**$250,000**
Jan – Dec 2009	Phasing in ongoing services	$588,000
	Total Funds 2009	**$588,000**
2010 and onward	Ongoing program expansion costs	$588,000
Ongoing Annual	**Total Funds**	**$588,000**

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

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

Type of Provider:	Proposed additional FTE:	Proposed additional contracted positions:
Treatment Liaison	1.0	
Juvenile Drug Court JPC Case manager	2.0	
Public Defender	.25 FTE @ PDIII class	
Prosecutor (.25 FTE @ PDIII)	.25 FTE @ PDIII	
Contracted Mentor Program		3.0 FTE

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

Treatment liaison and case management positions will be recruited, hired and trained by KCSC 9/1/08 – 3/31/09. Public defense and prosecutor time assigned to JDC will also be increased during this same time period.

◊ *C. Partnership/Linkages*

Existing partnerships will continue to be fostered and developed between the substance abuse treatment provider community and the juvenile justice system. Linkages will also occur with MIDD strategy 6a.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Phase:	Timeline:	Strategies:	Target # of children:
Phase I – Build to capacity	08/15/08 –12/31/08	• Expand and implement eligibility criteria	36
Phase II	01/01/09 –12/31/09	• Continue expansion under revised criteria • Expand and provide earlier clinical screening and assessments (integrate short GAIN into risk assessment)	72
Phase III	Jan 2010 onward	• Sustained implementation	72

◊ *B. Procurement of Providers*

Dates:	Activity:
Sept 15 – Dec 2008	Amend existing contracts and add treatment capacity
Sept 15 – Dec 2008	Develop contact for mentoring services
January 2009	Phase in mentoring services
June 1, 2009	Fully operating programs

◊ *C. Contracting of Services*

The RFP for contracted mentor services will be issued and awarded 9/15 – 12/31/08 for service provision beginning 1/1/09.

◊ *D. Services Start Date(s)*

Services to clients will increase beginning in September 2008.

Jail and Hospital Diversion Programs 10a – 12d

Strategy Title: Pre-Booking Diversion Programs

Strategy No: 10a – Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff and Other First Responders

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.

1. Program/Service Description

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

In the police departments of cities in the United States with populations greater than 100,000, approximately 7% of all police contacts, both investigations and complaints, involve a person believed to have a mental illness.[19] It is a major challenge for police and other first responders to maintain the safety of everyone involved in these situations while also resolving the situation so they can move on to other calls and duties. Crisis Intervention Training (CIT) equips police and other first responders with the training needed to enable them to respond most effectively to individuals in crisis and to help these individuals access the most appropriate and least restrictive services while preserving public safety. The Seattle Police Department has had a successful, nationally recognized CIT program for a number of years, but this training has not been readily available to the other 25 police jurisdictions or to other first responders in King County.

◊ *B. Reason for Inclusion of the Strategy*

Research has shown CIT to be effective in improving community response to individuals with mental illness and chemical dependency, increasing the use of jail diversion options and reducing the number of people with mental illness going to jail, and reducing police officer injury rates.[20]

[19] Deane, Martha; Steadman, Henry J; Borum, Randy; Veysey, Bonita; Morrissey, Joseph P. "Emerging Partnerships Between Mental Health and Law Enforcement." *Psychiatric Services* Vol. 50, No. 1 January 1999: pp.99-101

[20] Reuland. Melissa and Cheney, Jason. Enhancing Success of Police-Based Diversion Programs for People with Mental Illness. Police Executive Research Forum. May 2005

◊ *C. Service Components/Design*

Provide 40-hour CIT training to police officers in any jurisdiction in King County who request full training. Provide one-day training for other officers and to other first responders.

◊ *D. Target Population*

Police officers (including officers working in public schools), firefighters, emergency medical technicians, ambulance drivers, and jail staff throughout King County. When space is available, other interested stakeholders who would benefit from the training, such as prosecuting attorneys and public defenders, may also be invited to participate.

◊ *E. Program Goal*

Increase the knowledge base and skill set of police and other emergency workers in responding to calls involving individuals who may be affected by mental illness and/or chemical dependency.

◊ *F. Outputs/Outcomes*

Provide full CIT to 480 police and other first responders per year and a brief, one day training to another 1200 first responders per year.

Training will result in increased safety for first responders and individuals in crisis and also increase the use of community resources resulting in decreased jail bookings and hospital emergency department admissions.

2. Funding Resources Needed and Spending Plan

The project needs $1.5 million per year to implement CIT throughout King County.

The spending plan is as follows:

Dates	Activity	Funding
Sept - Dec 2008	Start-up, which includes hiring 2 FTE staff. Funding pays for salary and benefits, overhead, office space, equipment and set-up. Classroom space is obtained	$ 50,000
	Total Funds 2008	**$ 50,000**
Jan – Dec 2009	King County Sheriff's Office (KCSO) staff, overhead, and office space	$ 220,000
	Training costs for 1,680 students, including training materials and classroom space	$1,280,000

	Total Funds 2009	$1,500,000
Ongoing Annual	Total Funds	$1,500,000

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

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

This strategy involves a single provider, the KSCO who will hire a 1.0 FTE Educator/Consultant II or III who will manage the program and a 1.0 FTE Administrative Specialist II who will provide administrative support. The KCSO will secure specialized training instructors as needed on a fee-for-service basis.

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

The KCSO has identified appropriate job classifications and can begin the hiring process as soon as funding is allocated.

Sept - Dec 2008 -- KCSO hires trained Educator/Consultant and Administrative Specialist staff. Specialized instructors are identified and secured as needed.

◊ *C. Partnership/Linkages*

King County MHCADSD will need to continue to maintain a significant partnership with the KCSO, which will be responsible for managing the crisis intervention training program for police officers and other first responders in King County. Other partners needed for a successful training program include the King County NAMI affiliates, all 26 law enforcement agencies in King County, tribal police, service providers, jails, and other first responder agencies.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

KCSO staff persons recruited and hired by November 1, 2008.

Program design and training curriculum will be substantially completed by December 1, 2008.

Specialized instructors and classroom space will be secured by December 31, 2008.

First trainings will be offered in January 2009.

◊ *B. Procurement of Providers*

Not applicable.

◊ *C. Contracting of Services*

Not applicable.

◊ *D. Services Start Date(s)*

Begin trainings in January 2009.

Strategy Title: Pre-Booking Diversion Programs

Strategy No: 10b – Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

Hospital emergency departments across King County are regularly overcrowded with individuals waiting for mental health or chemical dependency assessments and placement dispositions. In many cases, individuals who have been assessed as needing involuntary commitment have had to stay in emergency departments for up to three days waiting for admission to an involuntary inpatient unit. On any given day in jails throughout King County, an estimated 15 percent of inmates have a serious mental illness and 80 percent have substance abuse problems. Once in jail, individuals with mental illness stay much longer than inmates without mental illness, and the daily cost of serving them in the jail is much greater. Diverting individuals from the jail, when appropriate given the nature of the criminal offense and the potential risk to public safety, not only reduces costs for city and county governments, but also provides more appropriate and humane care.

◊ *B. Reason for Inclusion of the Strategy*

Creating a crisis diversion facility would give police options for diverting individuals who are in crisis due to mental illness and/or substance abuse from jails and hospital emergency departments. A crisis diversion facility, combined with mobile crisis teams and respite housing, would also link individuals in crisis with needed community services that would help keep individuals from constantly recycling through expensive emergency services.

◊ *C. Service Components/Design*

Establish a crisis diversion facility (CDF) where police and other first responders may refer/bring individuals in crisis for evaluation, crisis resolution and linkage to appropriate community-based care. Develop a mobile crisis team that can assist first responders in finding appropriate resources or transporting individuals to and from the diversion facility. Provide interim "respite" housing for homeless individuals ready to leave the CDF, but in need of temporary housing while permanent supported housing is being arranged. Includes data collection that will be linked to the high-utilizer database maintained by King County Mental Health, Chemical Abuse and Dependency Services Division.

◊ *D. Target Population*

Adults in crisis in the community who might otherwise be arrested for minor crimes and taken to jail or brought to a hospital emergency department. The exact criteria for diversion have not yet been established. Criteria will be established during a planning process involving community and criminal justice system stakeholders. Individuals who have been seen in emergency departments or at jail booking and who are ready for discharge, but still in crisis and in need of services, may also be eligible.

◊ *E. Program Goal*

Reduce admissions to jails, hospital emergency departments and psychiatric hospital units.

◊ *F. Outputs/Outcomes*

Estimated 3000-5000 admissions per year.
Outcomes will include linkages of individuals admitted to needed community treatment and housing, reduced admissions to emergency rooms, and reduced admissions to jails.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
April 2-3	Initial planning meeting with national consultants	$350
June-December 2008	Monthly planning meetings with stakeholders. Include visits to established successful diversion programs in other jurisdictions. Identify potential sites for diversion facility and strategy for securing site and building out facility. Determine strategy for crisis teams and respite/interim housing.	$ 10,000
	Total Funds 2008	**$10,350**
Jan – Mar 2009	Develop and issue Report For Proposal(s) (RFP). May consider one RFP for all services, or separate RFPs for each component of diversion strategy.	
March-October 2009	Phased-in selection of contractors, contracting, facility remodel, recruitment of staff, training, development of policies and procedures.	$4.5 million
November 1, 2009	Facility, crisis teams and crisis respite programs open for services	
	Total Funds 2009	**$ 4.5 million**
2010 and onward	Ongoing Crisis Diversion Program	$6.1 million
Ongoing Annual	**Total Funds**	**$6.1 million**

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

◊ *A. Number and type of Providers*

Still to be developed

May have one provider for all three components of strategy, or up to three providers providing separate but coordinated services

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

We have initiated a planning process that will continue through the remainder of 2008. The first meeting of the planning group was facilitated by consultants from the National GAINS Center and the Bexar County Jail Diversion Program, which was the recipient of the Gold Achievement Award from the American Psychiatric Association in the category of community-based programs. Partners in the ongoing planning process will include representatives from the criminal justice system (prosecuting attorneys, public defender, courts, jails, police), hospitals, community providers of mental health and chemical dependency services, housing providers, National Alliance on Mental Illness, Developmental Disabilities Division, Crisis Clinic, Department of Corrections, and King County Mental Health, Chemical Abuse and Dependency Services Division.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Monthly meeting of planning group:	May - December 2008
Develop and issue RFP(s)	January - March 2009
Phased-in selection of contractors, contracting, remodel, recruitment of staff, training, development of policies and procedures.	March - October 2009 facility
Open facility, begin crisis teams and open respite housing	November 2009

◊ *B. Procurement of Providers*

Exact timeline to be determined

◊ *C. Contracting of Services*

Exact timeline to be determined

◊ *D. Services Start Date(s)*

November 1, 2009

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

Strategy No: 11a – Increase Capacity for Jail Liaison Program

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

There are currently four jail liaisons working in King County and municipal jails, and in the Community Center for Alternative Programs (CCAP). These liaisons are now at full capacity, and an additional liaison is needed in order to expand this service to an additional jail population not currently being served. This strategy will expand the liaison service to the work release program so that these individuals will receive the community support services needed to meet their mental health and chemical dependency treatment needs and reduce the likelihood of their re-offending.

◊ *B. Reason for Inclusion of the Strategy*

Many individuals with mental illness and/or chemical dependency end up in jail due to behavior that is associated with their illness, and, once in jail, they stay longer than individuals charged with the same crime who do not have these illnesses. In many cases, entry into the criminal justice system could be avoided if people were provided with the appropriate community supports and services. Jail liaisons help link these individuals with appropriate community services and thereby reduce the length of stay in jails and increase the likelihood of successful community reintegration.

◊ *C. Service Components/Design*

The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) contracts with Sound Mental Health (SMH) to provide criminal justice liaison services. The goal of the liaisons is to directly connect adult defendants with the community services it will take to keep them from returning to jail.

Liaisons initially meet with adult defendants who are due to be released from jail within forty-five to ten business days, or who are court-ordered to CCAP, and assess what their needs will be upon release or discharge. They refer defendants directly to mental health treatment, co-occurring disorders programs, Reentry Case Management Services, Department of Social and Health Services (DSHS), Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) services, the Municipal Court Resource Center and Veterans Reintegration Services, among others. They also provide information on temporary housing, and dental and medical services in the community. Criminal Justice Liaisons work closely with Public Defenders and various probation and community corrections staff to negotiate release of inmates into treatment. As mental health professionals with specialties in co-occurring disorders, the Criminal Justice Liaisons are in a unique position to assist the large numbers of inmates with mental health concerns, as well as those with both mental health and chemical dependency disorders.

◊ *D. Target Population*

King County Work Education Release (WER) inmate-clients who are residents of King County or likely to be homeless within King County upon release from custody, and who are assessed as needing mental health services, chemical dependency treatment, other human services, or housing upon release.

◊ *E. Program Goals*

Expand criminal justice liaison services to WER inmates to enhance their access to mental health services, chemical dependency treatment, and co-occurring disorders programs in the community. Improve the likelihood that clients will be placed in housing (temporary or permanent) upon discharge from WER. Assist WER inmates in applying for DSHS benefits when they are within 45 days of discharge. Refer veterans to Veterans Reintegration Services.

◊ *F. Outputs/Outcomes*

- Total number of clients served per year: 360
- Outcomes will include increased referrals to and engagement with community-based treatment agencies, improved mental health status, reduced use of drugs and alcohol, and reduced jail recidivism.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept- December	SMH hires and trains 1 FTE liaison. Funding pays for salary and benefits, administrative overhead, office space, equipment.	$20,000
	Total Funds 2008	**$20,000**
Jan – Dec 2009	New FTE serves	$80,000
	Total Funds 2009	**$80,000**
Ongoing Annual	**Total Funds**	**$80,000**

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

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

This strategy involves a single provider, Sound Mental Health, since this is an expansion of a current service being provided by an agency that previously was selected in a competitive process. Specifically, the strategy will increase criminal justice liaison staffing by 1.0 FTE to be sited at the Work Education Release offices, administered by the King County Department of Adult and Juvenile Detention, Community Corrections Division. Current staffing consists of 4.0 FTE criminal justice liaisons located throughout King County. With the addition of the fifth liaison, staff will be sited at the following locations:

- CCAP (1.0 FTE funded by King County Current Expense)
- King County Correctional Facility (2.0 FTE funded by King County Current Expense)
- South and East King County municipal jails (1.0 FTE funded by State Jail Services Funds)
- Work Education Release (1.0 FTE to be funded by MIDD sales tax)

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

Sound Mental Health has already developed a complete job description, training requirements, and standard operating procedures for the criminal justice liaison position. Existing criminal justice liaison staff will provide orientation to the position. Technical assistance will be provided by King County MHCADSD/CJI staff.

◊ *C. Partnership/Linkages*

This strategy will involve a partnership with the King County Department of Adult & Juvenile Detention/Community Corrections Division (CCD) that operates WER. MHCADSD/CJI staff will work with CCD/WER managers to plan for locating the 1.0 FTE criminal justice liaison at WER upon approval. Planning will include the securing of necessary office space and equipment and outlining referral protocols between WER Case Workers and the criminal justice liaison assigned to WER.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

The agency will need to advertise and recruit to fill the additional Criminal Justice Liaison position. Expected timeline is 45 to 60 days after the Provider is notified. The candidate hired will need to successfully apply for jail clearance through the King County Department of Adult and Juvenile Detention. This application process typically takes about 30 days. Direct services will begin when the Criminal Justice Liaison has obtained jail clearance.

◊ *B. Procurement of Providers*

Since MHCADSD already contracts with Sound Mental Health to provide Criminal Justice Liaison services, as noted above, no RFP is required. King County will need to amend the Sound Mental Health contract to add funding for the additional position.

◊ *C. Contracting of Services*

See previous bullet.

◊ *D. Services Start Date(s)*

Services to consumers will begin November 1, 2008

Strategy Title: Expand Access to Diversion Options and Therapeutic Courts and Improve Jail Services provided to Individuals with Mental Illness and Chemical Dependency

Strategy No: 11b – Increase Services Available for New or Existing Mental Health Court Programs

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan, and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

The prevalence of people with mental illness in the criminal justice system is a nationwide problem. Estimates of the prevalence of people with mental illness in jails ranges from 5% to 16%, depending on the definition of mental illness that is used. On any given day in city jails throughout King County, an estimated 15% of inmates have serious mental illness. Once in jail, these individuals stay much longer than inmates with similar charges who are not mentally ill. Mental health court is an effective tool for engaging and keeping people with mental illness in community-based treatment. At the present time, access to mental health court is limited to just a few jurisdictions.

◊ *B. Reason for Inclusion of the Strategy*

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 bookings. Mental health court services are now limited to individuals in King County District Court, Seattle Municipal Court, and Auburn Municipal Court. Increasing access to mental health court could improve mental health outcomes for people in the criminal justice system and reduce the prevalence of people with mental illness in jails across King County.

◊ *C. Service Components/Design*

This strategy will enhance services and capacities at existing mental health courts or implement new mental health court programs to increase access to these programs

for eligible adult misdemeanants. Service enhancements may include the placement of a Mental Health Professional (called a "court monitor" or "court liaison") and a peer support specialist within the mental health court team. The mental health court program must have sufficient judicial, public defender and prosecutor staff to accommodate the increased or new court caseloads, along with sufficient probation staff to monitor eligible clients in terms of court compliance. Additionally, the mental health court program should arrange for necessary transports, including security, from jail to the court.

Treatment and other human service components may be included; for example, increased mental health and co-occurring disorder treatment capacity, housing resources and low-barrier access for direct referrals from the mental health court staff to community treatment providers may be considered. The capacity to serve both the population opting into the mental health court as well as those appearing before the court that are unable to opt-in because of their lack of legal competency may be included. However, most of the treatment and other human services provided in the community for mental health court participants, including case management, are expected to be covered by other resources including other strategies identified and funded under the MIDD.

◊ *D. Target Population*

Adult misdemeanants with serious mental illness who volunteer to participate in a mental health court program through an "opt-in" process. An important goal for this strategy is to provide access for participation from individuals in court jurisdictions in all parts of King County.

◊ *E. Program Goals*

1. Increase access to services for eligible misdemeanants at existing mental health courts or begin new mental health court programs in King County.
2. Expand access to mental health courts to municipalities within King County which would likely improve mental health treatment outcomes for adult misdemeanants.
3. Develop coordination between competency, civil commitment and the mental health court(s) to fill a much needed system gap and to benefit the respective client population through system advocacy and navigation, and direct (low-barrier) access to housing and treatment.
4. Increase the dedicated treatment capacity for the mental health court client to streamline the process of referral for services and to increase treatment retention for the chronic recidivists with on-going coordination between mental health court supervision/probation and the provider agency staff.

◊ *F. Outputs/Outcomes:*

1. Services provided to 250 new clients from throughout King County
2. Decreased length of stay in jail
3. Decrease in jail recidivism among participants

2. Funding Resources Needed and Spending Plan

This program needs $1,295,252 of MIDD funds per year to provide enhanced services and capacity at existing mental health courts or implement new mental health court programs to increase access to these programs for eligible adult misdemeanants in King County.

Dates	Activity	Funding
Sept – Dec 2008	Develop RFP in cooperation with King County Procurements	
	Total Funds 2008	
Jan – Mar 2009	Competitive Bidding Process, Selection of Provider, Contract Negotiations	
Mar – May 2009	Program startup and/or expansion and enhancement initiated in a court of limited jurisdiction; staff hired; subcontracts drafted and executed; data collection procedures established	$200,000
Jun – Dec 2009	Staff for new or expanded Mental Health Court Services (staffing to be proposed under RFP process), transportation, administration including data collection and reporting, and service components (services to be proposed under RFP process)	$750,000
	Total Funds 2009	**$950,000**
Ongoing Annual	**Total Funds**	**$1,295,252**

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

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

One or more courts of limited jurisdiction will be awarded funds to provide service enhancements for existing mental health courts or to implement new mental health court programs. The mental health court programs should include the placement of a 1.0 FTE court monitor/liaison and a 0.5 FTE peer support specialist within the mental health court team, with preference that either have expertise in the chemical dependency field. Both should have forensic experience and should assist clients whose underlying criminal case is dismissed as well as those who are eligible for mental health court and agree to opt in.

The mental health court must include sufficient judicial, public defender and prosecutor staffing to accommodate and serve the increased or new court caseloads, along with sufficient probation staff to monitor eligible clients in terms of

court compliance. Additionally, the mental health court program will arrange for defendant transports, where necessary, such as security and/ or corrections officers, from jail to the court.

The mental health court must have the capability and capacity to collect relevant data on defendants who opt in, as well as those appearing before the court that are unable to opt-in because of their lack of legal competency, and report aggregated and geocoded data to King County.

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

The staff resource and development plan will be addressed via a Request for Proposals (RFP) process. A required training program will incorporate and address *The Essential Elements of a Mental Health Court* as described in the following hyperlinked document:

(http://consensusproject.org/mhcp/essential.elements.pdf)

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between multiple jurisdictions to assure that mental health court programs and services are made available to eligible misdemeanants from throughout King County. Linkages are also needed with community mental health providers and with housing providers.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

An RFP will be developed by MHCADSD staff by December 31, 2008 for issuance to courts of limited jurisdiction in King County.

◊ *B. Procurement of Providers*

1. The RFP for a mental health court(s) will be released by January 5, 2009.
2. The response date will be February 20, 2009.
3. The award(s) for the accepted bid(s) will be made by March 16, 2009.

◊ *C. Contracting of Services*

MHCADSD will begin negotiating a contract with the successful bidder immediately after the selection process is completed.

◊ *C. Services Start Date(s)*

Enhanced or new mental health court program services will begin June 1, 2009.

Strategy Title: Expand Re-Entry Programs

Strategy No: 12a - Increase Community Re-entry from Jail Program Capacity

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

On any given day in the King County jail, an estimated 15 percent of inmates have a serious mental illness and 80 percent have substance abuse problems. Re-entry from jail or a court-ordered alternative for these populations is imperative to assure they follow through on their re-entry plans and get connected to treatment and other services in the community. King County Criminal Justice Initiatives data show that, without re-entry case management services, many offender-clients fail to connect to treatment and other services on their own – or drop out of services within a short timeframe.

◊ *B. Reason for Inclusion of the Strategy*

The Re-entry Case Management Services (RCMS) program is intended to provide intensive, short term case management to individuals with mental health and/or substance abuse problems who are close to release and in need of assistance to reintegrate back into the community in order to keep from re-offending and returning to jail. This intensive case management is the "hand off" from the staff working inside the jail or at the Community Center for Alternative Programs (i.e. Criminal Justice Liaisons) to have immediate day of release/discharge assistance in creating longer term linkages to outpatient treatment services, and support in navigating the complex funding, treatment, housing, and health care systems in the community.

The County recognizes that gainful employment and earning a livable wage is a necessity for successful reintegration into the community for those individuals who are employment ready. Employment and vocational services are necessary components of a comprehensive re-entry program but currently limited in the RCMS.

◊ *C. Service Components/Design*

RCMS is administered by Sound Mental Health via collaboration between the King County Department of Community & Human Services/Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and the King County Department of Adult & Juvenile Detention (DAJD)/Community Corrections Division (CCD). RCMS services, provided by re-entry case managers, are available to adult offenders exiting a King County Jail or CCD program, such as Work and Education Release (WER) or the Community Center for Alternative Programs (CCAP). Eligibility for RCMS includes individuals who have a mental health and/or substance abuse disorder and are within 45 days of release from a King County Jail or currently serving a sentence at WER or CCAP.

Re-entry Case Management consists of:

- Re-entry needs assessment
- Pre-release engagement consisting of a minimum of one face-to-face meeting
- Facilitation of application for public entitlements and other benefits
- Medication monitoring
- Linkage to mental health services and substance abuse treatment
- Assistance with basic needs
- Assistance with transportation (i.e., bus tickets)
- Assistance with physical health care resources
- Assistance with shelter and transitional housing resources
- Linkage to pre-vocational and employment services and resources

◊ *D. Target Population*

1. Adult inmates with mental illness and/or chemical dependency housed in the King County Correctional Facility (KCCF), Norm Maleng Regional Justice Center (RJC), or WER who are within 45 days of release and will not be transferred to prison or another county, assessed as needing treatment, and are not currently enrolled in outpatient treatment services.
2. Adult defendants and offenders with mental illness and/or chemical dependency who are court-ordered to CCAP or another CCD program, – and adult inmates who are within 45 days of release from KCCF, RJC, or WER – and assessed as being employment ready and/or amenable to participating in vocational/pre-employment services.

◊ *E. Program Goals*

1. Provide increased access to intensive, short term case management to individuals with mental health and/or chemical dependency disorders who are close to release and in need of assistance in reintegrating back into the community. Provide immediate assistance for more participants in accessing

publicly funded benefits (if eligible), housing, rental assistance, and outpatient treatment and other services in the community upon release.

2. Focused re-entry case management will be provided to individuals participating in jail-based vocational programs to secure successful linkage to community-based employment and vocational service providers. Additionally, individuals participating in a CCD alternative program who are in treatment and employment ready will be targeted for focused reentry case management and linked to employment and vocational services.
    a. Individuals will be initially linked with County funded resources including, but not limited to, the WorkSource system and King County Jobs Initiative (KCJI).
    b. Linkages would also be made with CCD's partner agencies for other employment and vocational services.

◊ *F. Outputs/Outcomes*

1. Three re-entry case managers will serve an additional 1,000 individuals per year
2. The re-entry employment liaison will serve 200 individuals per year
3. Increased treatment involvement and treatment completion
4. Increased housing stability
5. Reduced criminal justice involvement
6. Increased employment among program recipients

2. Funding Resources Needed and Spending Plan

$320,000 per year will provide four additional FTE to this program. This includes the cost per FTE as well as office space/equipment, a flexible fund account for participant incidentals, and administration.

1. $240,000 for three FTE re-entry case mangers will be earmarked for Target Population #1 (see Target Population section above). The contract related to Target Population #1 is managed by MHCADSD, which intends to amend its contract with Sound Mental Health to add capacity immediately upon allocation of funds.

Target Population #1 – Reentry Case Managers		
Dates	**Activity**	**Funding**
Sept 2008	Amend Sound Mental Health contract to add 3 FTE re-entry case managers plus flex funds	$80,000
	Total Funds 2008	**$80,000**
Jan – Dec 2009	3 FTE re-entry case managers plus flex funds	$240,000
	Total Funds 2009	**$240,000**
Ongoing Annual	**Total Funds**	**$240,000**

2. $80,000 for one FTE re-entry employment liaison plus administration will be earmarked for Target Population #2. The contract related to Target Population #2 is managed by DAJD/CCD, which will issue a new Request for Proposals (RFP).

Target Population #2 – Reentry Employment Liaison		
Dates	**Activity**	**Funding**
Sept – Nov 2008	Develop and issue RFP, competitive bidding process, selection of provider, contract negotiations	
December 2008	Start-up for selected provider to hire and train 1 FTE re-entry employment liaison	$6,000
Sept – Dec 2008	CCD Administration	$1,500
	Total Funds 2008	**$7,500**
Jan – Dec 2009	Funding pays for 1.0 FTE contracted salary and benefits, office space, and equipment.	$76,500
Jan – Dec 2009	CCD Administration	$3,500
	Total Funds 2009	**$80,000**
Ongoing Annual	**Total Funds**	**$80,000**

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

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

1. Target Population #1: The strategy currently involves a single provider, Sound Mental Health (SMH), and will increase RCMS staffing capacity for Target Population #1 by adding 3.0 FTE to the current 1.3 FTE Re-entry case managers. This increase allows staff to be sited both downtown near KCCF, WER and CCAP as well as in South King County near the RJC. The provider agency will assist with providing office space for the Re-entry Case Managers serving South and East King County.
2. Target Population #2: This strategy will involve a single provider who will be contracted by King County DAJD/CCD following a successful bid for services via a RFP process. The 1.0 FTE Re-entry Employment Liaison staff will be sited downtown near KCCF, WER and CCAP.

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

1. Target Population #1: SMH has developed a complete job description and classification, training requirements, and standard operating procedures for the Re-entry Case Manager position. The existing SMH Criminal Justice Liaison and Re-entry Services Program Manager and Re-entry Case Managers will provide orientation and training. Technical Assistance with be

provided by King County MHCADSD/Criminal Justice Initiative (CJI) Staff. Training includes, but is not limited to:

- Working with mentally ill and chemically dependent offenders
- Staff Safety
- Working knowledge of community-based resources throughout King County
- System navigation (State, County, City)
- Working with the criminal justice system (jails, courts, public defense, probation)

2. Target Population #2: The selected provider agency will develop a complete job description and classification, training requirements and standard operating procedures for the Re-entry Employment Liaison position, as approved by CCD. Technical Assistance will be provided by King County DAJD/CCD Administrator for Re-entry and Education Programs and Services. An orientation and training will be provided by the King County DAJD community programs staff at KCCF and RJC. Other training, including Gordon Graham's Breaking Barriers series and case management trainings available from KCJI, will be provided to increase the staff's knowledge of safety issues, employer/employment-related case management, and build effective strategies for working with populations with criminal history.

◊ *C. Partnership/Linkages*

This strategy involves cooperation and collaboration between the MHCADSD and CCD, which manage separate contracts for the services described in this strategy. MHCADSD intends to amend its existing contract with Sound Mental Health to expand services for Target Population #1 and add capacity. CCD intends to issue a Request for Proposal and award a contract with a community-based provider to provide employment and vocational focused services for Target Population #2. Other partnerships involved in increasing employment services include Worksource and the Division of Vocational Rehabilitation.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Target Population #1: Sound Mental Health will recruit and hire the additional 3.0 FTE staff to expand services for Target Population #1 and add capacity. At least 2.0 FTE will be sited in South King County. The expected timeline for this is 45 to 60 days after the provider is notified. Eligible candidates will need to be approved for jail clearance by the DAJD.
2. Target Population #2: Once funding is secured, CCD will develop and release a RFP. The expected timeline from development to contract award notification is three to four months. The 1.0 FTE staff will be recruited and hired within one month of award notification and execution of a contract. Eligible candidates must be approved for DAJD clearance to enter a King County jail. Direct services can be provided in the provider office and in the community only until such candidate

has obtained clearance, which takes approximately 30 days. Overall implementation is expected to take approximately six months.

◊ *B. Procurement of Providers*

MHCADSD currently contracts with Sound Mental Health for RCMS services. Since this is an expansion of an existing program, no RFP is required. King County contract staff will amend the existing SMH contract to add funding and positions dedicated to the program.

Procurement of a provider for Reentry Employment Liaison services will be completed no later than November 30, 2008.

◊ *C. Contracting of Services*

Target Population #1: See previous section pertaining to MHCADSD contract.

Target Population #2: CCD plans to contract for Reentry Employment Liaison services by January 1, 2009. If funds are available, the contract may begin December 2008 to include one month of start-up.

◊ *D. Services State Date(s)*

Target Population #1: October 1, 2008

Target Population #2: January 1, 2009

Strategy Title: Expand Re-entry Programs

Strategy No: 12b – Hospital Re-entry to the Community Respite Beds

County Policy Goal Addressed

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

Homeless people with mental illness and/or chemical dependency often stay in local hospitals longer than medically necessary due to the challenges hospitals face in finding placement options to meet the complex needs of these individuals. Current programs do not meet these needs. A recent survey conducted by four local hospitals over a six- week period identified 333 homeless people who needed housing upon discharge. These people spent a total of 244 days in the hospital due solely to the lack of a safe placement, representing an estimated annual cost of three million dollars. The existing Medical Respite Program, a collaborative project between Health Care for the Homeless Network (HCHN) and Harborview Medical Center's Pioneer Square Clinic, is at capacity and provides recuperation options for some types of patients, but is not able to serve those with more complex medical and behavioral health needs. In addition, the network of boarding and nursing homes is challenged to serve individuals with current substance abuse and/or mental illness.

◊ *B. Reason for Inclusion of the Strategy*

There is a pressing need for hospital beds, and particularly psychiatric beds, in King County. About one out of every four individuals detained under the mental illness involuntary commitment law has had to be held in emergency rooms and hospitals. These facilities are not licensed for involuntary treatment services due to unavailability of psychiatric in-patient beds. This practice, which is a national problem, is called "boarding". Freeing up capacity on psychiatric units by discharging individuals when they no longer require a hospital level of care would reduce the incidence of boarding, reduce hospital costs, and assist individuals in their recovery. Individuals with mental illness and/or chemical dependency, along with ongoing medical needs, also are often kept longer than necessary on inpatient medical units and in the emergency department. These individuals also need a new recuperative care resource, including medical and psychiatric monitoring and intensive case management, to help them re-enter the community and begin their recovery.

◊ *C. Service Components/Design*

The proposed service model being considered by the Respite Expansion/ Hospital Discharge Project planning group includes one or more facilities equipped to accept individuals being discharged from hospitals and staffed by health care professionals, mental health and chemical dependency professionals, and discharge planners. Services would include case management, medical (including medication) management, transportation to appointments and housing options, and the provision of basic needs (food, hygiene, laundry, etc.) while in the program. Case management will be focused on linking homeless people to more stable housing and ongoing medical and mental health care and substance abuse treatment.

◊ *D. Target Population*

Homeless persons with mental illness and/or chemical dependency who require short-term medical care upon discharge from hospitals.

◊ *E. Program Goal*

Develop expanded respite care options for homeless individuals with mental illness and/or chemical dependency being discharged from hospitals. Provide case management services to help these individuals access permanent supported housing, if needed.

◊ *F. Outputs/Outcomes*

Estimated 350-500 individuals served per year, depending on the final service model.

Reduce the length of hospital stay for the target population. This will reduce public costs for these individuals, free up capacity for those in need of a hospital level of care, and reduce the boarding of involuntarily detained individuals in emergency rooms and on medical units.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
April-Sept 2008	Continued planning under auspices of Medical Respite Expansion Project	
Sept-December 2008	Hire consultant/facilitator to complete planning	$20,000
	Total Funds 2008	**$20,000**
Jan–March 2009	Find facility and finalize design. (retain consultant)	$15,000
March-June 2009	RFP and contracting process	
June-Aug 2009	Start-up : Hire and train staff; buy	$85,000

	medical equipment, furniture, supplies, etc.	
Sept-Dec 2009	Services begin	$190,000
	Total Funds 2009	**$290,000**
Ongoing Annual	**Total Funds**	**$565,000**

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

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

To be determined

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

To be determined

◊ *C. Partnership/Linkages*

In June 2007, Public Health-Seattle and King County convened a workgroup to address the issues of recuperative care needs and hospital discharge of homeless patients and the need for a system-wide approach to developing and managing placement options. Participants in this workgroup have included representatives from Harborview, Swedish, University of Washington, and Virginia Mason Medical Centers; the Committee to End Homelessness in King County; King County Mental Health, Chemical Abuse and Dependency Services Division; Life Care Centers; Downtown Emergency Service Center; City of Seattle Human Services Department, King County Office of Management and Budget; and United Way. The planning group is continuing to meet, and this planning process includes potential use of the MIDD Sales Tax Funds for the component of the hospital discharge plan that would provide the critical mental health and chemical dependency services for the individuals in the respite program.

4. **Implementation/Timelines**

◊ *A. Project Planning and Overall Implementation Timeline*

Development of recommendations for model	Nov. 2007-June 2008
Develop agreements among stakeholders regarding financing, responsibilities, policies	July -December 2008
Find facility, complete specifics for plan	Sept.-Dec. 2008
RFP/contracting process	March –June 2009

◊ *B. Procurement of Providers*

RFP process (if needed under final plan) for mental health and chemical dependency services component of plan	March-June 2009

◊ *C. Contracting of Services*

Complete contracts	June 2009

◊ *D. Services Start Date(s)*

Hire and train staff	June-Aug 2009
Open for services	September 2009

Strategy Title: Expand Re-entry Programs

Strategy No: 12c – Increase Capacity for Harborview's Psychiatric Emergency Services to Link Individuals to Community-Based Services upon Discharge from the Emergency Room

County Policy Goals Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

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

This strategy was proposed during the original development of the Mental Illness and Drug Dependency Action Plan (MIDD) as a way of addressing the needs of individuals who are repeatedly admitted to Harborview Medical Center's Psychiatric Emergency Services (PES) and to the Emergency Department (ED) as a whole, due to substance abuse and/or mental illness. In 2007, there were over 6000 admissions to PES and over 80,000 to the entire ED. In 2006, there were 332 individuals identified as the highest utilizers of ED services. Of these 332 people, 62% were homeless, 49% were diagnosed with a mental illness and 74% were diagnosed as substance dependent. In addition, over 70% of these 332 individuals had a significant medical illness that required treatment in the Emergency Department. Without referral and linkage to housing and services, many will continue to return frequently in the future. Increasing visits of high utilizers contributes to PES and ED crowding, thus increasing the number of individuals with mental illness and chemical dependency who are directed to other hospital emergency departments across King County.

◊ *B. Reason for Inclusion of the Strategy*

Hospital emergency departments are increasingly experiencing difficulty in placing individuals who are frequent users of emergency services due to mental illness, homelessness and chemical dependency. Emergency rooms are a very expensive resource, and individuals, and the public, would be better served if community service alternatives were provided to reduce the use of emergency services.

◊ *C. Service Components/Design*

The final service design has not been determined at this time. There are a number of programs targeting homeless individuals who are high utilizers of emergency medical services and jails that are being developed in the next year, and it is critical that these efforts be well-coordinated in order to reduce duplication of effort and to achieve the most efficient and effective results. The High Utilizer Referral System is a major effort underway to serve homeless individuals who are frequently involved

with the criminal justice and hospital emergency systems. Funding is provided by the Veterans and Human Services Levy and the United Way Campaign to End Chronic Homelessness. The Service Improvement Plan being developed this year includes a redesign of the Emergency Services Patrol and Dutch Shisler Sobering Center, increased outreach and service engagement for individuals with chemical dependency and improved coordination among key stakeholders to identify high utilizers of criminal justice and emergency medical services in order to facilitate placement into dedicated supported housing. In addition, strategy 1b in the MIDD targets this same population and includes providing outreach and engagement for individuals being discharged to shelters from hospitals and jails.

We propose delaying the final determination of design for this strategy in order to coordinate with these other strategies in order to create a well-coordinated and efficient system for responding to the needs of individuals who are high utilizers of emergency department services and jails.

◊ *D. Target Population*

Adults who are frequent users of the Harborview Medical Center ED.

◊ *E. Program Goal*

Provide increased coordination with other initiatives and providers to link individuals who are high utilizers of Harborview ED with ongoing community supports and housing

◊ *F. Outputs/Outcomes*

Outputs will be determined once a final model is developed.
Expected outcomes include increased linkage of individuals to needed community treatment and housing and reduced use of emergency medical services.

2. Funding Resources Needed and Spending Plan

To be determined. The budget identified in the MIDD is $200,000 per year to pay for two full-time professional staff and one program assistant.

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

◊ *A. Number and type of Providers*

To be determined

◊ *B. Staff Resource Develop Plan and Timeline*

Still to be developed

Will depend on the model developed through the planning process

◊ *C. Partnership/Linkages*

Stakeholders include Harborview Medical Center, The Committee to End Homelessness, The Veterans and Human Services Levy Boards, United Way of King County, shelter providers, jails, and hospitals throughout King County, the King County Department of Community and Human Services, and Public Health –Seattle and King County.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

To be determined

◊ *B. Procurement of Providers*

To be determined

◊ *C. Contracting of Services*

To be determined

◊ *D. Services Start Date(s)*

To be determined

Strategy Title: Expand Re-entry Programs

Strategy No: 12d – Urinalysis Supervision for Community Center for Alternative Program Clients

County Policy Goal Addressed:

- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

The King County Community Center for Alternative Programs (CCAP) is an effective diversion resource for individuals who no longer need secure detention but who are required by a court to complete certain conditions for release, such as urinalyses. This strategy will increase the efficiency in operation of CCAP. Currently, community corrections staff conducts urinalyses on their clients to assure compliance with court requirements.

◊ *B. Reason for Inclusion of the Strategy*

It is more cost-efficient and clinically appropriate to have designated non-Community Corrections staff perform this service. In addition, the Community Corrections staffing patterns do not always assure that staff of the same gender as the client is available to complete the monitored urinalyses.

◊ *C. Service Components/Design (Brief)*

A contract with an independent agency for a Urinalysis Technician(s) to provide analyses for both female and male clients of CCAP will be developed. Urinalyses will be done for those who are ordered by the court to have one or more urine samples taken and analyzed each month. Monitored urinalyses samples will be taken on-site at the CCAP location (presently located in the Yesler Building in Seattle).

◊ *D. Target Population*

King County Community Center for Alternative Program clients who have been mandated by Superior Court or District Court to report to CCAP and participate in treatment

◊ *E. Program Goals*

An increase in the efficiency of the services offered at CCAP. Assure gender-specific staff is available for the collection of urine samples.

◊ *F. Outputs/Outcomes*

Increased number of urinalyses each month collected and a decrease in CCAP staff time dedicated to providing this service.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Sept- December	Plans for office space and equipment are finalized with Facilities by CCD. Funding pays for office space modifications and fixtures. Request for Proposal (RFP) developed, issued and rated and contract negotiated.	$20,000
	Total Funds 2008	**$20,000**
Jan – Dec 2009	New provider begins urinalyses on schedule determined by CCD.	$75,000
	Total Funds 2009	**$75,000**
Ongoing Annual	**Total Funds**	**$75,000**

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

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

A single provider of one FTE will be needed. Time and staffing will need to include both male and female Urinalysis Technicians.

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

Current staff resources at Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and Community Corrections Division (CCD) are adequate to develop the request for proposals and establish a timeline for the project.

◊ *C. Partnership/Linkages*

This strategy will involve a partnership with the King County Department of Adult & Juvenile Detention/Community Corrections Division (CCD) that operates CCAP. MHCADSD/CJI staff will work with CCD/CCAP managers to plan for locating space for monitoring and processing of urinalyses and developing a request for proposals upon approval. Planning will include the securing of necessary office space and equipment and outlining referral and processing protocols between CCAP Case Workers and the contracted provider.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Dates:	Activity:
Sept- December 2008	Plans for office space and equipment are finalized with Facilities by CCD. Funding pays for office space modifications and fixtures (portable fixtures will be considered as an option).
Sept- December 2008	RFP developed, issued and rated, and contract negotiated.
Jan – Dec 2009	Contract issued. New provider begins urinalyses on schedule determined by CCD.

◊ *B. Procurement of Providers*

Sept - November 2008 – RFP developed, issued and rated. and award selection/notification made.

◊ *C. Contracting of Services*

December 2008 - Contract negotiations completed.

◊ *D. Services Start Date(s)*

Services to clients will begin February 1, 2009.

Domestic Violence, Sexual Assault, and Expansion of Adult Drug Court
13a – 15a

Strategy Title: Mental Health Services for Domestic Violence Survivors with Associated Coordination and Training

Strategy No: #13a Domestic Violence/Mental Health Services and System Coordination

Policy Goal Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Individuals who experience ongoing abuse by an intimate partner ("survivors") are at increased risk for developing depression, post-traumatic stress disorder (PTSD), and other mental health problems. Analysis of research studies across multiple settings serving battered women, including hospital emergency rooms, and psychiatric settings, indicated that an average of 48% of women were experiencing depression and 64% were experiencing PTSD[21].

There are many access barriers to survivors of domestic violence (DV) who have mental health and substance abuse concerns. DV survivors experience unique safety concerns due to stalking, threats, physical violence, and ongoing emotional abuse by their abusive partners. Nationally and in King County, providers of mental health and substance abuse treatment services are often unfamiliar with the needs of DV survivors. Many providers of DV services are unfamiliar with screening for or responding to mental health and substance abuse issues. As a result of these and other barriers, DV survivors who need mental health services are often either not identified or are unable to receive services.

Community-based DV advocacy programs in King County currently provide a broad range of services to DV survivors, including safety planning, support, shelter and transitional housing, assistance with employment, etc. at confidential locations. These programs do not currently have the ability to assess for or respond to survivors' mental health concerns. Nationally and in King County, providers of mental health and substance abuse treatment services often do not have the ability to assess for or respond to the unique safety and support needs of DV survivors.

◊ *B. Reason for Inclusion of the Strategy*

Services described in this strategy will increase access to early intervention for mental health and substance abuse issues, and prevention of severe mental health and substance abuse issues for survivors of DV, throughout King County.

[21] *Domestic Violence, Mental Health and Trauma, Carole Warshaw and Holly Barnes, Domestic Violence and Mental Health Policy Initiative, April, 2003.*

As described above, many DV survivors who are experiencing or are at-risk for significant mental health and substance abuse problems can not access services. This can have a negative impact on their functioning, their safety, and their ability to leave abusive relationships. DV survivors from East African, Eastern European, South Asian and other immigrant and refugee communities, face the additional barrier of the lack of available culturally-appropriate mental health services.

The 2006 Safe and Bright Futures report and 2006 WA State Coalition Against Domestic Violence Fatality Review Project report recommend that mental health and substance abuse professionals and domestic violence programs: a) collaborate on cross-training in order to increase their ability to provide the appropriate range of services to domestic violence survivors who are suicidal or have other mental health concerns, and b) coordinate services and ensure systematic changes to agency policies, procedures and practices.

◊ *C. Service Components/Design*

Licensed mental health professionals (MHPs) with expertise in DV and substance abuse will be employed by community-based domestic violence victim advocacy programs around King County to provide assessment and mental health treatment to DV survivors. Treatment will include brief therapy, and mental health support, in group and/or individual sessions. MHPs will provide assessment and referrals to community mental health and substance abuse agencies for those DV survivors who need more intensive services. One of these MHPs will be housed at an agency serving immigrant and refugee survivors of DV. Mental health professionals will offer consultation to DV advocacy staff and staff of community mental health or substance abuse agencies. In addition, a Systems Coordinator/Trainer will be funded to coordinate ongoing cross training, policy development, and consultation on DV and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County.

◊ *D. Target Population*

- DV survivors who are experiencing mental health and substance abuse concerns will have access to early intervention services and prevention of severe mental health and substance abuse issues.
- Providers at sexual assault, mental health, substance abuse, and domestic violence agencies who work survivors of DV with mental health and substance abuse/substance abuse issues and participate in the coordination and cross training work of this program.

◊ *E. Program Goal*

Integrate mental health services within community-based domestic violence agencies, making them accessible to DV survivors. Improve screening, referral, coordination and collaboration between mental health, substance abuse, domestic violence and sexual assault service providers.

◊ *F. Outputs/**Proposed** Outcomes*

Total number of clients served per year: 175-200
Total numbers of counselors and advocates trained per year: 200

Expected outcomes for Domestic Violence survivors served

- Increased access to mental health and substance abuse treatment services for domestic violence survivors
- Culturally relevant mental health services provided to DV survivors from immigrant and refugee communities in their own language
- Decreased mental health concerns among DV survivors served
- Increased resiliency and coping skills among DV survivors served

Expected System Outcomes

- Consistent screening for DV among participating mental health and substance abuse agencies, and increased referrals to DV providers
- Consistent screening for mental health and substance abuse needs among DV agencies
- Improved ability of DV, sexual assault, mental health and substance abuse providers to serve individuals with DV and mental health issues

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
October-December, 2008	Funding for start-up, equipment, administrative costs	$31,000
January-December 2009	Funding for 3.5 MHPs and a.5 FTE systems coordinator/trainer, as well as interpreter services, to provide services and service coordination. (Funding includes administrative costs) Training is provided to DV, substance abuse, and mental health providers on screening protocols. Coordination efforts are put in place.	$310,000
2009	Total Funds	**$310,000**
Ongoing Annual	Total Funds	**$310,000**

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

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

Providers will provide regional access to services: Domestic Abuse Women's Network in South King County, Eastside Domestic Violence Program on the Eastside, and New Beginnings for Battered Women and their children in Seattle. The DV program at Refugee Women's Alliance (REWA), which serves 16 language communities, will house a mental health provider to serve refugee and immigrant survivors. The King County Coalition Against Domestic Violence will house the .5 FTE systems coordinator/trainer, as this community-based coalition has unique leadership with and access to all of the community-based DV agencies, as well with Community Sexual Assault Providers described in #14a in King County.

3 MHPs added to community-based DV agencies

.5 FTE MHP housed at culturally-specific provider of domestic violence and sexual assault advocacy services (linking with the .5 FTE in the Sexual Assault Services strategy 14a)

.5 Systems Coordinator/Trainer (linking with the .5 FTE in the Sexual Assault services strategy 14a).

Interpreters for service provision to immigrant and refugee survivors at REWA

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

Dates:	Activity:
October-December 2008	Start up (hire and train MHPs at DV agencies and hire systems coordinator)
January 2009	Staff at DV agencies work with staff at mental health agencies to develop protocols for service provision at DV agencies
February-March 2009	Protocol development and staff training continue.
March 2009	Services begin.
May-December 2009	Services continue Training is provided to DV, sexual assault, substance abuse, and mental health providers on screening protocols, coordination efforts in place

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between community based DV agencies, mental health and substance abuse treatment programs, and sexual assault agencies. Mental health professionals will consult with and refer to staff of the Domestic Violence Early Intervention/Prevention program described in strategy 13b. In addition, there will be linkages with the DV and Mental Health Collaboration funded by the Office on Violence Against Women through the City of Seattle.

Note: This strategy is linked with the sexual assault strategy, which will fund also fund an .5 FTE systems coordinator and trainer to providing systems coordination and training on sexual assault issues, and an .5 FTE MHP to serve immigrant and

refugee victims of sexual assault who are experiencing mental health and substance abuse concerns.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Staff identified and hired by January 31, 2009

Services to DV survivors begin March, 2009.

Systems coordination and training efforts begin March 2009.

◊ *B. Procurement of Providers*

The strategy is designed to be implemented within the DV provider community by agencies providing a full continuum of services, including emergency shelter, transitional housing and community-based advocacy programs. The County will contract with the three large regional providers of this service continuum, as well as with the Refugee Women's Alliance, which is uniquely positioned to serve survivors from refugee and immigrant communities. DV agencies offer services in confidential locations, and have a high level of statutory protection for client records and client communication (Relevant statutes are RCW 5.60.060 (8), 70.123.075, 70.123.076).

◊ *C. Contracting of Services:*

See above.

◊ *D. Services Start date(s)*

March 2009.

Strategy Title: Provide early intervention for Children Experiencing Domestic Violence and for Their Supportive Parent

Strategy No: #13b – Domestic Violence Early Intervention/Prevention

Policy Goal Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

Approximately 60,000 children in King County are exposed to domestic violence (DV) each year. In King County, there are a broad range of services available to adult victims and adult perpetrators of DV, as well as mental health services for adults and for children. However, there are no specialized counseling services in the King County region to help children recover from DV.

Children who experience DV are at great risk for becoming aggressive, antisocial, withdraw, or fearful and for having poor social skills. They often experience high levels of anxiety and depression and other symptoms of trauma. The strongest known risk factor for becoming a DV perpetrator is witnessing DV as a child. A study conducted in King County found that increased exposure to violence was associated with lower cognitive functioning and that exposed children were more likely to be suspended from school.

The Safe and Bright Futures project was a two-year federally-funded community planning project involving several community partners led by the Health Department and the Department of Judicial Administration. The project conducted a needs assessment and developed recommendations to improve regional responses to children affected by DV in King County. The priority recommendation of the plan was to develop and implement a Children's DV Response Team to provide direct services to children who experience DV.

A very small pilot project was begun in South King County 2007 through Sound Mental Health (Tukwila office), Domestic Abuse Women's Network, and the South King County YWCA. This pilot currently serves 10 families at a time. MIDD funds would allow for program expansion to families throughout South King County, where there is the greatest need for services.

◊ *B. Reason for Inclusion of the Strategy*

Currently there is no integrated mental health and DV advocacy service in King County to meet the unique needs of children who experience DV. Provision of these services will help to reduce the negative mental health impacts on children who

experience DV, strengthen the child's relationship with their supportive parent, and their linkages to other supportive people in their lives. In addition the project has potential to reduce the risks of future battering, victimization and associated behavioral problems among children served, thereby reducing the prevalence of DV in the community in the long-term.

◊ *C. Service Components/Design*

A team will provide mental health and advocacy services to children, ages 0-12 who have experienced DV, and support, advocacy and parent education to their non-violent parent. The team will consist of a children's mental health therapist, a children's DV advocate, and other team members as identified by the family (including supportive family members, case workers, teachers, etc.). Children will be assessed through a parent and child interview, and use of established screening tools. Children's treatment will include evidence-based Trauma Focused Cognitive Behavioral-Therapy, as well as Kids Club, a tested group therapy intervention for children experiencing DV. Children and families will be referred through the DV Protection Order Advocacy program, as well as through other partner agencies.

◊ *D. Target Population*

Children who have experienced DV and are identified by their parents, teachers and providers as needing services, and their supportive parents, who are residents of King County.

◊ *E. Program Goal*

Develop and maintain an evidence-based intervention for children who experience DV and their supportive parent.

◊ *F. Outputs/Outcomes*:

Team members will provide ongoing services annually to approximately 85 families with 150 children. Services will include one or more of the following: therapeutic intervention, service coordination and connection, and advocacy and support.

Projected outcomes to include:

- Decrease trauma symptoms exhibited by children.
- Reduce children's externalizing behaviors as observed in school, community, and family settings.
- Reduce children's internalizing behaviors.
- Increase protective/resiliency factors available to children and their supportive parents.
- Reduce children's negative beliefs related to the domestic violence, including that the violence is their fault, and/or that violence is an appropriate way to solve problems.
- Improve social and relationship skills so that children may access needed social supports in the future.

- Support and strengthen the relationship between children and their supportive parents.
- Increase supportive parents' understanding of the impact of domestic violence on their children, and ways to help.
- Increase the awareness of the impact of DV on children among other supportive adults in the children's natural environment so that they may support the family in positive change.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
September-December 2008	Start-up (Hire, train and orient staff), develop subcontracts and begin providing services	$70,000
	Total Funds 2008	$70,000
January-December 2009	Provide services to children and their supportive parent 1 FTE lead children's mental health clinician at Sound Mental Health 1 FTE children's DV advocate at DAWN 1 FTE children's DV advocate at the South King County YWCA	$200,000
Ongoing Annual	**Total Funds**	**$200,000**

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

◊ *A. Number and type of providers* (and where possible FTE capacity added via this strategy):

This strategy involves one provider and its two subcontractors who were involved in regional planning for this project, and in a small ongoing pilot to initiate services in 2007-2008: (Sound Mental Health, Domestic Abuse Women's Network (DAWN) and the South King County YWCA). One lead clinician will be added at Sound Mental Health. Two FTEs children's DV advocates will be added at the subcontractors.

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

A pilot team from these three agencies has already begun providing services to a small number of families in South King County. Program protocols were developed through a small start-up grant in 2007.

Dates:	Activity:
September- December 2008	Funding to Sound Mental Health and the two sub contractors. Hire and train program staff. Update and expand program protocols. Coordination with referral sources to generate additional referrals.
January 2009-December 2009	Services provided to children and families.

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between the three listed agencies, as well as the DV Protection Order Advocacy Program, schools, Child Protective Services, Safehavens Supervised Visitation Center at the Regional Justice Center, and other relevant agencies. Staff will consult with and refer to staff of the Mental Health Services for Domestic Violence Survivors program described in strategy 13b.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline:*

Staff identified, hired, and trained September-December 2008

Services begin January 1, 2009

◊ *B. Procurement of Providers*

MHCADSD already contracts with Sound Mental Health. A contract amendment would allow for funding of this program.

◊ *C. Contracting of Services*

See previous

◊ *D. Services Start date*

Services to children and families will begin January 1, 2009.

Strategy Title: Expand Access to Mental Health Services for Survivors of Sexual Assault

Strategy No: 14a-Sexual Assault Services

Policy Goal Addressed:

- Reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

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

One third of women in King County will have a sexual assault experience during their lifetime, based on the Washington State Prevalence Survey. Of these women, at least 30% will develop Post Traumatic Stress Disorder (PTSD), a trauma-specific diagnosis, or depression. These women will have higher rates of binge drinking and drug use than women who have not experienced sexual assault, as well as co-morbid depression and substance abuse disorders. In the study sample, 80% of the women's experiences had occurred by the age of 18. The prevalence study only included women, but men are sexually assaulted as well and have comparable rates of mental health conditions. Virtually all sexual assault victims are affected by their experiences and have at least some distressing mental health symptoms. There is effective treatment; however, victims frequently cannot access treatment for the following reasons:

- A significant number of victims do not have insurance and therefore have limited access to specialized mental health services. Some are experiencing impaired functioning but their symptoms are not severe enough to enable them to qualify for services at public mental health programs. Those victims who do not get access to timely treatment may deteriorate or develop maladaptive ways of coping such as abusing substances.
- Public mental health programs do not always have the specialized expertise to deliver the proven treatments combined with advocacy and support services. Their treatment focus is often on other urgent problems and needs for victims that do not include the impact of the victimization.
- For sexual assault victims from many immigrant and refugee communities, there are no cultural and sexual assault-specific mental health or substance abuse services available.

Washington State is a national leader in providing integrated services to sexual assault victims through Community Sexual Assault Programs (CSAPs). In 1995, recognizing the unique service needs of sexual assault victims, the Washington State Office of Crime Victim's Advocacy established the CSAP model to ensure that sexual assault victims would receive uniform, integrated services throughout the state. CSAPS must be accredited, and are required to meet specific service training requirements, participate in a common data collection system, provide legal and

medical advocacy, prevention education, case management, therapy or access to therapy, and a 24-hour response. In King County the accredited CSAP programs provide evidence-based cognitive-behavioral therapy integrated with the other sexual assault advocacy services described above. For example, a child victim who has been abused, is experiencing PTSD, and has to go to a trial as a witness, receives integrated legal and medical advocacy, therapy and support through a single program. The four Community Sexual Assault Programs (CSAPs) in King County have limited capacity and funding for treatment (for example, for every client accepted at the King County Sexual Assault Resource Center for mental health treatment, eight were turned away/ referred out).

◊ *B. Reason for Inclusion of the Strategy*

This strategy will increase access to early intervention services for mental health issues, and prevention of severe mental health issues for survivors of sexual assault throughout King County, and increase coordination between programs serving sexual assault survivors who are experiencing mental illness, substance abuse and domestic violence.

◊ *C. Service Components/Design*

Expand the capacity of Community Sexual Assault Programs (CSAPs) and culturally specific providers of sexual assault advocacy services to provide evidence-based mental health services to adult and child victims of sexual assault throughout King County. Increase access to services for women and children from immigrant and refugee communities by housing a mental health provider specializing in evidence-based trauma-focused therapy at an agency serving these communities. Develop consulting relationships between specialized providers of sexual assault services and community mental health agencies to ensure mental health treatment that addresses the specific trauma of sexual assault. A Systems Coordinator/Trainer will coordinate ongoing cross training, policy development, and consultation on sexual assault and related issues between mental health, substance abuse, sexual assault and DV agencies.

◊ *D. Target Population*

- Adult, child and youth survivors of sexual assault who are experiencing mental health and substance abuse concerns will have access to early intervention services and prevention of severe mental health issues.
- Providers at sexual assault, mental health, substance abuse, and domestic violence agencies who work survivors of DV with mental health and substance abuse issues and participate in the coordination and cross training work of this program.

◊ *E. Program Goal*

Increase access to evidence-based and culturally-appropriate services for adult and child victims of sexual assault with mental health and advocacy needs. Improve

screening, referral, coordination and collaboration between mental health, substance abuse, domestic violence and sexual assault service providers.

◊ *F. Outputs/ Outcomes*

Expected Outcomes for Sexual Assault survivors served:

- Therapy and case management services provided to 400 adult, youth and child victims of sexual assault.
- Increased access to services for adult, youth and child victims who currently do not have access to specialized sexual assault services.
- Reduction in trauma symptoms for adult, youth and child victims of sexual assault receiving services.
- Culturally relevant mental health services provided to sexual assault survivors from immigrant and refugee communities in their own language
- Increased resiliency and coping skills among sexual assault survivors served

Expected System Outcomes

- Increased coordination between public mental health programs and CSAPS to better serve sexual assault victims.
- Increased coordination between CSAPS and culturally specific providers of sexual assault advocacy services.
- Improved ability of sexual assault, domestic violence, mental health and substance abuse providers to serve individuals with DV and mental health issues.

2. Funding Resources Needed and Spending Plan

This program requires $500,000 of MIDD funds annually to expand the regional capacity to provide evidence-based trauma-focused therapy to adult, youth and child victims of sexual assault throughout King County.

Date	Activity	Funding
Sept 2008 October-Dec 2008	Providers identify, hire and train staff Begin service provision	**$110,000**
	Total Funds 2008	**$110,000**
Jan – Dec 2009	Service provision continues. Establish and maintain consultation between CSAPS and mental health providers. Provide annual training in evidence-based therapy for PTSD and depression in child, youth and adult sexual assault victims.	$500,000
	Total Funds 2009	**$500,000**
Ongoing Annual	**Total Funds**	**$500,000**

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

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

- 4 FTES added to CSAP agencies.
- .5 FTE added for Mental Health Provider housed at culturally-specific provider of sexual assault and domestic violence advocacy services (linking with the .5 FTE in the domestic violence proposal for the MIDD)
- .5 Systems Coordinator/Trainer (linking with the .5 FTE in the domestic violence services strategy 14a).
- Funds for interpreters for services to immigrant and refugee survivors

Providers will be the accredited CSAP agencies providing services throughout King County. The Refugee Women's Alliance will house a mental health provider to serve refugee and immigrant victims of sexual assault, as this program serves sexual assault survivors from 16 different language communities. The King County Coalition Against Domestic Violence will house the .5 FTE systems coordinator/trainer.

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

Dates:	Activity:
Oct-Dec 2008	• CSAPS begin service provision • Staff of CSAPS and culturally-specific provider collaborates to develop protocols for culturally specific provider to incorporate MHP onto staff.
Jan – Dec 2009 and ongoing	• CSAPS continue service provision. • MHP at culturally-specific provider agency begins service provision. • Coordination efforts begin. • CSAPS, mental health providers and culturally-specific providers establish consult group re service provision to sexual assault victims, and consult on complex cases. • Annual training for mental health providers in providing evidence-based therapy for PTSD and depression in child, youth and adult sexual assault victims.

◊ *C. Partnership/Linkages*

The CSAPs, public mental health agencies, and culturally specific providers of sexual assault advocacy services will work together to strengthen and maintain existing partnerships to improve the quality of mental health services available to victims of sexual assault. The project will partner with all member agencies of the King County Sexual Assault Coalition.

Note: This strategy is linked with the domestic violence strategy, which will also fund an .5 FTE systems coordinator and trainer to providing systems coordination and training on sexual assault issues, and an .5 FTE MHP to serve immigrant and refugee victims of sexual assault who are experiencing mental health concerns.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

1. Staff identified and hired by or before September 30, 2008
2. Services at CSAPS begin October 2008.
3. Services at Refugee Women's Alliance will begin January 2009
4. System coordination efforts begin January 2009.

◊ *B. Procurement of Providers*

The strategies are designed to be implemented within the Community Sexual Assault Provider agencies. The County will contract with the accredited CSAP programs, with the Refugee Women's Alliance, which is uniquely positioned to serve survivors from refugee and immigrant communities, and with the King County Coalition Against Domestic Violence (as described in #13a). CSAP programs have a high level of statutory protection for client records and client communication (Relevant statutes are RCW 5.60.060 (8), 70.123.075, 70.123.076).

C. Contracting of Services:

◊ *D. Services Start Date(s)*

October 2008

Strategy Title: Enhancement Services for King County Adult Drug Diversion Court

Strategy No: 15a –Drug Court: Expansion and Enhancement of Recovery Support Services

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

This strategy funds critical gaps in services to individuals in the King County Adult Drug Diversion Court. State funding that supports drug courts can only be used for Division of Alcohol and Substance Abuse approved chemical dependency treatment and transportation services. In order to succeed, drug court defendants need a broad range of recovery support services. The services must address not only the needs and circumstances of the general drug court population, such as lack of employment and housing, but also those needs endemic to specialized populations served by the program, such as young adults and women. Research is clear that providing additional recovery support services increases the likelihood of long term success and reduces recidivism in both substance use and criminal behavior. Proposed services include:

- Access to employment and training through dedicated linkage to MIDD strategy 2b.
- Housing case management services.
- Access to evidence-based treatment such as multisystemic therapy and wraparound services adapted for the young adult drug court population (ages 18 to 24)
- Access to increased evidence-based treatment for women with co-occurring disorders, substance abuse and other disorders related to trauma such as post-traumatic stress and borderline personality disorders.
- Access to suboxone treatment. A medication approved for the treatment of opiate dependence. Currently, opiate dependent clients receiving methadone must go to a limited number of outpatient clinics. Opiate dependent clients can receive suboxone instead of methadone and receive services in

traditional outpatient agencies. This change will provide more patients the opportunity to access treatment.

- Access to an educational program – *CHOICES*. Designed for adult offenders with learning disabilities and/or attention deficit disorders.

◊ *B.* Reason for Inclusion of the Strategy

The proposed services will increase the likelihood of long-term recovery for drug court participants, and decrease jail days, hospitalization and use of other crisis services. The specific strategies have been identified and prioritized for the following reasons:

- **Access to employment and training** - 65% of participants in King County Drug Court are unemployed.

- **Access to housing and housing support services** - 53 % of King County Drug Court participants have been homeless during the prior 6 months. An estimated 40% are homeless at the time that they opt-in to the program; an estimated 200 will be in need of housing or residing in subsidized housing at any one time. According to a 2004 report on drug courts and public policy, housing has been identified by most drug court programs as the most immediate and critical need presented by many participants. The report further notes that regardless of the quality of treatment and other services provided, a defendant who returns daily to a drug using environment will have little chance of overcoming his/her addiction.[22]

  Internal housing case management services are needed to assist participants with acquiring supportive recovery oriented housing that will be made available through MIDD and other funding sources. The housing case manager will provide linkage to necessary services and assist participants in overcoming obstacles to permanent housing such as lack of rental history, prior criminal and poor credit history.

- **Enhanced treatment for young adults - Access to evidence-based treatment and ancillary services for the young adult population (ages 18 to 24).** Drug Court participants in this age category would benefit from multi-systemic therapy, wraparound and other proven treatments currently reserved for youth under age 18. The services would be adapted and individualized for the 18 to 24 year old drug court population currently being served in a specialized age-appropriate program.

[22] *Drug Courts --Just the Beginning: Getting Other Areas of Public Policy in Sync.* Caroline S. Cooper, Research Professor. Justice Programs Office, School of Public Affairs, American University, Washington D.C. 2003-2004.

- **Enhanced and expanded treatment for women with co-occurring disorders undergoing treatment in a women's program.** Currently approximately 150 women are enrolled in drug court, 15% are enrolled in a specialized women's program at Harborview Addictions Program. Studies have shown that a majority of women involved in the criminal justice system suffer from trauma-related disorders and are in need of specialized services. Summary Observations from "Information Relevant to Female Participants in Drug Courts:" prepared by: Bureau of Justice Administration Drug Court Clearinghouse Project Date: February 10, 2007,reports that although significantly more males than females are enrolled in drug courts, many programs report that women participants appear to be more heavily involved with drugs and a drug "lifestyle"(including prostitution) by the time they become involved in the criminal court process than men; this situation necessarily bears on the likelihood of a woman's success in the program and the special needs they will likely present –

  Three of the most significant of which are:
  - The need for clean and sober housing
  - The need for support in dealing with negative relationships which likely keep many women in drugs (e.g., economic, domestic violence, etc.); and
  - The need to deal with the impact of physical and other abuse they have likely experienced. [23]

- **Access to the Adult CHOICES program for offenders with leaning disabilities and/or Attention Deficit Disorders.** King County District Court has referred offenders with learning disabilities and/or attention deficit disorders to the CHOICES program designed to address offenders' difficulties in social skills, anger management, decision making and problem solving since 1989. Graduates of the CHOICES program re-offend 49% less than individuals in the comparison group; the comparison group included people who were screened, received an intake interview and were seen as appropriate for the program but never enrolled or attended classes. These statistics have been consistent since 1988.[24]

  Researchers have found that compared to the general population, the offender population, especially those in corrections facilities needing special education include at least 50% of adult prisoners. [25]

[23] BUREAU OF JUSTICE ASSISTANCE (BJA) DRUG COURT CLEARINGHOUSE: FREQUENTLY ASKED QUESTIONS SERIES:
Information Relevant to Female Participants in Drug Courts:
Prepared By: BJA Drug Court Clearinghouse Project
Date: February 10, 2007.BJA
[24] Learning Disabilities Association of Washington: CHOICES Adult History and Overview July 7, 2007.
[25] Understanding the Complexities of Offenders' Special Learning Needs, Weisel, Laura, et. al from Winters, 1997; Mears and Aron, 2003).

Although, King County Drug Court defendants have not been screened for learning disabilities and attention deficit disorder to discern prevalence, a 1998 study of 512 King County Drug Court participants revealed that 31% did not have a high school degree or GED. [26]

◊ *C. Service Components/Design*

Expansion and enhancement of services for King County Drug Diversion Court participants, including, access to employment and training, access to evidence-based treatment for the young adult population (ages 18 to 24), housing case management services, and enhancement and expansion of services for women with co-occurring, substance abuse and trauma related conditions. The strategy also includes a plan to provide classes designed to attend to social and emotional difficulties posed by learning disabilities and attention deficit disorders.

◊ *D. Target Population*

King County Adult Drug Court participants

◊ *E. Program Goal*

Enhance and expand King County's Adult Drug Diversion Court's recovery support services.

◊ *F. Outputs/Outcomes*

450 individual participants will benefit from one or more of the proposed expanded services annually.

1. Reduce substance use and related criminal activity.
2. Provide resources and support to assist drug dependent offenders in the acquisition of skills necessary for the maintenance of sobriety.
3. Reduce the impact of drug related cases on criminal justice resources.

2. Funding Resources Needed and Spending Plan

Enhancement Services for King County Adult Drug Diversion Court will have an annual cost of $325,000.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Funding for 1.5 County FTE Housing Case Manager Position	$38,000
	Expansion of contract for young	$22,000

[26] King County Drug Court Evaluation, Final Report, M.M. Bell, Inc. February 27, 1998, p. 39.

	adult services, 1 FTE (salary, benefits, administrative overhead).	
	Expansion of contract by 1 FTE to allow expansion of women's group and enhancement of services for women with co-occurring disorders and trauma-related disorders.	$33,000
	Funding for suboxone for women in drug court women's group, to be added to existing contract.	$3000
	Contract with the Learning Disabilities Association of Washington to provide the Choices Adult Program to drug court participants.	$11,000
	Total Funds 2008	**$107,000**
Jan – Dec 2009	Funding for 1.5 County FTE Housing Case Manager Position	$115,000
	Expansion of contract for young adult services, 1 FTE (salary, benefits, administrative overhead).	$65,000
	Expansion of contract by 1 FTE to allow expansion of women's group and enhancement of services for women with co-occurring disorders and trauma-related disorders.	$100,000
	Funding for suboxone for women in drug court women's group, to be added to existing contract.	$10,000
	Contract with the Learning Disabilities Association of Washington to provide the Choices Adult Program to drug court participants.	$35,000
	Total Funds 2009	$325,000
2010 and onward	Ongoing program cost	$ 358,000
Ongoing Annual	**Total Funds**	**$358,000**

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

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

This strategy will provide funding for: 1.5 County FTE's, 2 contract FTEs through contracts with 2 separate treatment providers and 1 contract for delivery of services from a nonprofit organization, as follows:

- 1.5 County FTE housing case managers, internal to King County Adult Drug Court Program.
- Funding for 1 contract FTE for provision of evidence-based services to young adults (ages 18 to 24) in the adult drug court program will be added to a current contract.
- Funding for 1 contract FTE for expansion of women's group and enhancement of services for women with co-occurring disorders and trauma-related disorders, including suboxone, will be added to a current contract.
- Drug Court will enter into a contract with the Learning Disabilities Association of Washington the CHOICES program to treat 42 offenders. King County District Court and Community Correction Alternatives Program will inform the contract between Drug Court and the CHOICES Program

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

Dates:	Activity:
June – August 2008	Recruit for County Housing Case Management positions.
Sept – Dec 31, 2008	Hire housing case management positions
Sept – Dec 31, 2008	Add funds to existing contract for young adult services.
Sept – Dec 31, 2008	Add funds to existing contract for expansion of women's group and enhancement of services for women with co-occurring disorders and trauma-related disorders, including suboxone.
Sept – Dec 31, 2008	Contract with the Learning Disabilities Association of Washington Adult Choices Program
January 1, 2009	Fully operational programs

◊ *C. Partnership/Linkages*

King County Drug Court will continue to partner with King County Mental Health Chemical Abuse and Dependency Services, other criminal justice agencies, community treatment providers, residential facilities and housing programs.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

- Housing case manager positions will be recruited and in place September 2008.
- Amendments to an existing contract between the Department of Judicial Administration Drug Court Program and treatment providers for provision of evidence-based treatment services for young adults and expansion and enhancement of services for drug court women participants will be in place by September 2008.
- Contract with the Learning Disabilities Association of Washington Adult Choices Program will be in place in September 2008.

◊ *B. Procurement of Providers*

Not Applicable

◊ *C. Contracting of Services*

Amendment to an existing contract between the Department of Judicial Administration Drug Court Program and a treatment provider for provision of evidence-based treatment services for young adults will be in place by September 2008.

Amendment to an existing contract between the Department of Judicial Administration Drug Court Program and a treatment provider for provision of additional services for a drug court women's group will be in place by September 2008.

A contract between Department of Judicial Administration Drug Court Program and the Learning Disabilities Association of Washington will be in place by September 2008.

◊ *D. Services Start Date(s)*

September 2008

Housing Development
16a

Strategy Title: Increase Housing Available for Individuals with Mental Illness and/or Chemical Dependency

Strategy No: #16a – Housing Development

County Policy Goal(s) Addressed:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.
- Explicit linkage with, and furthering of, other council directed efforts including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness in King County, the Veterans and Human Services Levy Service Improvement Plan and the Recovery Plan for Mental Health Services.
- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

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

The 2007 One Night Count found a total of 2651 people without housing or shelter throughout King County. An additional estimated 6000 people were staying in shelters and transitional housing. It is likely, based on local and national estimates, that over half of the homeless population have either a serious mental illness, chemical dependency, or both. The Ten Year Plan to End Homelessness in King County calls for 9500 additional housing units by 2014: 4725 new and 4775 from existing stock. Production has not kept pace with goals due to the lack of funding to support production.

◊ *B. Reason for Inclusion of the Strategy*

- Homeless adults receiving outpatient mental health services are four times as likely to be incarcerated as those who have housing. In this same study, homeless clients stayed an average 22 days in jail, compared to an average of two days for similar clients who had housing.
- Supportive or affordable housing has been shown to be a cost-effective public investment for populations who are most at risk for criminal justice involvement, lowering corrections and jail expenditures and freeing up funds for other pubic safety investments. Additionally, providing affordable or supportive housing to people leaving correctional facilities is an effective means of reducing the chance of future incarceration.
- Local examples such as the Downtown Emergency Services Center 1811 Eastlake Project and the Plymouth housing group's Begin at Home Program have demonstrated large reductions in emergency medical visits as a result

of providing housing for homeless individuals with mental illness and chemical dependency.

◊ *C. Service Components/Design*

Funds will be used for four purposes:

- Provide funds to fill budget gaps for housing projects that have not acquired all of the necessary funding to complete their capital budget. Delays in securing capital results in significant start-up construction delays and possible cost overruns.
- Provide capital funding for new housing projects that might otherwise not be funded or that might be under funded due to lack of capital dollars.
- Provide funds for time limited rental subsidies for those individuals and/or housing projects waiting for subsidies from the Housing Authorities or other funders of operating costs.
- Provide funding for a revolving loan program for interim loans to affordable housing agencies for the acquisition of property that will be utilized for a housing project. Interim loans will have a low interest rate, will be available for application throughout the year and will not need to be paid back until all permanent financing for the project is acquired. The program will lower the costs of creating housing projects and will allow for the rapid acquisition of sites.

◊ *D. Target Population*

Housing units funded through this strategy will be dedicated for the use of individuals with mental illness and/or chemical dependency who are homeless or being discharged from hospitals, jails, prisons, crisis diversion facilities, or residential chemical dependency treatment.

◊ *E. Program Goals*

Increase the availability of housing specifically reserved for individuals with mental illness and/or chemical dependency.

◊ *F. Outputs/Outcomes*

The number of units to be developed or made available through rental subsidies is yet to be determined, and will depend on the amount of funding allocated for this strategy and the specific proposals received from housing providers. Outcomes will include a reduction in homelessness among the target population and an associated reduction in the use of jails and emergency medical services.

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
June-July 2008	Notice of funding availability and announcement of priorities	
September 2008	Transfer of funds to the Housing and Community Development Program; housing applications received	
December 2008	Funding award decisions finalized	$18,000,000
	Total Funds 2008	**$18,000,000**
Ongoing annual	**Total Funds**	**To be determined**

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

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

Mental health treatment providers, chemical dependency treatment providers, and affordable housing providers that serve the target population

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

Not needed.

◊ *C. Partnership/Linkages*

Funds for new housing projects, a loan program and for gap funding would be made available to the King County Housing and Community Development Program (HCD) within the Department of Community and Human Services (DCHS) and included in their 2008 Funding Round. This will enable funds to be managed without creating a new administrative structure.

Rental subsidies would be made available to mental health and chemical dependency treatment providers serving homeless adults and youth.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Identify partially funded housing projects that have gap funding needs by May 8, 2008.

Announce the (contingent) availability of the new capital funds in May, 2008.

Conduct budget gap negotiations with agencies that have partially funded projects, to be completed by June 3, 2008.

Secure DCHS approval for amendments to partially funded projects by September 1, 2008.

◊ *B. Procurement of Providers for new housing projects*

HCD announces availability of MIDD funding in the fall 2008 funding round by the end of June, 2008.

Pre-applications received and pre-app meetings with applicants completed by June 30, 2008.

Project applications received the first week in September 2008.

Final award decisions made by December 15, 2008.

◊ *C. Contracting of Services*

For "budget gap" projects where MIDD provides the last needed capital, HCD will complete contracts as expeditiously as possible, not later than December 1, 2008. For new projects partially funded with MIDD capital, contracting will depend on agencies securing all other sources of public and private capital needed. It is anticipated that projects that are successful in other competitive funding rounds may be under contract and beginning construction by December, 2009.

◊ *D. Services Start Date(s)*

Variable, depending on status of each proposal.

Appendices
A-E

Appendix A
Mental Illness and Drug Dependency Oversight Committee

Bill Block, Project Director
Committee to End Homelessness in King County
Representing: the Committee to End Homelessness in King County

Linda Brown, Member
King County Alcohol and Substance Abuse Administrative Board
Representing: the King County Alcohol and Substance Abuse Administrative Board

Will Callicoat, Director, Financial Policy
Washington State Hospital Association
Representing: the Washington State Hospital Association/King County Hospitals

Nancy Cole, Executive Director
National Alliance on Mental Illness-Greater Seattle
Representing: the National Alliance on Mental Illness in King County

Merril Cousin, Executive Director
King County Coalition Against Domestic Violence
Representing: domestic violence prevention services in King County

Bob Ferguson, Councilmember
King County Council
Representing: the King County Council

David Fleming, Director and Health Officer
Public Health – Seattle & King County
Representing: Public Health

Helen Halpert, Assistant Presiding Judge
King County Superior Court
Representing: Superior Court

Shirley Havenga, Chief Executive Officerf
Community Psychiatric Clinic
Representing: a provider of both mental health and chemical dependency services in King County

Mike Heinisch, Executive Director
Kent Youth and Family Services
Representing: an agency providing mental health and chemical dependency services to youth in King County

David Hocraffer, Director
Office of Public Defense
Representing: the Office of Public Defense

Reed Holtgeerts, Director
King County Department of Adult and Juvenile Detention
Representing: Adult and Juvenile Detention

Darcy Jaffe, Interim Assistant Administrator
Ambulatory & Allied Care Services
Harborview Medical Center
Representing: Harborview Hospital

Norman Johnson, Executive Director
Therapeutic Health Services
Representing: A provider of culturally specific chemical dependency services in King County

Bruce Knutson, Director
Juvenile Court, King County Superior Court
Representing: the King County Systems Integration Initiative

Pete Lewis, Mayor
City of Auburn
Representing: the Suburban Cities Association

Barbara Linde, Presiding Judge
King County District Court
Representing: District Court

Marilyn Littlejohn, Executive Manager, Human Services
City of Seattle, Mayor's Senior Staff
Representing: the City of Seattle

Jackie MacLean, Director
King County Department of Community and Human Services
Representing: the Department of Community and Human Services

Donald Madsen, Director
Associated Counsel for the Accused
Representing: a public defense agency in King County

Barbara Miner, Director
King County Department of Judicial Administration
Representing: Department of Judicial Administration

Phil Noble, Councilmember
City of Bellevue
Representing: the City of Bellevue

Kurt Ofsthus, Discharge Planner
NAVOS Inpatient Services
Representing: labor, representing a *bona fide* labor organization

Mario Paredes, Executive Director

Consejo Counseling and Referral Service
Representing: a provider of culturally-specific mental health services in King County

Susan Rahr, Sheriff
King County Sheriff's Office
Representing: the Sheriff's Office

Dan Satterberg, Prosecutor
King County Prosecuting Attorney's Office
Representing: the Prosecuting Attorney's Office

Mary Ellen Stone, Director
King County Sexual Assault Resource Center
Representing: a provider of sexual assault victim services in King County

Crystal Tetrick, Associate Director for Health Care Operations
Seattle Indian Health Board
Representing: the Council of Community Clinics

Eugene Wan, Member
King County Mental Health Advisory Board
Representing: the King County Mental Health Advisory Board

Sheryl Whitney, Assistant County Executive
Office of the King County Executive
Representing: the Executive

Appendix B
Strategy Implementation Process

Strategy Number and Description		Service Category		Age Category			Existing or New Service / Provider			RFP/ RFQ Needed	Services Start	
		MH=Mental Health	SA=Substance Abuse	Y=Youth/ Parents	A=Adult	OA=Older Adult	Exist-ing	New	Both		September 15, 2008 Or Upon Spending Authorization Approval by Council	Other Start Date
1a-1	Increase access to community mental health treatment	MH		Y	A	OA	X				X	
1a-2	Increase access to community substance abuse treatment		SA	Y	A	OA	X				X	
1b	Outreach and engagement to individuals leaving hospitals, jails, or crisis facilities	MH	SA	Y	A	OA		X		X		To be determined
1c	Emergency room substance abuse early intervention program*		SA	Y	A	OA			X	X So KC Provider	X Harborview	Jan-1-09 South KC Provider
1d	Mental health crisis next day appointments and stabilization services	MH		Y	A	OA	X				X	
1e	Chemical dependency professional education and training		SA				X				X	
1f	Peer support and parent partner family assistance	MH	SA	Y				X		X		Jul-1-09
1g	Prevention and early intervention mental health and substance abuse services for older adults	MH	SA		A	OA	X					Nov-1-08
1h	Expand availability of crisis intervention and linkage to on-going services for older adults	MH	SA			OA	X					Dec-1-08
2a	Caseload reduction for mental health	MH		Y	A	OA	X				X	

	(use $3 million MIDD to leverage additional $3 million federal)											
2b	Employment services for individuals with mental illness and chemical dependency	MH	SA		A	OA			X	X SA		Nov-1-08
3a	Supportive services for housing projects	MH	SA		A	OA		X		X		Nov-1-08
4a	Comprehensive chemical dependency outpatient services for parents in recovery		SA		A	OA		X		X		Jun-1-09
4b	Prevention services to children of substance abusers		SA	Y				X		X		Apr-1-09
4c	School district based mental health and substance abuse services	MH	SA	Y				X		X		Sep-8-09
4d	School based suicide prevention	MH	SA	Y			X					Oct-1-08
5a	Increase capacity for social and psychological assessments for juvenile justice youth	MH	SA	Y					X	X Assess Profess.	X CDP/MH Liaison	Jan-1-09 Assessment Professional
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	MH		Y				X		X		Sep-1-09
7a	Reception centers for youth in crisis	MH	SA	Y				X		X		To be determined
7b	Expanded crisis outreach and stabilization services for children and youth	MH		Y					X?	X?		Sep-1-09
8a	Expand family treatment court services and support to parents		SA	Y	A		X				X	
9a	Expand juvenile drug court treatment		SA	Y					X	X	X	Jan-1-09
10a	Crisis intervention training program	MH	SA	Y	A	OA	KSO					Jan-1-09
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	MH	SA		A	OA		X		X		Nov-1-09
11a	Increase capacity for jail liaison program	MH			A	OA	X					Nov-1-08

11b	Increase services available for new or existing mental health court programs	MH			A	OA		X		X		Jun-1-09
12a	Increase jail re-entry program capacity	MH	SA		A	OA			X	X Pop #2	X Pop #1	Jan-1-09 Pop #2
12b	Hospital re-entry respite beds	MH	SA		A	OA		X		X		Sep-1-09
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community-based services upon discharge from Emergency Room*	MH	SA	Y	A	OA	To be determined					To be determined
12d	Urinalysis supervision for Community Center for Alternative Programs clients		SA		A	OA		X		X		Feb-1-09
13a	Domestic violence and mental health services	MH		Y	A	OA	To be determined					Mar-1-09
13b	Domestic violence prevention	MH	SA		A	OA	X					Jan-1-09
14a	Sexual assault and mental health and chemical dependency services	MH	SA	Y	A	OA	X					Oct-1-09
15a	Expansion of Recovery Support Services		SA		A	OA	X				X	
16a	New housing units and rental subsidies	MH	SA		A	OA			X	X		Variable
35	Total	26	27	20	24	24	14	12	7	19	11	28

*Services not countywide (1c – Harborview and South King County, 12c – Harborview)

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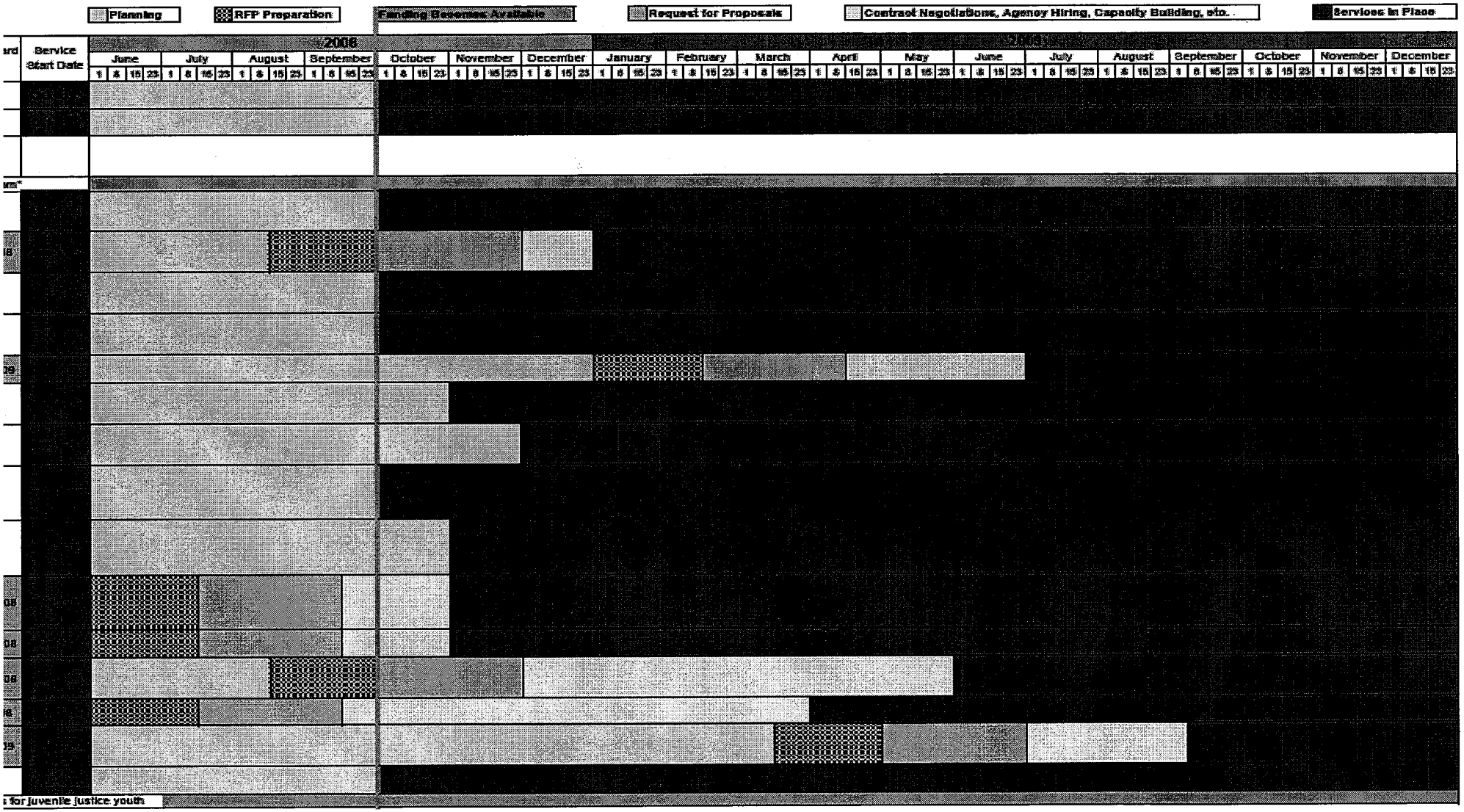
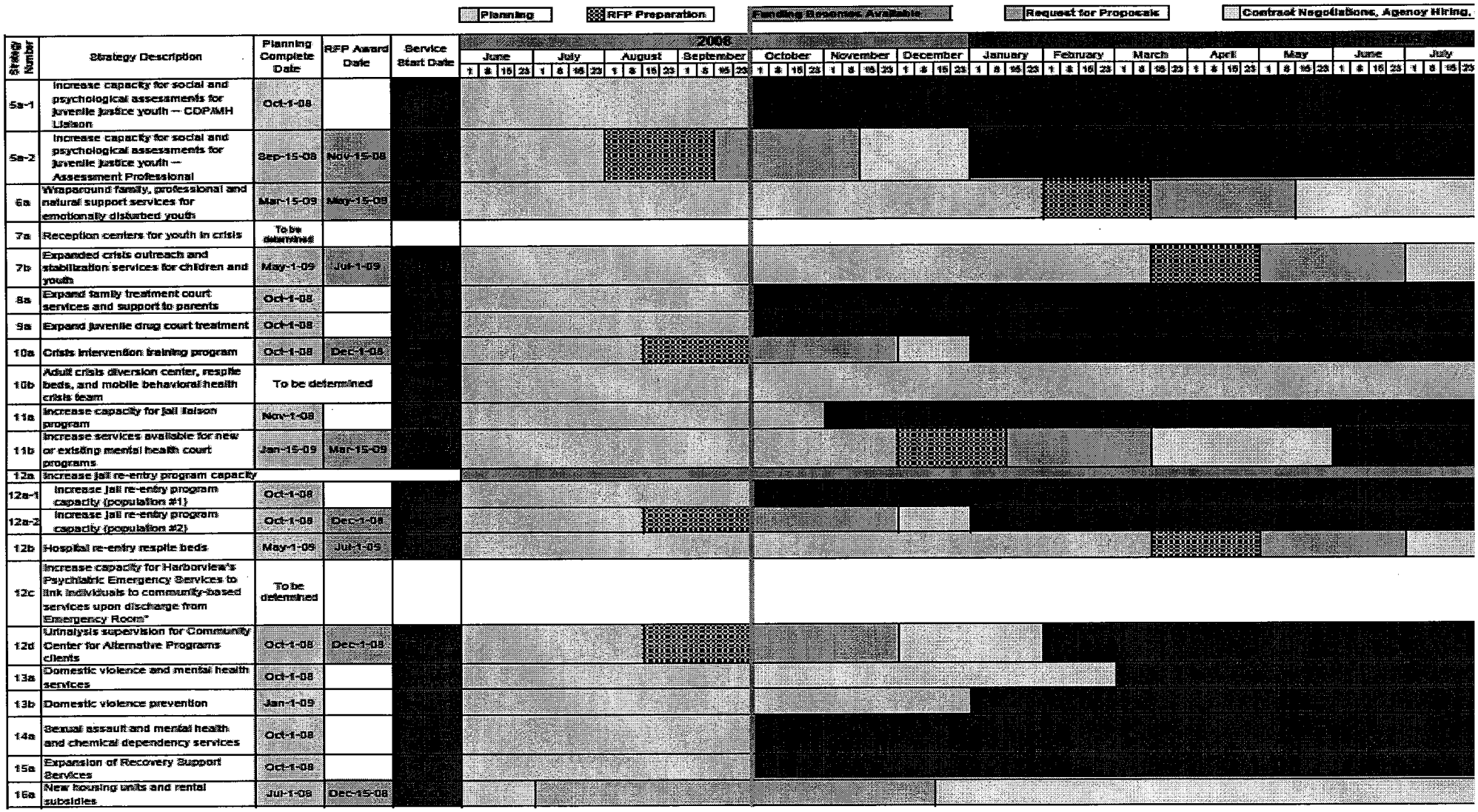
Implementation Timeline MIDD Strategies
Appendix C



King County

Mental Illness and Drug Dependency Action Plan

Implementation Timeline MIDD Strategies
Appendix C



Strategy Number	Strategy Description	Planning Complete Date	RFP Award Date	Service Start Date
5a-1	Increase capacity for social and psychological assessments for juvenile justice youth — CDP/MH Liaison	Oct-1-08		
5a-2	Increase capacity for social and psychological assessments for juvenile justice youth — Assessment Professional	Sep-15-08	Nov-15-08	
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	Mar-15-09	May-15-09	
7a	Reception centers for youth in crisis	To be determined		
7b	Expanded crisis outreach and stabilization services for children and youth	May-1-09	Jul-1-09	
8a	Expand family treatment court services and support to parents	Oct-1-08		
9a	Expand juvenile drug court treatment	Oct-1-08		
10a	Crisis intervention training program	Oct-1-08	Dec-1-08	
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	To be determined		
11a	Increase capacity for jail liaison program	Nov-1-08		
11b	Increase services available for new or existing mental health court programs	Jan-15-09	Mar-15-09	
12a	Increase jail re-entry program capacity			
12a-1	Increase jail re-entry program capacity (population #1)	Oct-1-08		
12a-2	Increase jail re-entry program capacity (population #2)	Oct-1-08	Dec-1-08	
12b	Hospital re-entry respite beds	May-1-09	Jul-1-09	
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community-based services upon discharge from Emergency Room*	To be determined		
12d	Urinalysis supervision for Community Center for Alternative Programs clients	Oct-1-08	Dec-1-08	
13a	Domestic violence and mental health services	Oct-1-08		
13b	Domestic violence prevention	Jan-1-09		
14a	Sexual assault and mental health and chemical dependency services	Oct-1-08		
15a	Expansion of Recovery Support Services	Oct-1-08		
16a	New housing units and rental subsidies	Jul-1-09	Dec-15-08	

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Appendix D
Spending Plan

Strategy Number and Description	Original 2008 Budget Proposal	2008 Revised Budget Proposal		
		Development & Start-Up	Ongoing Services	2008 Total
community mental health treatment	$ 8,357,419		$ 2,130,000	$ 2,130,000
community substance abuse treatment			635,806	635,806
gement to individuals leaving hospitals, jails, or crisis facilities	181,740			0
bstance abuse early intervention program	265,500		120,000	120,000
next day appointments and stabilization services	83,333		73,000	73,000
cy professional education and training	205,225		160,000	160,000
rent partner family assistance	150,000	75,000		75,000
/ intervention mental health and substance abuse services for older	166,677	150,000		150,000
f crisis intervention and linkage to on-going services for older adults	117,250	87,500		87,500
for mental health (use $1 million MIDD to leverage additional	1,333,333		1,750,000	1,750,000
s for individuals with mental illness and chemical dependency	500,217	350,000		350,000
for housing projects	666,640		2,000,000	2,000,000
participating in substance abuse outpatient treatment programs	166,429			0
to children of substance abusers	300,000			0

4c	School district based mental health and substance abuse services	411,450		
4d	School based suicide prevention	66,000	75,000	
5a	Increase capacity for social and psychological assessments for juvenile justice youth	119,147	60,000	
6a	Wraparound family, professional and natural support services for emotionally disturbed youth	1,563,928	175,000	
7a	Reception centers for youth in crisis	165,600	75,000	
7b	Expanded crisis outreach and stabilization services for children and youth	750,000		
8a	Expand family treatment court services and support to parents	521,045		
9a	Expand juvenile drug court treatment	33,763	250,000	
10a	Crisis intervention training program	846,878	50,000	
10b	Adult crisis diversion center, respite beds, and mobile behavioral health crisis team	1,515,965	10,350	
11a	Increase capacity for jail liaison program	60,000	20,000	
11b	Increase services available for new or existing mental health court programs	368,330		
12a	Increase jail re-entry program capacity	240,000	7,500	
12b	Hospital re-entry respite beds	186,450	20,000	
12c	Increase capacity for Harborview's Psychiatric Emergency Services to link individuals to community-based services upon discharge from Emergency Room	150,000		
12d	Urinalysis supervision for Community Center for Alternative Programs clients	56,250	20,000	
13a	Domestic violence and mental health services		31,000	

/ Action Plan

revention		70,000		70,000
nental health and chemical dependency services		110,000		110,000
on of Recovery Support Services			107,000	107,000
)n Fund	2,000,000		2,000,000	2,000,000
			500,000	500,000
luation / Data Systems	2,663,036		900,000	900,000
	$ 24,211,605	**$ 1,636,350**	**$ 10,977,806**	**$ 12,614,156**
	$ 28,096,730			**$ 32,415,000**
and New Strategy Reserve			19,800,844	19,800,844
and rental subsidies - See **Note 1**			18,000,844	18,000,844
ve			2,500,000	2,500,000

49 of the $18,000,000 allocated to Housing can be spent in 2008 unless a supplemental appropriation is requested.

Appendix E
Decision Model Determining the Need for Requests for Proposals/Competitive Procurement

Principles of Purchasing

King County will apply principles that promote effectiveness, accountability and social justice.

Ethical Behavior and Conduct

The objectives of ethical behavior and conduct are to insure that in its procurement activities, the County will:

- Behave with impartiality, fairness, independence, openness, integrity and professionalism in its dealings with suppliers
- Advance the interests of the County in all transactions with suppliers.

Open and Effective Competition

The objectives of open and effective competition are:

- To instill confidence in the County and the public about the integrity and cost effectiveness of public sector procurement
- To maximize the most economically beneficial outcome for the County
- To ensure that all suppliers wishing to conduct business with the County are given a reasonable opportunity to do so
- To ensure that bid documents and contracts reflect the requirements and desired outcome of the County and that all participants are subject to equivalent terms, conditions and requirements.

Open and Effective Competition means:

- Procurement procedures and processes are visible to the County, suppliers, and the public
- Suppliers have a real opportunity to do business with the County
- Competition is sought to provide value for money, to achieve the best possible return from County spend on goods and services.

When is a Competitive Process to Secure a Contract Required?

Purchases over $2,499 for a single purchase of goods or services and/or purchases of over $2,500 in a calendar year to a single vendor or provider require a contract. When the County initiates a contracting process the default procurement stance is that a competitive process to identify the vendor/provider must occur. A competitive bid process shall be utilized when:

A. The County has new funding to purchase services(e.g. new grants, new levies, new allocations from funders)

B. A new program/service is to be implemented
C. There is a change in requirements or regulations related to services/programs currently under contract with the County requiring a substantial revision in the scope of services
D. The funder of programs/services requires competitive procurement process for new funds and/or ongoing funds at a specified frequency.

The following categories of purchases are exempt from the requirement of a competitive bid process:

A. Purchases that are covered by a blanket contract entered into by King County Purchasing
B. Purchases of services where an there is an existing contract within the Division/Department that purchases the same scope of work:
    1. The purchase adds capacity to the program (e.g. purchases more program slots, or bed days); or
    2. The purchase expands the population to be served (without changing the scope of work);
C. Purchases where there is only one source that can provide the scope of work (A Sole Source Waiver must be sought and authorized from King County Purchasing):
    1. The County has been told by a funder to hire a particular (sub)contractor; or
    2. There is only one expert/specialty organization in the region that can deliver the scope of work.

Methods Utilized for Competitive Bid Processes

The competitive bid processes below are solicited by the County. The responses to these solicitations are evaluated against the County's criteria/requirements for the service/program and awards are made for responses that best meet the County's needs/specifications.

1. Requests for Proposals – Prospective bidders complete a proposal to provide services that includes details about: a) their experience providing similar service; b) details on how the agency meets required qualifications; c) a proposal for how the needed/required services will be provided; and d) a detailed expenditure budget
2. Requests for Qualifications/Applications – Prospective bidders complete a response detailing their qualifications to provide the needed/required services according to the County specifications and funding
3. Letters of Intent – A response to a request for a letter of intent that describes the responder's interest, qualifications, and a description of their plan to provide services according to the County's specifications and funding.

Special Purchasing Issues

Divisions/Departments have been delegated the authority to competitively procure and purchase services that are designed to address the needs of the County's citizens (e.g. treatment, supportive services, prevention services, etc.). King County Purchasing may be utilized for the purchase of services if the Division/Department wishes to.

Goods and Consultant Services purchased for King County Divisions/Departments can be competitively procured by the Divisions/Departments if the total expenditure for the consultation will be less than $25,000. For consultation purchase/contracts that exceed $25,000 the competitive procurement process must be directed and run by King County Purchasing.

August 27, 2007 Operating Budget, Fiscal Management and Select Issues Committee
2008-0376 Staff Report-Kelli Carroll

BACKGROUND

Because the committee is familiar with the background of the MIDD Implementation Plan, this section provides background information on the housing and financial plan areas as directed by committee members from the July 23, 2008 Operating Budget, Fiscal Management and Select Issues Committee. The committee's questions were primarily focused in two areas: housing and financial planning.

Housing

In March of 2008, the state Legislature passed into law an amendment to the statute providing county-authorized sales and use tax for mental health and chemical dependency services and therapeutic courts. The amendment allows for the tax revenues to be used for housing that is a component of a coordinated chemical dependency or mental health treatment program or service.

The initial MIDD Action Plan that was accepted by the Council in October of 2007 did not include housing development or housing subsidies as strategies because providing housing with the tax revenues was not allowed under the original statute.

The Implementation Plan[1] proposes utilizing $18 million of unspent funds for a new housing strategy to include housing development capital and rental assistance/subsidies.

The Implementation Plan states that the new housing strategy will use unspent funds resulting from the delayed start-up of programs in 2008. Funding the housing strategy will not take away from resources to be used for the service strategies. The MIDD spending plan shows that the strategies (except housing) are proposed to be funded at a lower than budgeted level in 2008.

The Implementation Plan outlines the rationale for including housing as a strategy of the MIDD, stating:

1. Homeless adults receiving outpatient mental health services are four times as likely to be incarcerated as those who have housing. In one study, homeless clients stayed an average 22 days in jail, compared to an average of two days for similar clients who had housing.

2. Supportive or affordable housing has been shown to be a cost-effective public investment for populations who are most at risk for criminal justice involvement, lowering corrections and jail expenditures and freeing up funds for other public safety investments. Additionally, providing affordable or supportive housing to people leaving correctional facilities is an effective means of reducing the chance of future incarceration.

3. Local examples, such as the Downtown Emergency Services Center, 1811 Eastlake Project and the Plymouth housing group's Begin at Home Program have demonstrated

[1] The Implementation Plan is not attached to this staff report; it was included in the July 23, 2008 staff report to the Operating Budget, Fiscal Management and Select Issues Committee.

large reductions in emergency medical visits as a result of providing housing for homeless individuals with mental illness and chemical dependency.

The Implementation Plan also outlines that the housing funds will:

1. Fund budget gaps for housing projects that have not acquired all of the necessary funding to complete their capital budget.

2. Provide capital funding for new housing projects that might otherwise not be funded or that might be under-funded due to lack of capital dollars.

3. Provide funds for time-limited rental subsidies for those individuals and/or housing projects waiting for subsidies from the Housing Authorities or other funders of operating costs.

4. Provide funding for a revolving loan program for interim loans to affordable housing agencies for the acquisition of property that will be utilized for a housing project. Interim loans will have a low interest rate, will be available for application throughout the year and will not need to be paid back until all permanent financing for the project is acquired. The program will lower the costs of creating housing projects and will allow for the rapid acquisition of sites.

Explicit outputs such as the number of units to be developed or made available through rental assistance have yet to be determined and were therefore not included in the Implementation Plan. Outcomes cited in the plan include reduction of homelessness among the target population and an associated reduction in the use of jail and emergency medical services.

At the end of July, the Department of Community and Human Services (DCHS), in conjunction with a variety of other funders, released a Notice of Funding Availability (NOFA). A NOFA is essentially a request for proposals on a certain topic. This NOFA will be a combined application for supportive housing capital, operating and services funding for homeless families, individuals and youth. The funders participating in the NOFA have combined a variety of funding sources to support initiatives to house homeless people in supportive housing. Funders participating are King County Department of Community and Human Services, City of Seattle Office of Housing, United Way of King county, Seattle Housing Authority, King County Housing Authority, and A Regional Coalition for Housing. King County intends to include MIDD funds if approved by the Council.

The department indicates that while funds are combined in one NOFA, each funding source will maintain its specific programmatic requirements; MIDD funding would only be approved for proposals that are dedicated for people with mental illness and/or chemical dependency-not for serving other homeless individuals or families. Department staff have indicated that the MIDD funds for the NOFA are subject to the Council's approval.

1. How does housing fit within the MIDD? Did the other MIDD reports address housing?
    a. In its initial motion directing creation of an action plan, the Council stated that the plan should "*... prevent and reduce chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems...by implementing a full continuum of treatment,* ***housing****, and case management services.*"

b. All three phases of the MIDD Action Plan called for housing to be included as a strategy, at the same time recognizing that the state statute prevented expenditure on housing.

   i. Phase I of the MIDD Action Plan transmitted to the Council in September 2006, included in the recommendations section the following: *"Provide a variety of appropriate, affordable housing options along with supportive services to help individuals* ***maintain their housing****".*
   ii. Phase II transmitted to the Council in April 2007 included in its recommendations, "***A range of accessible housing options (emergency, transitional, and long-term)*** *is another major resource needed."*
   iii. Phase III transmitted to the Council in June 2007 included in its recommendations a statement regarding the critical need for housing. "*3a.* ***Housing was identified by stakeholders as one of the most critical unmet needs in the community".***
   iv. Phase III plan also states, ***"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. Are there any other counties funding housing with their one tenth funds? If so, which ones, what are they doing and what is the ratio of service dollars to housing dollars?
   a. Like King County, other counties that have passed the sales tax developed their plans for the funds prior to the legislation that specifically allowed sales tax funds to be used for housing. However, several counties are already devoting resources to housing.
      i. Skagit County is providing $1 million per year for capital development and $80,000 for supportive services linked to housing (27.9% of its budget). The plan says that "housing was identified by local stakeholders as one of the most critical unmet needs in the community. Funds will support the increase in available housing stock as well as case management and other treatment services within supportive housing projects. This strategy includes joining with funders of housing to increase the development of housing units for individuals who have mental illness and chemical dependency treatment needs and who are homeless, exiting jails and hospitals, or who continue to cycle in and out of our crisis system."
      ii. Okanagan County is setting aside $40,000 in the first year for safe and sober short term housing and as match to develop special needs housing, $45,000 in the second year and then $15,000 per year ongoing.
      iii. Spokane County is setting aside $3.3 million to support residential treatment programs or people with serious mental illness.
      iv. Snohomish County's draft plan proposes $4,240,000 to develop housing.
      v. Whatcom County's draft plan proposes $525,300 for expanding access to re-entry and recovery housing.

3. What kind of results can the County get for its investment in housing?
   a. Outcomes from national studies and local projects provide a range of comparable metrics to consider

i. A 1989-1997 New York/New York study[2] on the effectiveness of providing housing for homeless individuals with mental illness provides compelling data: Placement in housing reduced use of state psychiatric hospitals by 50%, local hospitals by 21%, jails by 38%, and prison by 85%. The study's 4,697 individuals were placed into housing and services with the researchers comparing usage of shelters, jails, and hospitals in the two years before the individuals were housed and the two years after they were housed. They also compared results with a control group of clients who were not housed, but instead stayed in shelters.
ii. The State of California evaluated its programs[3] that provide increased mental health services and found that consumers who have stable housing are much more likely to stay in treatment and that housing is a key factor in the positive program results such as decreased hospitalization and incarceration rates. The biggest structural barrier to success noted in the evaluation was the lack of affordable housing for those being served.
iii. A Justice Policy Institute Report released in 2007[4] found that for populations who are most at risk for criminal justice involvement, supportive or affordable housing has been shown to be a cost-effective public investment, lowering corrections and jail expenditures and freeing up funds for other public safety investments. Additionally, providing affordable or supportive housing to people leaving correctional facilities is an effective means of reducing the chance of future incarceration.
iv. The 2008 first year preliminary findings of the 1811 Eastlake Project[5] found that providing housing to chronic alcoholics, even without the requirement that they enter treatment or stop drinking, resulted in a 45% decrease in jail bookings, an 87% decrease in admissions to the Sobering Center, a 32 % decrease in visits to Harborview Emergency Room, and an overall annual reduction in the cost of community services used of $2.5 million.
v. Another local example is the Plymouth Housing group's "Begin at Home" program. This program provided housing and services for 20 long-term homeless men and women who had multiple medical problems in addition to mental illness and/or substance abuse disorders. In the first year of the program, emergency room and medical costs for the individuals in the program were reduced from $1.6 million to $400,000-a savings of 75% over the previous year.

4. How great is the need for housing among the mentally ill and chemically dependent in King County?
    a. The MIDD contained a prevalence study that included the following data:
        i. Characteristics of the 300 highest utilizers of Harborview emergency room shows that in 36%of admissions, the person was homeless. Those 2894 admissions by homeless individuals cost close to $2 million.
        ii. 95% of people admitted to detox and 90% of those admitted to Sobering Services are homeless.

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[2] The New York/New York Agreement Cost Study: The Impact of Support Housing Services Use for Homeless Mentally Ill Individuals, 2004
[3] Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness, 2007
[4] Justice Policy Institute: Housing and Public Policy, November, 2007
[5] 1811 Eastlake: First Year Preliminary Findings, January, 2008

iii. Half of the individuals seen by King County Jail Health in a 2005 study were homeless (note: home status is not a data point that is currently collected by Jail Health).
iv. On April 1, 2008, 990 of the 19,251 clients receiving outpatient mental health services through the King County Regional Support Network were homeless.
v. Homeless adults receiving outpatient mental health services are four times as likely to be incarcerated as those who are housed. Average jail days for homeless clients were 22 days, compared to two days for those who had housing.
vi. Homeless adults receiving outpatient mental health services are three times as likely to be hospitalized for psychiatric treatment as those who are housed.

5. How was $18 million determined to be the proposed amount to be spent on housing?
   a. $18 million represents the unspent 2008 funds. As noted above, the Implementation Plan states that the housing strategy will use unspent funds resulting from the delayed start-up of programs in 2008. Funding the housing strategy will not take away from resources to be used for the service strategies. The MIDD spending plan shows that the strategies (except housing) are proposed to be funded at a lower than budgeted level in 2008, providing $18 million in unspent funds.
   b. DCHS has stated it is not possible to spend all of the funds on services in year one because providers would not be geared up and staffed to accommodate the demand.

6. What was the stakeholder feedback on housing?
   a. Stakeholder groups involved in the 2006-2007 MIDD planning processes consistently included housing among their top priorities, despite being told that the law did not permit the county to use sales tax funds for housing development and rental assistance.

7. What is the break out of funds between housing development and housing/rental subsidies?
   a. DCHS stated that early estimates would have roughly $13 million allocated to housing development and $5 million for rental subsidies/assistance. The final allocations would depend on the results from July's NOFA.
   b. DCHS indicated that the $5 million for rental subsidies would be a one-time allocation with expenditure that may occur over more than one year.

8. How many units will be funded with the MIDD money?
   a. This question cannot be answered definitively at this time. In general, a unit of housing costs $250,000 to build. However, since MIDD funding would likely be one component of many funders, MIDD funds would not be underwriting the entire $250,000 per unit cost, but some portion of the development costs. Estimates range from $100,000 and up per unit. Other cost impacts include location, time to build and the leveraging power of other funders.

9. What is the vision for 2009 housing expenditures?
   a. At the July 24, 2008 MIDD Oversight Committee meeting, the Department of DCHS distributed an overview of the housing strategy for 2008 and potential options for 2009 (**Attachment 3**). The document states that for 2009, DCHS will propose to again use unspent funds for housing development estimated that about $8 million would be available for housing development. The Oversight Committee did not take action on the proposal at the July meeting.

Housing Development: Strategy #16A

Current Status

The Oversight Committee agreed to support a proposal to use funds that are not able to be spent in 2008 due to the delays in the MIDD implementation for housing development under strategy 16A. The estimated amount that will be available is $18 million. These are funds that cannot be spent on service strategies as a result of the requirement that no MIDD funds can be spent until the County Council has approved the Oversight, Implementation and Evaluation Plans, which will be sometime in September. In addition, a number of strategies will not begin until providers are selected through a procurement process and contracts are signed. Funding for these programs does not begin until contracts are signed. Finally, a number of strategies are still being developed and will not be implemented until sometime in 2009.

Housing Development Strategy for 2008

The top priority for 2008 is to fill gaps in housing projects that have not yet acquired all the necessary funds to complete their capital budgets. These are projects that will be able to start construction in 2009, and be completed much earlier than if they had to wait for other fund sources in future years. While not all projects that have funding gaps will necessarily qualify for MIDD funding, the estimated funding gap for these projects is approximately $16 million. Since we estimate the need for $3 million for housing vouchers for individuals leaving jails and hospitals, not all projects with funding gaps will be able to be funded in 2008.

Options for 2009 Funding for Housing

1. Some members of the Oversight Committee have argued that services that need housing to be successful should not be funded until housing is available for those who would be served by the program. Under this option, we would delay implementation of programs that need housing to be successful in achieving desired outcomes, and redirect funds for these programs to housing development.

2. Other members have argued that the MIDD Action Plan was approved to provide services and not housing, that funding for housing is available through other sources, and that funding for housing should not be provided beyond the first year of MIDD implementation (2008). Options for the use of the funds that cannot be spent on services as designed in 2009 (due to several programs needing further development and others being implemented gradually or in stages during 2009) would include adding new service strategies and increasing funding for those strategies that may be able to use additional funding.

3. The Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) proposes to again use funds that will not be able to be spent on services in 2009 for Housing Development Strategy 16A. Based on the forecast for sales tax revenues, MIDD revenues will exceed the amount that can be spent

on services by $10, 000,000. Assuming $2 million is reserved for additional housing subsidies and vouchers, $8 million will be left to fund any projects that meet MIDD priorities that were not funded in 2008, as well as new projects that will be chosen based on their ability to provide housing for individuals being served by MIDD strategies that are identified as most in need of dedicated housing.

Rationale for MHCADSD Proposal

- There is a substantial need for housing development dedicated to individuals with mental illness and chemical dependency.
- Without housing, the MIDD Plan will not be as successful in reducing the use of emergency services, hospitals, and jails.
- There are limits in how much housing can be developed in a given year, both in terms of provider capacity, and in terms of other funds that can be used to leverage County funds, such as the State Housing Trust Fund. Projects that are developed without using these other funding sources will yield far less housing units per MIDD dollar invested than will projects that leverage other funding sources.
- The proposal will not take away funds for service strategies, since the service strategies are not ready for implementation. There are a number of programs that will not be ready for full implementation at the beginning of 2009, and, in some cases, until the last quarter of 2009. These unspent funds are essentially one-time only funds.
- Adding funds for strategies in 2009, and then having to take away these funds in 2010 and beyond would create a hardship for agencies which would need to hire staff one year and lay them off the next year as funding is redirected to other programs. Similarly, it is not productive to develop and fund new strategies in 2009 with unspent funds from other programs, and then stop funding the new programs the following year.

MIDD Financial Plan
Fund 000001135 / Dept #0990
Department of Community and Human Services / MHCADSD/ Mental Illness and Drug Dependency Fund (MIDD)

	2007 Actual	2008 Adopted	2008 Estimated [1]	2009 Projected	2010 Projected	2011 Projected
Beginning Fund Balance	0	0	0	16,406,395	9,957,885	12,232,885
Revenues [2]						
* CD/MH Sales Tax		30,852,323	38,564,000	51,375,000	53,647,000	56,678,000
* Interest Earnings			54,000	233,000	275,000	346,000
*						
Total Revenues	0	30,852,323	38,618,000	51,608,000	53,922,000	57,024,000
Expenditures						
* Operating Expenditures		(22,211,605)	(10,614,156)	(51,653,959)	(51,647,000)	(54,678,000)
* Housing Expenditures [3]			(11,597,449)	(6,402,551)		
*						
Total Expenditures	0	(22,211,605)	(22,211,605)	(58,056,510)	(51,647,000)	(54,678,000)
Estimated Underexpenditures						
Other Fund Transactions						
*						
Total Other Fund Transactions	0	0	0	0	0	0
Ending Fund Balance	0	8,640,718	16,406,395	9,957,885	12,232,885	14,578,885
Reserves & Designations						
* Housing & Capital Reserve [4]		(6,418,602)	(6,402,551)			
* Revenue Stabilization Reserve [5]		(2,000,000)	(3,800,844)	(5,800,844)	(7,800,844)	(9,800,844)
*						
Total Reserves & Designations	0	(8,418,602)	(10,203,395)	(5,800,844)	(7,800,844)	(9,800,844)
Ending Undesignated Fund Balance	0	222,116	6,203,000	4,157,041	4,432,041	4,778,041
Target Fund Balance [6]		222,116	222,116	580,565	516,470	546,780

Financial Plan Notes:

[1] 2008 Estimated is based on accrued revenue and updated expenditure projections.

[2] MIDD sales tax collection began April 1, 2008. 2008 Adopted revenues are on a cash basis and include seven months of sales tax distribution to King County. GAAP standards require sales tax revenue to reflect sales that occurred in the year. Therefore, 2008 Estimated revenues are on an accrual basis and include a revenue adjustment to reflect a full nine months of sales tax revenue.

[3] Housing expenditures are limited by the 2008 adopted appropriation. Total anticipated housing expenditures of $18,000,000 include $11,597,449 in 2008 operating expenses and $6,402,551 in the Housing and Capital Reserve.

[4] 2008 Estimated Housing & Capital Reserve of $6,402,551 is unexpended balance of housing expenditures per the spending plan ($18,000,000 - $11,597,449). The approximate split of the $18,000,000 in housing expenditures is $13,000,000 for capital expenditures and $5,000,000 for rental subsidies.

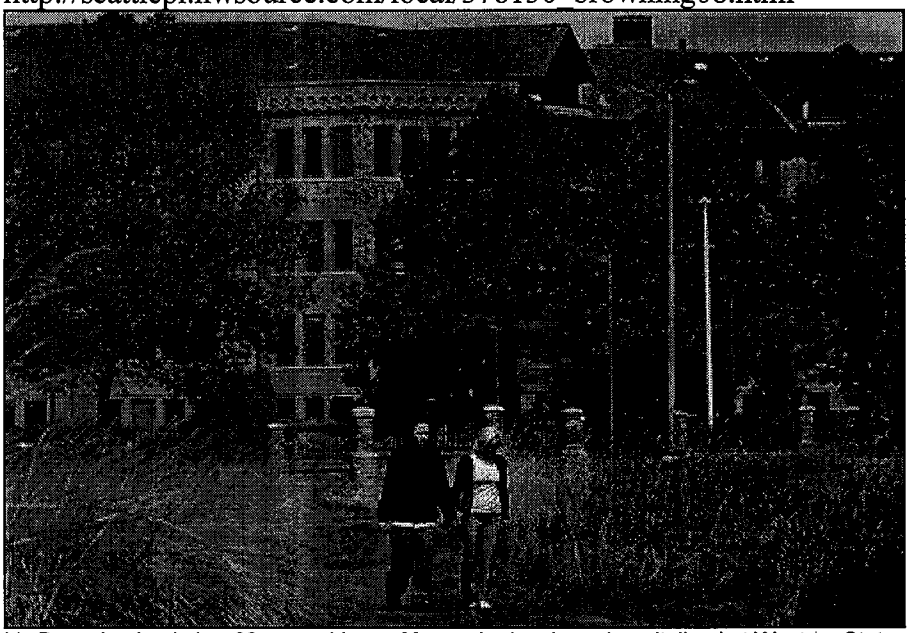
[5] A minimum of $2,000,000 will be reserved each year until $10,000,000 Revenue Stabilization Reserve is reached in order to create stable funding for comitted services. In 2008 revenues are greater than can be spent on services. As a result, an extra $1,800,000 was put into the reserve in order to free up funds in future years as program expenses increase over time.

[6] Target fund balance is set at 1% of expected expenditures. This is consistent with both the Mental Health and Substance Abuse funds.

ATTACHMENT 4

ATTACHMENT 5

Seattle Post-Intelligencer
http://seattlepi.nwsource.com/local/378130_browning08.html



Liz Browning leads her 22-year-old son, Marc, who has been hospitalized at Western State Hospital since April, for a walk in Fort Steilacoom Park. (Dan DeLong / P-I)

A 'gravely disabled' mental health care system

State's broken process wastes money, chances, lives

Monday, September 8, 2008
Last updated 9:42 a.m. PT

By CAROL SMITH
P-I REPORTER

Liz Browning nudged open the unlocked door of her son's Capitol Hill apartment and recoiled at the floor blanketed with garbage -- drifts of unopened bills, mounds of cigarette butts, rotting food and feces.

"Hello ... hello?" Her voice captured on a video taken in March sounds strained, wishing her 22-year-old son into view, and at the same time terrified of what she might find. "We brought you some food. ..."

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She was startled, as her son Marc loomed into the frame -- tall, baby-faced handsome but disheveled, his long dark hair hanging in his face, a cigarette hole in the crotch of his drooping pants. He muttered to himself, and glared at the camera.

Browning felt sick from the stench. She forced herself to keep talking, trying to reach some part of him that remembered who he was before: Marc -- the funny, sweet-natured scion of a prominent Seattle family and descendant of legendary firearm inventor John M. Browning; Marc -- the boy who once played Michael Darling in a Seattle Intiman Theatre production of "Peter Pan." That Marc had disappeared.

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Mental illness is an insidious form of identity theft, erasing one future and replacing it with another.

But the state's mental health care system abets the crime. The Brownings, like thousands of other Washington families dealing with mental illness, are snared in a Kafkaesque system that won't help people with serious symptoms until they are in imminent danger of harming themselves or others, or gravely disabled -- standards so high they exclude many who desperately need help.

But this strategy ends up costing the public more money, and puts citizens at greater risk, a scenario tragically highlighted in this state by a string of high-profile slayings by people who had severe mental illness but could not be treated despite signs that they needed help.

How the state treats -- or fails to treat -- its mentally ill is in the headlines again after Tuesday's bloody shooting spree, which left six dead. The family of Isaac Zamora -- the man arrested in the Skagit County killings -- has said the state didn't deal with his mental illness to help him and to protect the public.

It's not for lack of spending money that the state has failed. A Seattle P-I analysis found that the state spends at least $1.8 billion a year directly and indirectly dealing with mental illness, or its aftermath. Of that money, $530 million is spent directly on mental health care. The rest -- $7 out of every $10 -- goes toward prisons, police, homeless shelters and other social services that deal with the consequences of lack of treatment and preventive care.

This approach keeps people cycling through the streets, courts and jails. Beyond that, it squanders opportunities to intervene early on when there may be a better chance for successful treatment and recovery.

Ultimately, it wastes minds and costs lives.

The intruder

Liz Browning took in the bunker of her son's illness. An upright vacuum lay toppled on a table. Shaving cream blotted part of the bathroom mirror, and glass from a broken window littered the floor. Electronic devices -- a television, an iPhone and a computer -- all smashed. It appeared that a frantic intruder had trashed the place.

Marc insisted to his parents that there were people shadowing him -- people who vandalized his property and spoke to him in "voices you don't want to hear."

zoom Dan DeLong / P-I

Liz Browning wipes away a tear after visiting her son Marc at Western State Hospital.

But Marc's connection to reality had been spotty and fading for months. He started to lose himself in pieces. Strangers called his parents to tell them they'd found Marc's phone buried in their yard. Other strangers found his wallet in the street. Occasionally he would show up on the veranda of his family's gracious Capitol Hill home, ranting through the door until, feeling trapped, his mother called 911.

Now Browning stared into the face of the intruder. The invader had taken up residence in Marc's mind. The invader's name was schizophrenia.

A few months earlier, Marc had called for help. "I love you a lot," he began in a voice message left on

his parents' phone: "If I could ask for one thing -- if you could find me a good hospital ... I just can't do it ... I'm not thinking right -- everything is just going poorly for me. If I could just feel better, look to the future ... I feel so lost."

Over the next three days, Browning and her son went to three hospitals -- the University of Washington Medical Center, Harborview Medical Center and Swedish Medical Center -- none of which would or could accept Marc because he wasn't sick enough.

"You almost hope they are really, really bad," Browning said. "And that's just so wrong."

Do not pass go

Hospitalizing someone for mental illness has morphed from a medical decision into a legal issue, said Dr. Peter Roy-Byrne, chief of psychiatry at Harborview. "It's like if someone came into the ER with chest pain or cardiac arrhythmia, and we had to tell them, until they have a heart attack or need a heart transplant, we can't do anything."

Then when patients are sick enough to go to the hospital, they are often more difficult to treat. Or patients get stabilized just enough to be sent back to the community, where, without sufficient services and follow up, they fall apart again. In what becomes a malevolent sort of social Monopoly game, the players are constantly forfeiting their gains to start over -- or go to jail.

For families, it's a grim game with stakes that are too high. There's a complex web of reasons for their frustrations.

Washington is one of the few states where neither families nor their doctors can decide that someone needs to be committed involuntarily for care. The only people who can make that petition are county-designated mental health professionals -- government workers, who are not typically psychiatrists or clinical psychologists.

There are 28 such workers to handle crisis calls from a county with a population of 1.8 million, a ratio that frustrates many clinicians who say that between the laws and the decision-making process, they are frequently unable to provide care, or are forced to release people when they are still in a precarious mental state.

Strict application of only the most severe criteria for commitment, coupled with a critical shortage of psychiatric hospital beds, prevents many people from being hospitalized when they might most benefit from it. Group housing with supervised treatment, scarce to begin with, is disappearing, limiting options for people facing hospital discharge. Although community outpatient mental health programs exist, the majority of patients who end up in them eventually vanish from treatment.

Nearly two-thirds of people who used public mental health services at least once never returned, according to the state's Institute for Public Policy Research, which recently looked at compliance levels. In the lexicon of mental health workers, they are known as "leavers."

"We wouldn't let an Alzheimer's patient leave the hospital to go sit on a sidewalk grate and rot," Roy-Byrne said. "But we do that all the time for people who are mentally ill."

Jails as 'psych wards'

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Between January, when he asked for help, and March, when the police finally put him into restraints and hauled him to West Seattle Psychiatric Hospital, Marc's prognosis darkened.

By then, whatever inclination he might initially have had to help himself had been subsumed by illness. On his admission, Marc told social workers he wanted to "get a restraining order against the police because they won't leave me alone."

According to hospital notes, he didn't seem aware of why he had been brought in. He was angry, his mood unstable, and he denied being sick. He refused antipsychotic medication, and the hospital by law couldn't force injections without an additional court order. Within days, Marc was out of control, attacking staff members during an altercation over his smoking privileges. Several orderlies had to forcibly restrain and sedate him.

Then they called the police.

On April 24, Browning waited behind a glass enclosure while her son, wearing an orange jailhouse jumpsuit, was led into the courtroom. He seemed oblivious to the seriousness of the occasion, or even why he was there.

Marc stared around the courtroom, and glimpsed his mother behind the glass. The judge dismissed the charges and ordered him to Western State Hospital to be re-evaluated for civil commitment. When the judge asked him if he had anything to say to the court, he said: "Why is my mother crying?"

Psychotic break

After the hearing, Browning stood on a street corner outside the jail still shaking with frustration. She had been operating on adrenalin for months as her attempts to get treatment for Marc verged into theater of the absurd. At every turn, either the law, or the disease, blocked her attempts to intervene.

On this day, her shoulders hunched forward, and fatigue pressed its thumbs under her eyes. Behind her, the giant image of a man somersaulting down a wall in perpetual freefall decorated the side of a county parking structure, an apt, if unintended, metaphor.

It felt, she said, like they were back where they started, only worse off. Now instead of a treatment plan, her son had a jail record.

"It's like I don't even know him anymore," she said.

Marc, the youngest of three children, was an unassuming, well-adjusted, happy kid growing up, said family and friends.

"He was a sensitive and sweet with a natural charm and kindness," said his older sister, Ann.

Though he was smart, school was hard for him, and he drifted with little ambition, said one of his elementary school teachers.

In eighth grade, his parents sent him to a small private school for boys with dyslexia, but his problems continued. A year later, a school psychiatrist diagnosed him with bipolar disorder.

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During his junior year in high school, he was hospitalized for depression and suicide risk. Though he graduated and started college at Eastern Washington University, he dropped out in January 2005 -- the middle of his freshman year -- to go live with his older brother in Las Vegas.

One night, Marc began tearing apart the attic in the house he shared with his brother, looking for cameras he was convinced were tracking him. He accused his brother of controlling his thoughts. His parents persuaded him to go voluntarily to a hospital in Las Vegas for a week, then flew him back to Seattle.

But at home, his mental health continued to deteriorate, and in June 2005, a court committed him to a private psychiatric hospital. This time, Marc was uncooperative and tried to escape. The hospital wouldn't take him back.

So his parents did.

zoom Photo Courtesy Of Liz Browning

Marc Browning, shown at age 2 in 1988. Growing up, Marc was a well-adjusted, happy kid.

Marc's behavior grew increasingly erratic and frightening. He withdrew to his room for days at a time. Once, he slammed a chair through a window. His mother began locking herself into her own room at night, fearful of what he might do next.

In February 2006, the Brownings were able to get him committed on an involuntary basis, this time to Harborview Medical Center, where doctors diagnosed him with schizophrenia.

He was 20 years old.

For Liz Browning, her son's diagnosis confirmed a haunting heritage she had feared on some level since her children were young -- a genetic loading the family couldn't escape.

A genetic bullet

On a recent morning, Browning hurried to meet her mother-in-law, Gloria Browning, at a Belltown cafe. They have much in common -- both strong-willed and articulate, they also share a body of knowledge few of their friends comprehend. It's Gloria to whom Browning turns when she needs someone who understands how mental illness shape-shifts a life.

The cafe is just steps from where Gloria Browning lives in a luxury high-rise condominium, and also where many of the city's mentally ill wander the streets, untreated and unhinged. She rarely goes out in her neighborhood after nightfall.

This irony is not lost on Gloria, now the matriarch of her famous family, but she speaks unflinchingly about the Browning legacy. Browning inventions helped build the most widely used firearms of the 20th century -- weapons that saw the nation through two world wars.

No gun John M. Browning designed, however, and no amount of wealth the family enjoyed, could defend against the genealogical bullet ricocheting through their family tree.

Gloria had six sons. Her eldest, namesake of his famous grandfather, leapt from the Golden Gate Bridge at age 27 after suffering for years with symptoms of schizophrenia and struggling to tolerate his medications.

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He left a note saying he wished he could have lived.

A few years after his older brother's death, a second son shot himself. That son had struggled with addictions, including to anti-anxiety medications.

Now, two of Gloria's grandsons, including Marc, also struggle with mental disorders.

Gloria keeps track of advances in brain research and hopes for the day better treatments and earlier interventions let more of those with severe mental illness reclaim their lives.

The imposter

Liz Browning thought Marc had almost gotten his own life back.

After hospitalization at Harborview in the spring of 2006, he was released and lived for seven months at the Inn, a transitional group home in Seattle, which since has closed. There, he was supervised to make sure he took his medications, and soon, the witty and easygoing Marc re-emerged.

Encouraged, his family supported a move to his own apartment. He found one himself, outfitted it from Ikea and started back to school at Seattle Central Community College. He stayed on his antipsychotic medication, and paid his bills on time. His past few years began to seem a surreal detour.

But it's under this cloak of normalcy that mental illness lays its trap. People living with mind disorders start to believe that they no longer need the programs or medications that keep their thoughts in line, the voices at bay.

Within a year, Marc quit his medications. He stopped going to school. Quit paying his bills. Stopped making sense.

Because he had been out on his own, the mental health system had no mechanism for intervening, no way to break the freefall to come. Untreated, schizophrenia has its own kind of gravity, sucking its victims in like a black hole.

Even Marc could feel himself slipping. In January, he called his parents for help.

Browning saved the message, and plays it when she wants to make a point -- to doctors, to lawyers, to mental health professionals -- that the Marc they see -- the hostile youth, the disoriented inmate, the uncooperative patient -- that Marc is an imposter.

She plays it for herself.

Call back later

Liz Browning puts out a pot of tea for visitors on her back porch one recent sunny morning. She has a low threshold for small talk, and the conversation quickly turns to mental disorders. If schizophrenia has seized her son's mind, it has also taken over her own life, consuming most of her time and energy. After the April assault charges, a mental health court ordered Marc to an involuntary commitment at Western State Hospital, where he remains today. His progress there has been slow, aggravated she feels by the long periods of time he spent off medications as he pinballed through the system.

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Doctors confirm that it's harder to recover from each psychotic break.

"My greatest fear is the psychosis will be so damaging, we can't get him back at all -- that he will be so ill, he's not really treatable," she said. "I might not know what I am fighting for."

She's helping to spearhead a movement to train more defense attorneys for work in mental health courts. She's advocating for the need to get commitments sooner. She's trying to organize an effort to create long-term care facilities where people with intractable mental illness can live together, work and have a decent quality of life.

But what she really wants, right at this moment, is to reach her son. She picks up the phone and dials the pay phone in the community room of his ward at Western State. A patient answers. She introduces herself and reminds the patient that she's met him, that she's Marc's mother, that Marc's the one who always wears a stocking cap. Could he tell him she's on the line?

Browning hangs on, the phone cradled against her shoulder. A few minutes pass. The patient never returns. Marc never picks up.

"I'll have to call back later," she says, to no one in particular.

This is what having your life hijacked by mental illness is like, being on perpetual hold.

Waiting to connect.

FOR MORE INFORMATION GO TO:

National Alliance on Mental Illness: **www.nami.org**
National Alliance for Research on Schizophrenia and Depression: **www.narsad.org**
www.schizophrenia.com
www.psychlaws.org

P-I reporter Carol Smith can be reached at 206-448-8070 or carolsmith@seattlepi.com.