MIDD Briefing Paper

ES 1a1 Increase Access to Community Mental Health and Substance Abuse Treatment
BP 32 Increase access to community-based mental health and chemical dependency or substance abuse needs in King County
BP 132 Community-Based Mental Health Care
BP 135 Juvenile In-Patient Drug Treatment

Existing MIDD Program/Strategy Review ☐X MIDD I Strategy Number __1a_____ (Attach MIDD I pages)
New Concept X☐ (Attach New Concept Form) 132-Community-Based Mental Health Care and 135-Juvenile In-Patient Drug Treatment
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: MIDD Strategies 1a1 and 1a2 have been used to provide mental health (MH) and substance use disorder (SUD) services to those who are not receiving and/or eligible for Medicaid. These groups of people include undocumented individuals, incarcerated individuals, people who solely have Medicare, people who are under 220 percent of the federal poverty level but have extremely high co-pays and deductibles in order to access service, people on Medicaid spendown (meaning they have to pay a certain amount of out of pocket expense every six months before Medicaid reimbursement kicks in), and people who are pending Medicaid coverage. In addition, there are services that are part of the treatment continuum that are not Medicaid funded that this strategy has covered such as sobering, outreach, clubhouses, drug testing and peer support (SUD specifically). Lastly, this resource has been used to pay for a Medicaid funded service when that service has not been available at a Medicaid reimbursable facility, i.e. withdrawal management (WM). With the passing of SB 6312 and the impending integration of behavioral health services on April 1, 2016, this briefing paper proposes combining the 1a funds to allow for maximum flexibility to address gaps in the behavioral health treatment continuum.

Collaborators:

Name	**Department**
Sherry McCabe	**DCHS**

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Victor Loo	Director of Recovery Services	Asian Counseling and Referral Service (ACRS)
Junko Yamazaki	Children, Youth and Family Department Director	ACRS
Yoon Joo Han	Behavioral Health Department Director	ACRS
Mario Paredes	Executive Director	Consejo Counseling and Referral Services (CCRS)
Dana Ritter	Chief Financial Officer	DCHS

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

MIDD Strategies 1a1 and 1a2 have been used to provide mental health (MH) and substance use disorder (SUD) services to those who are not receiving and/or eligible for Medicaid. These groups of people include undocumented individuals, incarcerated individuals, people who solely have Medicare, people who are under 220 percent of the federal poverty level but have extremely high co-pays and deductibles in order to access service, people on Medicaid spendown (meaning they have to pay a certain amount of out of pocket expense every six months before Medicaid reimbursement kicks in), and people who are pending Medicaid coverage. In addition, there are services that are part of the treatment continuum that are not Medicaid funded that this strategy has covered such as sobering, outreach, clubhouses, drug testing and peer support (SUD specifically). Lastly, this resource has been used to pay for a Medicaid funded service when that service has not been available at a Medicaid reimbursable facility, i.e. withdrawal management (WM). With the passing of SB 6312 and the impending integration of behavioral health services on April 1, 2016, this briefing paper proposes combining the 1a funds to allow for maximum flexibility to address gaps in the behavioral health treatment continuum.

Strategy 1a1 currently provides expanded access to outpatient MH services for children, youth, adults, and older adults who have a mental illness but either do not receive or qualify for Medicaid. Priority is given to 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. These funds have also funded MH Clubhouse services since 2012.

Currently, strategy 1a2 provides SUD, Medication Assisted Treatment (MAT)- primarily methadone, WM (previously referred to as detoxification), and sobering services to individuals not eligible for Medicaid and who abuse substances or are chemically dependent. Priority is given to individuals who are leaving jails and inpatient treatment, pregnant women, 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, older adults, and youth. These funds have also been used to provide case management to 75 formerly homeless individuals with chronic alcohol addiction and important support services necessary for engagement and recovery, such as transportation for youth and Recovery Support Specialists (RSSs) at the Sobering Center.

The goals of the strategy are to increase access to and provide services for individuals who are currently ineligible, decrease the number of people with behavioral health issues who are re-incarcerated or re-hospitalized, and reduce jail and inpatient utilization, and homelessness.

An expansion of these strategies is proposed for the following reasons. King County has been actively outreaching to difficult to engage residents in order to increase penetration of the behavioral health system and provide treatment to more persons in need. This is resulting in increased numbers of

individuals identified as having MH and/or SUD needs, but ineligible for Medicaid due to a variety of reasons. Increasing the existing 1a funds will ensure that all individuals living in King County with a MH or SUD need can access care without regard to their financial status. In addition, increased 1a funds will allow funding for the appropriate treatment and recovery support services found to be essential in ensuring continuous, effective care that are not currently covered by another source.

Under an integrated behavioral health model, MIDD strategies 1a1 and 1a2 are being combined into one strategy moving forward. Consequently this unified strategy is addressed under one briefing paper. The types of mental health and substance use disorder treatment and services within the King County behavioral health system may include: Individual and group counseling; Inpatient treatment; Intensive outpatient treatment; Case or care management; Medication assisted treatment; Recovery support services; Peer supports; and withdrawal management.

The purpose of of expanding these strategies are to bolster the original goals identified above and to decrease disparities across King County so that all residents have the opportunity to achieve their full potential.

New concepts, 32, 132 and 135, fit well into this existing and modified strategy. Concept 32 proposes community based services for agencies with expertise in youth development that are culturally responsive services and trauma-informed care will provide mental health services for youth up to age 25 who do not qualify for Medicaid assistance or have private insurance. Concept 132 proposes a community-based, wraparound, supportive housing mental health care system that focuses mainly on people experiencing homelessness. Concept 135 proposes establishing a publicly-funded, youth inpatient center in King County. The concept proposals fit the intention of Strategy 1a and focus on two priority populations, youth and people experiencing homelessness, who would be served via this strategy.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☐ **Prevention and Early Intervention**

   ☒ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

The goal of the services provided under the 1a strategy is to provide needed crisis and treatment services that assist people to return to productive life roles within their families and the community. Additionally, the primary goals of the strategies are to improve the system by intervening with treatment support to assist people to avoid jail, emergency room and psychiatric hospital admissions that otherwise they would not be able to receive.

The goal of concepts 32, 132 and 135 is mainly System Improvement. Concept 32 addresses the service needs for culturally relevant behavioral health services for high trauma exposure. Concept 132 would place services at locations mental health services for at-risk children and youth of color who need culturally relevant behavioral health services for high trauma exposure. Concept 132 would place services at locations where homelessness is most evident, making services more accessible and providing supportive housing. Supportive housing is outside the scope of Strategy 1a, and is addressed in Briefing Paper ES 3a ES 16a BP 18 19 21 67 Supportive Housing; however, treatment needs for those in supportive housing could be served via this strategy. Concept 135 would build and operate a youth

inpatient treatment facility here in King County so that youth would not have to travel to Eastern Washington for treatment.

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

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

The current community need is great. There is a large unserved population of people who are not on Medicaid, or do not qualify for Medicaid, whose behavioral health needs are only addressed when their need reaches crisis proportions - either in hospital emergency departments, in-patient care, or jails. Over half of the individuals with mental illness who are admitted to psychiatric hospitals do not have Medicaid coverage. Eleven percent of people in King County over the age of 18 suffer from frequent mental distress; most are living in poverty and many live in South King County.[1] 27 percent of school-aged youth are experiencing depression, many of which are minorities living in South King County;[2] 29 percent of in-school youth in King County report having used some type of illicit drug within the past 30 days. [2] The number of older adults in the United States is expected to increase dramatically from 40.3 million in 2010 to 72.1 million in 2030[3] and according to the King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card, the number of older adults who have accessed behavioral health treatment has steadily increased since 2012[4]. Between 14 to 20 percent of older adults have one or more mental health and substance use conditions. Depressive disorders are one of the most prevalent diagnoses, but substance use is also a significant problem.[5] The number of people experiencing homelessness has grown the last few years and was recently declared a state of emergency by the County Executive and Mayor of Seattle[6]. And finally, King County currently does not have a publicly funded youth drug inpatient facility; youth must travel away from their families and communities to Eastern Washington for in-patient treatment, creating travel burdens for families and limiting their ability to support the youth in treatment, thereby limiting the potential for maximum clinical success.

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[1] Behavioral Risk Factor Surveillance System. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

[2] Healthy Youth Survey. Public Health – Seattle & King County, Assessment, Policy Development and Evaluation Unit. December, 2014.
http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/indicators/BehavioralHealth/FreqMentalDistressAdults.ashx

[3] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.

[4] King County Regional Support Network 2015 Second Quarter Mental Health Plan Report Card. Pages 1 and 3. November 2015. http://www.kingcounty.gov/~/media/health/mentalHealth/reportsAndPlans/151202_2015_Q2_Mental_Health_Report_Card.ashx?la=en.

[5] Institute of Medicine. (2012). *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* 2012. Washington, DC: The National Academies Press.

[6] http://allhomekc.org/news/2015/11/declaration-homelessness-is-in-a-state-of-emergency-in-king-county-2/.

Having adequate, accessible and available behavioral health treatment in King County is one step toward suicide prevention. Youth suicides are not uncommon. Of the 443 firearm suicides between 2006 and 2010 in King County, 13 (3%) were youth age 19 and under. In King County, American Indian/Alaska Natives and whites had the highest suicide and firearm suicide rates. However, the rates for American Indian/Alaska Natives were not significantly different from the white rates due to small numbers.[7] Risks for suicide include depression, other mental illnesses and substance use disorders[8].

Medicaid expansion under health care reform has resulted in the percentage of residents who are uninsured dropping from 16.4 percent in 2013 to 10.1 percent in 2014. Currently it is estimated that 139,000[9] people are uninsured in King County and are thereby not eligible for Medicaid –funded MH and SUD services. A substantial number of individuals are deemed ineligible 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. There are also individuals who have Medicaid or are eligible for Medicaid or other type of insurance, yet are unable to access treatment due to Medicaid spendown or unaffordable cost-sharing fees. Since 2008, almost 64 million 1a1 and 1a2 dollars have been spent for these groups and services.[10] If these funds were not available, individuals in need of treatment would be more likely to either enter or remain in the criminal justice system and access expensive crisis services, such as emergency rooms.

One King County contracted behavioral health provider, Consejo Counseling and Referral Service, states that they use 1a1 and 1a2 funding "to serve low-income immigrant and undocumented residents of King County that lack the financial supports to receive private care and who are ineligible for the majority of publicly funded behavioral health services. Due to their immigration status, this population does not qualify for Medicaid or the health care reform Medicaid expansion. MIDD funding helps to meet the needs of both our clients and King County as a whole. Without MIDD, the population that we serve would receive no assistance until their conditions exacerbated to the point that they would either pose significant dangers to themselves, those around them, the community they live in or become financial and operational burdens upon hospitals through increased use of emergency rooms and/or Western State hospitalizations. Many others may end up in jail rather than receiving the care they need, which increases the costs to correction facilities that are not well equipped to serve behavioral health needs. With this funding we are able to provide treatment to our clients at the earliest onset of behavioral health issues, thereby improving their chances of recovery, stabilization and becoming productive members of society."[11] Additional follow up with Consejo identified that Non-Medicaid covered individuals also do not have access to much needed psychiatric medication. Without this medication, behavioral health treatments are often rendered difficult, if not impossible to impact meaningful change for individuals.

Another provider, Asian Counseling and Referral Service (ACRS) states, "due to immigration status, our clients are not eligible for Medicaid. Some of them barely exceed the Federal Poverty Line, and become ineligible, and are "forced" to choose Qualified Health Plans, which often times, they cannot afford the premium, and deductible. For these clients, they rely solely on Non-Medicaid funds for MH, and SUD services, and this is their only option. It is also important to know that not all eligible clients can be

[7] http://www.kingcounty.gov/healthservices/health/data/GunViolence/suicide.aspx
[8] http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
[9] http://www.kingcounty.gov/healthservices/health/data/~/media/health/publichealth/documents/data/affordable-care-act-enrollment-king-county.ashx
[10] 2008 – 2015 MIDD 1a budget report. Provided by Dana Ritter, King County Chief Financial Officer.
[11] Mario Paredes, Executive Director at Consejo Counseling and Referral Service, email dated 01/05/2016.

naturalized [sic] to become citizens to access Medicaid due to cultural/language barriers, and the cost to become [sic] citizens/waivers' request."[12]

Requests from providers show that having more 1a1 and 1a2 funds available would allow them to expand services to people in need, as Mario Paredes from CONSEJO says, "the need to provide more outpatient behavioral health services to low-income Latinos and other minority groups throughout the county goes far beyond our current allocation."[8]

In addition to uninsured groups there are treatment and support services provided using these Strategy funds that are not reimbursable with other State or Federal funding. These services currently include outreach and engagement, recovery support specialists (RSS), Sobering, jail-based treatment, Clubhouse services, and transportation. An expansion of these strategies is requested to broaden the menu of services covered by this Strategy found to be essential to recovery-oriented care as identified by members of the behavioral health provider network. ACRS says "it will be helpful if additional Non-Medicaid funds can also support outreach, engagement, early intervention, and prevention for Adult and Youth MH clients"[13] and "for clients with cultural and language barriers, it will be helpful to have Non-Medicaid funds to assist them with health navigation to access Medicaid/Qualified Health Plans if they are eligible" and "we highly recommend that additional Non-Medicaid funds be allocated to support infrastructure building, training, and enhancement of cultural competency."[10] Additionally, CONSEJO states, "the current MIDD funding does not cover all of the same expenses associated with treatment that would be covered by Medicaid. Whereas transportation, prescriptions, and interpreter services are covered costs in Medicaid and Medicare, MIDD does not reimburse for those essential expenses. Although the current tier system covers psychiatric/ARNP services, it does not cover the cost of medications. This becomes a major challenge for the monolingual and undocumented consumer that does not receive SSI or State financial assistance. In most cases, when a client is discharged from an emergency room they are only given as low as three days or as high as seven days of medication. Once they run out of medication, the consumer is at high risk of decompensation. CONSEJO partners with pharmaceutical companies and provides patients with medication samples. However, we are limited to the number of medication samples and types of medication we are able to receive. MIDD funded clients will benefit if every tier that needs care could have access to short term medication vouchers."[14] Allowing the use of MIDD 1a funds to cover psychologist/psychiatrist services and medications would provide individuals without Medicaid the full gamut of services accessible to persons on Medicaid.

If Strategy 1a funds are not implemented and expanded, thousands of King County residents would not be able to receive needed behavioral health services, which would result in increased homelessness, incarceration, use of emergency services, and inequities.

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

The public MH 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 MH treatment but are not on Medicaid and are financially unable to pay for services. Existing Strategy 1a1 has been utilized to

[12],Yoon Joo Han, Victor Loo, and Junko Yamazaki. Asian Counseling and Referral Service. Email dated 01/05/2016.
[13] Yoon Joo Han, Victor Loo, and Junko Yamazaki. Asian Counseling and Referral Service. Email dated 01/05/2016.
[14]Mario Paredes, Executive Director at Consejo Counseling and Referral Service, email dated 01/05/2016.

provide MH outpatient treatment capacity for an average of 4,200 individuals annually that would otherwise not have access to publicly funded MH treatment. Existing Strategy 1a2 has provided additional capacity in SUD outpatient treatment services, MAT, WM, and sobering services for individuals who would otherwise not have access to publicly funded treatment services. Since 2008, these strategies have funded treatment and support for approximately 30,000 residents who otherwise would not have had access.[15] Due to increased outreach and engagement efforts, along with shifting to a more recovery-oriented system of care, these numbers are expected to grow over the coming years.

Additionally, as treatment access becomes less of a barrier with increased Medicaid accessibility, some 1a1 and 1a2 funds have provided other services not covered by the Federal or State government. Examples are Clubhouse memberships for persons with mental illness, urinalysis tests for those in recovery from SUD, Sobering services and RSS services at the Sobering Center. Strategy 1a2 funds were also recently used to help bridge the gap of WM services when the sole contracted provider suddenly terminated their contract, requiring the County to utilize WM services from private organizations whose cost of services were triple the cost of publicly funded WM services. Without the 1a2 funds there would have been no publicly funded WM services in King County between the time of the contract termination and on-boarding a new WM provider who is now able to bill Medicaid. This would have resulted in persons in need of WM services overloading emergency rooms or not getting the help they needed at all.

New concept 32 would address the need for youth who are at-risk by enhancing and expanding mental health counselling serves (individual, group and family) that are trauma-informed and culturally and linguistically appropriate. New concept 132 would address the recent homelessness emergency declaration announced by Seattle Mayor Murray by providing community-based, intensive, wraparound, supportive housing services to those experiencing homelessness. This would provide supportive housing to those in need and access to behavioral health and medical services before they escalate to a crisis situation. As mentioned previously, 1a funds would not be used for the housing itself, but would assist with paying for the wrap-around supports. New concept 135 would provide a youth inpatient center closer to home for many youth in need of residential care avoiding the travel to Eastern Washington. By having a local inpatient center, families can stay connected and be included in their child's treatment. Additionally, discharge planning and transitioning back into the community will be more effective.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The annual MIDD evaluation reports show that Strategies 1a1 and 1a2 have resulted in an overall reduction in jail and psychiatric hospitalization incidences for most people and reduced emergency room admissions overall. The MIDD Sixth Year evaluation report found that there was a 173 percent increase in 90-day drug and alcohol abstinence in school-aged youth receiving SUD treatment.[16] The

[15] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Second, Third, Fourth, Fifth, Sixth, and Seventh Annual Reports.

[16] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Seventh Annual Report: Implementation and Evaluation Summary for Year Six October 1, 2013—September 30, 2014. February 2015.

MIDD Fifth Year evaluation reports that 85 percent of individuals receiving MH treatment had improved anxiety and depression symptoms over time and 26 percent of adults in SUD treatment had achieved abstinence.[17] The Fifth Year report also stated, "nearly half of the one-year outcomes sample for those in substance abuse treatment (3,458 of 7,588) had encounters with the local criminal justice system. On average, those jailed were incarcerated for just over a month in the year preceding their MIDD funded treatment start. During their first year of services, the average time spent in jail was about 24 days. Over time, average days in jail dropped below 17 days for the opiate substitution (MAT) sample that was eligible for longer term outcomes."[14]

The effectiveness of 1a1 and 1a2 is also evidenced in provider reports, "MIDD works to give all residents of King County the opportunity to receive behavioral health care and support when they need it most. Unlike other funding, MIDD treats all residents equally, regardless of their financial or legal circumstances. The openness of MIDD means that everyone in King County will always be able to get treatment and help if they want it, which has helped to achieve more in the realm of equality and social justice than any other recent legislation. This community tax funded effort placed King County high in the nation as an integrated care model that treats all patients the same regardless of their circumstances."[18]

Concept 132 is based on The Community Research Foundation in San Diego. Their published research states that community-based residential care resulted in "significantly fewer hospital and/or crisis residential admissions and days during the follow-up year. At the one-year follow-up, a significantly greater proportion of clients were employed and living independently and fewer were homeless. GAF scores were significantly improved at the one-year follow-up"[19].

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

There have been many studies published regarding the effectiveness of crisis and outpatient treatment services, including several published by the State of Washington Research and Data Analysis Division. Many County-contracted providers utilize programs identified as evidence-based, research-based, and promising as identified in the Washington State Institute for Public Policy and the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices.[20,21]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

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[17] King County Mental Illness and Drug Dependency (MIDD) Oversight Committee. MIDD Sixth Annual Report: Implementation and Evaluation Summary for Year Five October 1, 2012—September 30, 2013. February 2014.

[18] Mario Paredes, Executive Director at Consejo Counseling and Referral Service, email dated 01/05/2016.

[19] William B. Hawthorne, William Fals-Stewart, and James B. Lohr. Treatment Outcome Study of Community-Based Residential Care. Community Research Foundation. http://www.comresearch.org/researchDetails.php?id=MQ==.

[20] Marna Miller, Danielle Fumia, and Noa Kay. Updated Inventory of Evidence-based, Research-based, and Promising Practices: *Prevention and Intervention Strategies for Adult Behavioral Health, Benefit-Cost & Meta-Analysis Results*. Washington State Institute for Public Policy. January 2015.

[21] Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices, http://nrepp.samhsa.gov/01_landing.aspx.

The MIDD Evaluation indicates that strategy performance exceeded goal expectations on the two primary goal areas (1. Reduce jail, emergency room, and psychiatric hospital use, and 2. Reduce incidence and severity of mental health and substance use disorder symptoms) targeted in MIDD 1a1 and 1a2. It is probable that adoption of the two new concepts would contribute to these successful outcomes.

Outcomes include:[22]

- Reduced substance use disorder symptoms
- Improved psychiatric symptoms and functioning
- Decreased unnecessary hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

Youth related outcomes include:

- Increased access to person-centered, culturally appropriate counseling and case management services.
- Reduced risk factors for substance use and mental health disorders
- Increased retention in school (and employment for older youth)
- Improvement in life domains: Family Functioning; Peer Relations; Community Attachment; Individual Emotional/Behavior; Academic Achievement and School Readiness. HSD currently collects data on improvement in these life domains via monthly status reports from contracted youth mental health providers.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

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

[22] http://www.samhsa.gov/treatment

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Strategy 1a1 and 1a2 serves all King County residents not on Medicaid and financially unable to pay for services.

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

Contracted behavioral health providers are located throughout King County and efforts are being made to expand providers in areas currently underserved and identified as having the most need.

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

Partnerships with behavioral health providers in King County are already established, although the County is currently working to expand its option of providers and service areas to meet the needs of each individual community. Collaborations are continuously being explored with other jurisdictions and cities, law enforcement, first responders, housing providers and employers in order to outreach and engage individuals with a MH/SUD need. Expanding this strategy is imperative in responding to community collaborators' identified system improvement needs, such as funding non-Medicaid service (SUD outreach) or providing the full scope of services to King County populations (undocumented behavioral health clients).

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The Affordable Care Act expanded access to MH and SUD treatment for more King County residents, however not everyone qualifies and this still does not make care more affordable for some, nor are all needed services covered. Strategy 1a1 and 1a2 fills this gap. SUD and MH integration as well as integration with primary care will open the doors to treatment for more people. By having a dedicated fund source that will cover treatment for those without coverage or with an inability to pay ensures that there are no gaps in coverage for treatment for all.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

Most of these services are currently being provided under this existing strategy. There are no foreseeable barriers with the continuation or most of the expansions proposed for this strategy. Siting an in-patient youth treatment facility, unless it is within an existing facility, could potentially run into the

usual community opposition encountered when siting behavioral health facilities. Engagement with community leaders, youth serving institutions, and the community at large would likely be necessary..

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

No unintended consequences have been met under these Strategies and no future unintended consequences are expected.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

The potential negative impact is difficult to fathom. The possible catastrophe in King County's behavioral health system of care will be astounding. As previously mentioned, in the past seven years, approximately 30,000 King County residents have received services as a result of this strategy. If Strategy 1a is not implemented and expanded, residents living with MH and SUD diagnosis will be left untreated and based upon evaluation, it is known that jail incidences, emergency room admission, and psychiatric hospitalizations will increase. Additionally, if defunded, it is anticipated that disparities in Equity and Social Justice will increase due to this strategy's ability to treat undocumented individuals that are not of dominant race and ethnicity.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

There are no alternative approaches to address this need as non-Medicaid State and Federal funds for treatment have been cut significantly over the past several years. Private philanthropic dollars are generally geared toward innovative new programs and not the fundamental bread and butter services described here.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

MIDD 1a1 and 1a2 funds a variety of treatment and support within the continuum of care, from initiation through treatment and aftercare, including outpatient MH, Clubhouse membership, limited transportation, outpatient SUD, MAT, WM, Sobering, and RSS services. These funds also cover treatment when individuals lose their Medicaid coverage or are intermittently eligible, which prevents disruption of their continuity of care and maintains the individual's clinical stability. If approved, concept 32 would further enhance services for youth, concept 132 would further enhance the service delivery of Strategy 1a and concept 135 would fund a new, local youth inpatient facility.

These strategies fit within Behavioral Health Integration and Health and Human Services Transformation in that it removes the financial barrier to treatment, which will allow eligible persons to receive the treatment they need, regardless if its MH or SUD. This, in turn, makes navigating the behavioral health system easier for a person struggling with mental illness and/or addiction, which fits within the County's Equity and Social Justice Initiative. These strategies also fit within All Home in that persons struggling with addiction or mental illness are more likely to experience homelessness.

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

Strategy 1a1 and 1a2 is rooted in the principles of recovery and resiliency in that it supports all individuals regardless of status to receive treatment for their MH and SUD needs. These strategies fund gaps in the continuum of care which allows individuals to access care specific to their needs. Strategy 1a1 and 1a2 is also rooted in the principles of trauma-informed care in that the funds support persons who are the most marginalized in the community and more likely to have experienced trauma such as immigrants, refugees, inmates, persons experiencing crisis, and people experiencing homelessness, to name a few.

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

Strategy 1a1 and 1a2 furthers the County's Equity and Social Justice work in that it offers the ability for individuals to reach their full potential regardless of whether or not they are insured. The Affordable Care Act guarantees access to care (including making MH and SUD treatment one of the ten essential health benefits) for millions more Americans, but leaves out important groups. 1a1 and 1a2 focuses on these groups and ensures that they have the same access to care as their neighbors. Individuals with behavioral health disorders as a population suffer from premature death[23], as well as high rates of incarceration. Providing adequate treatment is essential to reducing these disparities.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

Most resources are already in place for these strategies; concept 135 would require a building that could function as a youth residential facility, as well as staffing and all the things that would need to go in the building to support the program.

2. **Estimated ANNUAL COST. More than $5 million Provide unit or other specific costs if known.**

The current funding level for the combined MH and SUD 1a strategies is $10.25 million. The demand for non-Medicaid outpatient services and the need to increase the amount of funding to better address the real costs of providing equitable outpatient services for MH and SUD out strips the current funding level by over $3 million. To fund the outpatient need and the other services identified in the information above, the strategy will require at least $17 million.

[23] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1563985/

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

State and Federal funds used to cover SUD treatment for low income, uninsured individuals. However these funds have been significantly cut both prior to and since Medicaid Expansion, so they are no longer available to the degree they are needed. The public MH system has long been driven by Medicaid funding. Medicaid regulations require that funds be expended only for persons on Medicaid so there are no other revenue sources to cover MH treatment for these persons.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?** There are no factors in the time to implementation as these Strategies are already underway, with the exception off concept 135. If this component of the Strategy were to be accepted, steps to contract with a new youth residential provider and site a facility would need to be taken.
    b. **What are the steps needed for implementation?** For concept 135, a provider and location would need to be identified.
    c. **Does this need an RFP?** Continuation of existing Strategy 1a does not. An inpatient facility would need an RFP**.**

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

H.

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[24] and non-opiate substitution substance abuse treatment[25] 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 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.

[24] 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)

[25] 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)

◊ *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.

#32

Working Title of Concept: Increase access to community-based mental health and chemical dependency outpatient services for youth at risk (not on Medicaid).

Name of Person Submitting Concept: Pat Wells
Organization(s), if any: City of Seattle Human Services Department
Phone: 206-684-0524
Email: pat.wells@seattle.gov
Mailing Address: 700 5th Ave., Floor 56, Seattle, WA 98124-4215

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

This funding would provide mental health services for children and youth at risk up to age 25 that do not qualify for Medicaid assistance or have private insurance. Those at risk include lower-income youth; youth of color; LGBTQ youth; immigrants and refugees; those who have experienced violence and other traumas and homeless/unstably housed youth.

Mental Health counseling services will include access to individual, group and/or family counseling that is culturally and linguistically appropriate in a community or school-based setting for 3-24 months. Services would also include case management and wraparound support to support retention in school and/or employment, and stabilize families.

This funding would allow Seattle Human Services Department's Youth and Family Empowerment Division to expand and enhance currently contracted mental health counseling services for youth at risk to include Native American and other underserved groups. Focus would include expanded services for youth specific to early onset mental illness, addiction and family support systems.

2. What community need, problem, or opportunity does your concept address?

Please be specific, and describe how the need relates to mental health or substance abuse.

Nationally, 21% of low-income children and youth have mental health disorders. Youth of color experience disparities in prevalence and treatment for mental health needs. (source: Centers for Disease Control and Prevention). In Seattle, African American, Latino and Native American children are less likely to be covered than white children by health insurance (source: American Community Survey 2009-2013). "Considered suicide" responses were higher from Asian, Latino and Black respondents in the Seattle Youth Risk Behavior Survey 2012. Homeless youth are three times more likely than youth with homes to suffer from a mental health issue-e.g., major depression, anxiety, conduct disorder and post-traumatic stress syndrome (Source: National Center on Family Homelessness). Trauma related to Adverse Childhood Experiences (ACES) has been shown to be a legacy that extends/is repeated in ensuing generations. The King County "Healthy Youth Survey" from 2008-2012 demonstrated the following results for youth who reported feeling sad/hopless for last two weeks: 37% American Indian; 32% Latino; 28%multi-racial; 26% Pacific Islander and 24% Black. In 2013, 284 youth were served by HSD-contracted mental health youth service providers; of these youth, 84% were youth of color and 15% were immigrants/refugees. With additional funding, more youth could be served with culturally and linguistically appropriate counseling with a trauma-informed lens.

3. How would your concept address the need?
Please be specific.

Mental health services are provided in school based settings and in the community where the youth and families naturally gather and live. Several studies have shown that school based services are particularly effective for youth.

Adolescents are 21 times more likely to make a mental health visit to a school-based provider than to a community site. Juszczak L, Melinkovich P, Kaplan D. Use of health and mental health services by adolescents across multiple delivery sites. The Journal of Adolescent Health. Jun 2003;32(6 Suppl):108-118

The increased availability of mental health services in schools reduces the stigma of seeking mental health care and increases accessibility of that care. Brown MB, School-based health centers: implications for counselors. The Journal of Counseling and Development. 2006;84(2):187-191

There is a high prevalence of depressive symptoms, suicidal thoughts, and suicide attempts among adolescents who forgo care due to confidentiality concerns. 28. Lehrer, J.A.; Pantell, R.; Tebb, K.; Shafer, M.A. 2007. Forgone Health Care Among U.S. Adolescents: Associations Between Risk Characteristics and Confidentiality concern. Journal of Adolescent Health 40(3): 218-226

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

Potential program participants would include children and youth to age 25 who do not qualify for Medicaid or have private insurance; low-income youth; youth of color, with a particular focus on Native American youth; children and youth who have experienced violence and other traumas; immigrant and refugee youth; Gay, Lesbian,Bisexual, Transgender and Questioning Youth; and youth who are homeless or unstably housed. Services would also be delivered to youth in crisis who are eligible but not receiving Medicaid or whose tiered mental health services have been exhausted.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

***Increased access to person-centered, culturally appropriate counseling and case management services.**
***Reduced risk factors for substance use and mental health disorders**
***Increased retention in school (and employment for older youth).**
***Improvement in life domains: Family Functioning; Peer Relations; Community Attachment; Individual Emotional/Behavior; Academic Achievement and School Readiness. HSD currently collects data on improvement in these life domains via monthly status reports from contracted youth mental health providers.**

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

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

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

Youth of color experience disparate health, education, employment, housing and economic outcomes which are exacerbated by their lack of access to culturally and linguistically competent mental health services. These funds would address this disparity for additional youth.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Community-based mental health providers serving youth will partner with schools and school-based health services to implement this model. In addition, human services agencies such as providers of housing for homeless youth, GLBTQ services and programs serving youth impacted by violence will refer youth at risk for mental health services.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation: $ 109,700 per year, serving 50 people per year
Partial Implementation: $ 219,491 per year, serving 100 people per year
Full Implementation: $ 438,732 per year, serving 200 people per year

Seattle City Attorney Peter S. Holmes

SEATTLE CITY ATTORNEY'S OFFICE 701 FIFTH AVENUE, SUITE 2050, SEATTLE, WASHINGTON 98104-7097 (206) 684-8200 FAX (206) 684-8284
TTY (206) 233-7206 an equal employment opportunity employer

October 31, 2015

#132 New Concept Submission Form
Please review the preceding pages before completing this form.
Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#132 **Working Title of Concept:** Community-Based Mental Health Care

Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097
Please note that county staff may contact the person shown on this form if additional information or clarification is needed.
Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.
Build and operate a community based mental health system like San Diego that addresses the intersection of mental health and homelessness. Prioritize 0-24 year olds.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.
Community Research Foundation (CRF) is similar in design to Sound Mental Health or Community Psychiatric Center here in town (a large non-profit focused on community mental health care). However, their approach is more multifaceted and focuses on different programs on different treatment needs at a larger scale. Their START programs have crisis houses that are a cross between an intensive outpatient and/or partial hospitalization that is focused in the community rather than at the hospital. As a step down, they have "club houses" that are more day treatment and helping to get chronically mentally ill/homeless off the street during business hours. An additional interest may be

their IMPACT programs that are intensive wrap around services for the chronically homeless. http://www.comresearch.org/services.php

3. How would your concept address the need?
Please be specific.

It is too burdensome and costly to make people travel long distances for care. It is not user-friendly, and it does not work. Mental health care must be community-based, culturally appropriate, easy to access and supportive and residential.

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

This would benefit all mental health patients, especially the homeless. Equally important it will be bring great relief to families and communities impacted by the mentally ill and homeless.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Patients will receive supportive housing, wrap around services, and mental health treatment in their communities.

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

X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

X **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

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

Supportive housing has been very successful in Seattle and elsewhere. This would help improve the lives of people living with mental illness by providing them with treatment in a residential context

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.
Sound Mental Health, Community Psychiatric Clinic, Downtown Emergency Services Center.
9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**

Seattle City Attorney Peter S. Holmes

SEATTLE CITY ATTORNEY'S OFFICE 701 FIFTH AVENUE, SUITE 2050, SEATTLE, WASHINGTON 98104-7097 (206) 684-8200 FAX (206) 684-8284 TTY (206) 233-7206 an equal employment opportunity employer

October 31, 2015
New Concept Submission Form
Please review the preceding pages before completing this form.
Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.
#135 Working Title of Concept: Juvenile In-Patient Drug Treatment
Name of Person Submitting Concept: Darby DuComb
Organization(s), if any: Seattle City Attorney's Office
Phone: 206-684-8228
Email: darby.ducomb@seattle.gov
Mailing Address: 701 Fifth Avenue, Suite 2050, Seattle, WA 98104-7097
Please note that county staff may contact the person shown on this form if additional information or clarification is needed.
Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*
1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.
Build and operate a juvenile alcohol and drug dependency in-patient treatment facility.
2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.
It is our understanding that juveniles must travel to Eastern Washington to receive in-patient treatment for alcohol and drug addiction.
3. How would your concept address the need?
Please be specific.
It is not appropriate for young people to be so separated from their families, friends and community in order to receive in-patient alcohol and drug treatment. This would allow all juveniles to obtain community based, culturally appropriate treatment. October 29, 2015 Page 2

4. Who would benefit? Please describe potential program participants.
This would benefit all juveniles in need of in-patient alcohol and drug treatment. In addition to the patients, families are also better served.
5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.
Juveniles would receive alcohol and drug treatment and maintain connections to family, friends, and school, allowing for more long-term success.
6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)
X **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
X **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
X **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
X **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.
7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?
It can be very detrimental to young people to be removed from their family, friends and community in a time of crisis and poor health. This would better enable extended support for our young people, maintain positive relationships, and allow for a smoother re-entry into a community after in-patient treatment.
8. What types of organizations and/or partnerships are necessary for this concept to be successful?
Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.
Drug and Alcohol Treatment providers, Department of Social and Health Services.
9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?
Pilot/Small-Scale Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: $ # of dollars here **per year, serving** # of people here **people per year** October

Full Implementation: $ # of dollars here **per year, serving** # of people here **people per year**
Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.
If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.