BP 22 Jail-based Substance Abuse Treatment through a Modified, Variable Length of Stay and Evidence-based Model at the Maleng Regional Justice Center
BP 81 Jail-based Chemical Dependency Treatment

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept ☒ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This is a proposal to expand substance use disorder (SUD) treatment at the King County Maleng Regional Justice Center (MRJC). Persons are often arrested and incarcerated for behaviors either directly or indirectly related to substance abuse. The National Center on Addiction and Substance Abuse (CASA) at Columbia University published a study in 2010 showing that 65 percent of all incarcerated persons in the United States (U.S.) meet medical criteria for a substance use disorder (SUD), yet only 11 percent receive any treatment.[1] Initial withdrawal management (detoxification) is provided at King County correctional facilities. Currently there are very limited resources for SUD treatment at the King County Jail outside of King County Adult Drug Diversion Court (Drug Court) programming at the Maleng Regional Justice Center (MRJC). This program is called the *Transitional Recovery Program* (TRP), and is limited to certain case mitigation and a small number of offender-patients who are not participating in Drug Court.[2] While in jail, the nature of the controlled setting and limited "competing demands" offer an opportunity to initiate evidence-based SUD treatment to a broader population. This new concept proposes that physician level oversight from King County Jail Health Services address relevant medication options, and work with contracted SUD counselors in developing individual treatment plans, including for participants with co-morbid mental illnesses.

Collaborators:

Name	**Department**

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

Name	Role	Organization
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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**

[1] http://www.casacolumbia.org/newsroom/press-releases/2010-behind-bars-II. Accessed 01/24/16.
[2] TRP is available to a few King County Regional Mental Health Court participants with co-morbid mental illness and SUDs.

Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

This is a proposal to expand substance use disorder (SUD) treatment at the King County Maleng Regional Justice Center (MRJC). Persons are often arrested and incarcerated for behaviors either directly or indirectly related to substance abuse. The National Center on Addiction and Substance Abuse (CASA) at Columbia University published a study in 2010 showing that 65 percent of all incarcerated persons in the United States (U.S.) meet medical criteria for a substance use disorder (SUD), yet only 11 percent receive any treatment.[3] Initial withdrawal management (detoxification) is provided at King County correctional facilities. Currently there are very limited resources for SUD treatment at the King County Jail outside of King County Adult Drug Diversion Court (Drug Court) programming at the Maleng Regional Justice Center (MRJC). This program is called the *Transitional Recovery Program* (TRP), and is limited to certain case mitigation and a small number of offender-patients who are not participating in Drug Court.[4] While in jail, the nature of the controlled setting and limited "competing demands" offer an opportunity to initiate evidence-based SUD treatment to a broader population. This new concept proposes that physician level oversight from King County Jail Health Services address relevant medication options, and work with contracted SUD counselors in developing individual treatment plans, including for participants with co-morbid mental illnesses.

King County seeks to reduce recidivism among populations with recurring incarcerations in the King County Jail. Through the application of risk/need/responsivity principles,[5] including access to fidelity adherent jail-based and community-based SUD and integrated behavioral health disorder treatment, recidivism can be reduced among this criminal justice involved population. This new concept seeks to increase access to SUD treatment at the MRJC beyond those served by the TRP primarily for Drug Court participants.

A provider will be selected through a competitive Request for Proposals (RFP) process with demonstrated skill and expertise in employing fidelity adherent, evidence-based practices to train corrections and treatment staff in the implementation of a modified therapeutic community (TC); the provider will be contracted to provide a continuum of services including screening, assessment, and a variable length of outpatient SUD treatment and criminogenic interventions at the MRJC. The Drug Court/TRP component will be incorporated in the RFP to ensure a single provider is engaged to serve the Drug Court/TRP and the modified TC.

The implementation of the proposal will provide a modified TC in the MRJC's L-Unit (men participants) where the TRP program is currently based. Thirty-four beds (proposal) will be devoted to the modified TC model in L-Unit (men) and the remaining 30 beds of the 64-bed unit will be dedicated to Drug Court participants. Up to 12 beds will continue to be dedicated to Drug Court participants in P-Unit (women); any of these beds that are not used by Drug Court will be available to other women at the MRJC in need of SUD treatment under the proposal. Clinical program coordination will be provided by Jail Health Services via a newly hired program coordinator requested in the proposal.

Participants will be admitted/transferred to designated therapeutic units based on their gender and receive appropriate services, including psychiatric services for participants with co-occurring mental health disorders, with the expectation that they will be released directly to the community for on-going

[3] http://www.casacolumbia.org/newsroom/press-releases/2010-behind-bars-II. Accessed 01/24/16.
[4] TRP is available to a few King County Regional Mental Health Court participants with co-morbid mental illness and SUDs.
[5] http://offenderchange.org/programs/risk-need-responsivity-model/.

care and not returned to the general population upon completion of a predetermined number of days in in-custody treatment, such as currently structured in the TRP.[6]

A partial implementation scenario will assure Drug Court participants and veterans will be included in the modified TC milieu (proposal) in L-Unit; the treatment experience for Drug Court participants will be enhanced through participation in this dedicated therapeutic environment. The leveraged Drug Court component is (and will continue to be) funded via Washington State Criminal Justice Treatment Account funds via Chapter 70.96A.350 Revised Code of Washington (RCW)[7]. Additionally, the partial implementation concept will extend outpatient treatment to veterans housed in other units, as well as providing gender-specific, trauma informed care to women at the MRJC.

A full implementation scenario will further provide for a coordinated handoff to continued outpatient and other re-entry services for those participants who are court-ordered to report to the King County Community Corrections Division's Community Center for Alternative Programs (CCAP) upon release from custody. There is an intensive outpatient (IOP) SUD treatment program that has operated at CCAP since 2004, funded primarily via Title XIX-Medicaid. A full implementation of the proposal will incorporate one caseload of 15 maximum participants in Integrated Dual Disorders Treatment (IDDT) at CCAP, including transitional housing for participants who are homeless and for participants with co-morbid mental health conditions. A half-time care coordinator hired by the Community Corrections Division will assist with triage and matching proposal participants to appropriate services at CCAP, including IDDT.

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).

This combined new concepts briefing paper fits under the MIDD II Strategy Area of Recovery and Re-entry as it focuses on facilitating in-custody SUD treatment with re-entry services in the community for court-involved individuals as they work towards recovery.

It also represents a systems improvement as it provides a modified TC at the MRJC, and employs evidence-based practices within a continuum of services, including screening, assessment, and variable length of outpatient SUD treatment and criminogenic interventions at the MRJC; the proposal will include IDDT services at CCAP in the full implementation scenario only.

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

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.**

[6] The *Transitional Recovery Program* is presently structured as a static 60-day treatment program, per contract, with no flexibility for variable lengths of stay.
[7] http://apps.leg.wa.gov/RCW/default.aspx?cite=70.96A.350.

The Department of Justice's Bureau of Justice Statistics estimates that nearly 75 percent of all released prisoners will be rearrested within five years of their release and about 60 percent will be reconvicted.[8] For many persons involved in the criminal justice system, preventing future crime and re-arrest is near impossible without the benefit of SUD treatment. To date, King County has not prioritized comprehensive SUD treatment in its jails despite clear benefits to the people in need, their families, and communities, in promoting recovery. Treatment consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration caused by drug use.[9] Holding someone with a SUD in jail without access to SUD treatment, and with no specific plans for intervention and recovery support upon release is ineffective and expensive.

SUD treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offender-patients with SUDs. Jail should be a place where individuals can get the help they need to return to their communities with reason for hope. Untreated individuals with SUDs are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources. Scientific research shows that treatment that specifically employs evidence-based practices to fidelity—such as cognitive behavioral therapy, trauma informed care, contingency management and role play—can and does help many people change their criminal attitudes, beliefs, and behaviors; it provides tools to avoid relapse and successfully remove them from lives of substance use and crime.[10] Treatment for the jail population "can cut drug use in half, decrease criminal activity, and reduce arrests."[11] Even those who are not initially motivated to change can become engaged in a continuing treatment process. In fact, research suggests that court-ordered SUD treatment can be just as effective as voluntary treatment.[12]

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

This proposal seeks to greatly expand SUD treatment capacity for incarcerated persons in the King County Jail through the application of a modified TC approach throughout L-Unit. The modified TC is the most researched and evidence-based intervention for incarcerated persons with SUDs (Vanderplasschen, et al; 2013),[13] and a modality that has long been desired at the King County Jail.

The proposal will expand treatment services to veterans with SUDs and others residing in other units at the MRJC. Moreover, this concept will provide gender-specific SUD treatment to non-TRP women in P-Unit. Finally, physician level oversight from Jail Health Services will address relevant medication options, and work with contracted SUD counselors in developing individual treatment plans, including for participants with co-morbid mental illnesses.

Discussions are underway between the King County Behavioral Health and Recovery Division and Public Health—Seattle & King County/Jail Health Services to improve in-custody opioid treatment program

[8] Matthew R. Durose, Alexia D. Cooper, and Howard N. Snyder, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010, NCJ 244205, April 2014, p. 1. Cited from https://fas.org/sgp/crs/misc/RL34287.pdf on 01/24/16.
[9] National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. Bethesda, MD: National Institutes of Health, National Institute on Drug Abuse. NIH publication No. 11-5316, revised 2012. Available at www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations.
[10] https://prezi.com/agu1gruaaims/should-criminals-be-treated-or-incriminated-for-addiction/, (Dec. 2014). Accessed 01/25/16.
[11] Ibid, https://prezi.com/agu1gruaaims/should-criminals-be-treated-or-incriminated-for-addiction/, (Dec. 2014).
[12] Ibid, NIDA. NIH publication No. 11-5316, revised 2012.
[13] http://www.hindawi.com/journals/tswj/2013/427817/. Accessed 01/25/16.

(OTP) services at the King County Jail. Incarcerated individuals served via the new concept introduced in this briefing paper, who are opioid dependent, will have access to the improved OTP in the jail. A jail-based component of a continuum of SUD treatment and services—with linkage to critical behavioral health, primary care, and social services in the community—will help offender-patients achieve stability in the community as they work towards recovery.

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.**

A number of studies have found that TC participants show improvements in substance abuse, criminal behavior, and mental health symptoms; this is especially true of participants who enter treatment with the most severe behavioral health problems.[14,15] The NIDA-sponsored Drug Abuse Treatment Outcome Studies (DATOS), which examined the effectiveness of several types of SUD treatment programs in the U.S., found TCs to be effective; TC participants who showed improved behavior after one year continued do so at a five-year follow-up.[16] Moreover, research indicates that modified TCs for correctional settings and for individuals with co-occurring disorders is effective.[17]

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

Practices grounded in research produce meaningful outcomes, can be/are standardized and replicated, and often have fidelity scales or tools to measure adherence to the model. The core evidence-based practices, best practices and promising practices to be required of the selected community provider will include the following: Use of evidence-based clinical practices for screening, assessments, jail in-reach, warm linkage facilitation and discharge planning. The proposal is in alignment with the following core clinical competencies and service delivery framework of evidence-based or best and promising practices.

Motivational Interviewing (Evidence-based practice)

Motivational interventions aim to respect and promote patient choice. Motivation interviewing (MI) is a directive, client-centered approach for eliciting behavior change by helping clients to explore and resolve ambivalence.[18] Compared with non-directive counseling, MI is more focused and goal-directed.

Standards of Care for Individuals with Co-occurring Disorders (Best practice)

Co-occurring mental health and SUDs should be expected, not considered an exception. Consequently, the whole system must be designed to be accessible to patients with co-occurring mental health and

[14] De Leon, G: Is the therapeutic community an evidence-based treatment? What the evidence says. *Therapeutic Communities.* 31:104–128 (2010).

[15] Vanderplasschen W., Colpaert K., Autriquem M., et al. Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective. *Scientific World Journal*. (2013) 2013:427817.

[16] Hubbard R., Craddock S., Anderson J. Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of Substance Abuse Treatment*. (2003) 25:125–134.

[17] http://www.drugabuse.gov/publications/research-reports/therapeutic-communities/how-are-therapeutic-communities-integrated-criminal-justice-system. Accessed 01/24/16.

[18] Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 23, 325-334. Cited from http://www.motivationalinterview.net/clinical/whatismi.html.

SUDs. Per Dr. Kenneth Minkoff's article (1991) on developing standards of care for individuals with co-morbid disorders, he recommends adoption of "a coherent set of principles on which system design will be based, embodying an integrated philosophy that is acceptable to both mental health care and substance use treatment providers."[19] These principles, which will be addressed in the proposed proposal, are as follows:

- Psychiatric and SUDs should be regarded as primary disorders when they co-exist, each requiring specific and appropriately intensive assessment, diagnosis, and treatment, in accordance with established practice guidelines.
- Serious psychiatric and SUDs are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery.
- Within each subtype of the treatment population, patients are in different phases of treatment and at different stages of change with regard to their illness. Thus a comprehensive array of interventions that are phase and stage specific is required.
- Whenever possible, treatment of persons with complex co-morbid disorders should be provided by programs with expertise in mental health and SUDs.
- The system should promote a longitudinal perspective on the treatment of patients with complex co-morbid disorders, emphasizing the value of continuous relationships with integrated treatment providers, independent of participation in specific programs.
- Admission criteria should not be designed to prevent individuals from receiving services, but rather, to promote acceptance of patients at all levels of motivation and readiness and with any combination of co-morbid disorders.
- The service system should not begin or end at the boundaries of formal treatment programs; rather, it should include interventions to engage the most detached individuals— for example, those who are homeless (or likely to be homeless upon release).
- The fiscal and administrative operation of the system should support the accomplishment of the system's mission and the implementation of these principles.[20]

The following evidenced based practices are proven effective and are the proposed treatment interventions to implement in the TC:

Seeking Safety (Evidence-based practice)

Seeking Safety is a counseling model, facilitated by a mental health professional (MHP), focused on the present to help individuals attain safety from trauma and/or substance abuse. It directly addresses both trauma and SUDs without requiring patients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of patients and relatively easy to integrate into the treatment plan. The model is highly flexible and can be conducted in a group or individual format, for men and women, for any length of treatment or level of care, and any type of trauma.[21]

Trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and

[19] Minkoff, K: Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders, in Dual Diagnosis of Serious Mental Illness and Substance Disorder: New Directions for Mental Health Services, no. 50:13–27, 1991.

[20] Kenneth Minkoff, M.D., Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders, *Psychiatric Services*, May 2001 Vol. 52 No. 5, p. 598.

[21] Implementing an evidence-based practice: Seeking Safety group ([dagger]).. (n.d.) *>The Free Library.* (2014). Retrieved 01/25/16 from http://www.thefreelibrary.com/Implementing+an+evidence-based+practice%3a+Seeking+Safety+group...-a0172776805. Also, see http://www.treatment-innovations.org/ss-description.html. Accessed 01/24/16.

programs can be more supportive and avoid re-traumatization. This includes understanding the individual's need to be respected, informed, connected, and hopeful regarding their own recovery and the interrelation between trauma and symptoms of trauma (e.g., SUDs, eating disorders, post-traumatic stress disorder, depression, anxiety). The selected provider of direct services must be trauma-informed, recognizing the impact of traumatic experiences on an individual.

The APIC Model of re-entry support from jail by The National GAINS Center (Best Practice)
The APIC Model—Assess, Plan, Identify and Coordinate—describes elements of re-entry planning associated with successful reintegration back into the community for people with co-occurring mental health and SUDs or other special needs who are being discharged from jails to the community.[22] The model is particularly important for breaking the cycle of repeated homelessness and incarceration.

Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM)[23] (Best practice)
SPECTRM is an approach to client engagement that is based on an appreciation of the "culture of incarceration" and its attendant normative behaviors and beliefs. Through their experience in the uniquely demanding and dangerous environment of jail and prison, many develop a repertoire of adaptations that set them apart from persons who have not been incarcerated. The so-called inmate code—which includes rules and values such as do not snitch, do your own time, and do not appear weak—may be manifest in certain behaviors, such as not sharing any information with staff, minding one's business to an extreme, and demonstrating intimidating shows of strength. Although these behaviors help the person adapt during incarceration and act as survival skills in a hostile setting, they seriously conflict with the expectations of most therapeutic environments and thus interfere with community adjustment and personal recovery. Simultaneously, treatment providers are frequently unaware of these patterns and misread signs of difficult adjustment as resistance, lack of motivation for treatment, evidence of character pathology, or active symptoms of mental illness. As a result, providers often experience unwarranted concerns about safety and lose opportunities for early and empathic engagement.

Integrated Dual Disorders Treatment (Evidence-based practice) (Full Implementation Only)
The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for individuals with co-occurring severe mental health and SUDs by integrating substance abuse services with mental health services. It helps people address both disorders at the same time in the same service organization by the same team of treatment providers. IDDT emphasizes that individuals achieve significant changes such as sobriety, symptom management, and an increase in independent living via a series of overlapping incremental changes that occur over time. It takes an individualized approach to address the unique circumstances of each individual's life. IDDT is multidisciplinary and combines pharmacological, psychological, educational, and social interventions to address the needs of participants. It also promotes participant involvement in service delivery, stable housing as a necessary condition for recovery, and employment for those who are job-ready.[24]

[22] Osher, F., Steadman, H.J., Barr, H. (2002) A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model: Delmar, NY: The National GAINS Center.
[23] Rotter, M., McQuistion, H., Broner, N. and Steinbacker, M. Best Practices: The impact of the "Incarceration Culture" on Re-entry for Adults with Mental Illness: A Training and Group Treatment Model. *Psychiatric Services*. 2005 (56): 265-267.
[24] https://www.centerforebp.case.edu/practices/sami/iddt. Accessed 1/25/16.

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?**

King County seeks to reduce recidivism among populations with recurring incarcerations in the King County Jail. Through the application of risk/need/responsivity principles, including access to jail-based and community-based SUD and behavioral health disorder treatment, recidivism can be reduced. Research has demonstrated that integrating SUD treatment services with criminal justice has been found to reduce recidivism and to be a cost-effective way to decrease substance use and improve related outcomes and public safety.[25]

Outcomes for participants would include reduced jail bookings, reduced jail days, successful linkage to and retention in treatment post-release, reductions from pre-incarceration drug use, and housing stability for those who receive housing services.

Table 1: Proposed Data Sources

Data sources currently available	Notes	**Possible additional data sources**
Medicaid eligibility files (MCO)	DCHS available	
DAJD jail bookings	DCHS available*	Housing Authority(s)
Misdemeanor jail bookings	DCHS available*	Medicare claims
Jail Health Services diagnosis, meds	PHSKC	Emergency Medical Services data
Public mental health service data	DCHS available*	
Public substance use service data	DCHS available*	Courts
Sobering Center data	DCHS available*	Sheriff's Office
Homeless Management Information System (HMIS)	DCHS – soon	King County Medical examiner
Health Care Authority claims data –including EDs/Hospitals	PHSKC/DCHS -time lag	

*may need amendments to data sharing agreements

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**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☒ **Older Adults**
- ☐ **Families**
- ☐ **Anyone**
- ☒ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**

[25] Wexler H., Prendergast M. Therapeutic communities in United States' prisons: effectiveness and challenges. *Therapeutic Communities*. 32:157–175 (2010).

☒ **Offenders/Ex-offenders/Justice-involved** ☒ **Women**

☐ **Other – Please Specify:**

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.

King County books about 25,000 unique persons annually in the two adult jails, the King County Correctional Facility (KCCF) in Seattle and the MRJC in Kent. Given these estimates, it is anticipated that over 16,000 of those booked annually will have a SUD and 5,000 will have a major mental health disorder. If fully implemented, including post-incarceration services at CCAP, this proposal will serve approximately 600 participants per year at the MRJC and CCAP.

Individuals with substance use disorders with or without co-morbid mental illness incarcerated at a King County operated jail are the intended population of this proposal. Based on past research, approximately 30 percent of the King County Jail population receives some form of jail-based behavioral health services;[26] however, less than one percent (about 150 individuals) of incarcerated individuals with SUDs receives State-certified SUD treatment per year at the MRJC.[27]

All proposal program participants must meet the following criteria prior to placement on the therapeutic unit at the MRJC:

a. Meet established Classifications criteria approved by DAJD;
b. Are screened by Jail Health Services staff for medical and psychiatric housing needs, if requested by DAJD Classifications;
c. Are medically stable, including medication management; and
d. Meet American Society of Addiction Medicine (ASAM) Criteria[28] for outpatient or intensive outpatient SUD treatment.

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

Any eligible and appropriate individuals from throughout King County who are assessed as having a SUD via validated American Society of Addiction Medicine (ASAM) Criteria may be placed in the proposed program whether they were booked into the KCCF or the MRJC. If booked into the KCCF, such individuals may be transported and rehoused at the MRJC to receive treatment.

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.**

The proposal at the MRJC will require the key cooperation of the King County DAJD, King County Jail Health Services and the selected treatment provider, and the following governmental and non-profit agencies:

- Public Health – Seattle & King County

[26] Stanfill, M. (January 2016).
[27] Figures based on the avg. number of TRP graduates/completions per year since the program was implemented in 2005.
[28] https://en.wikipedia.org/wiki/American_Society_of_Addiction_Medicine.

- City of Seattle Municipal Court
- King County Adult Drug Diversion Court
- King County Executive's Office (incl. the Recidivism Reduction and Re-entry Policy Work Team)
- King County Prosecuting Attorney's Office
- King County Department of Public Defense
- King County District Court, including Regional Mental Health Court/Regional Veterans Court
- King County Superior Court
- King County Regional Veterans Initiative Project
- King County Veterans Program
- All Home
- WA State Department of Corrections
- WA State Department of Social and Health Services, including the Behavioral Health Administration, and the Belltown Community Service Office
- Northwest Justice Project
- WA State Department of Veterans Affairs, including Veterans Integration Services
- U.S. Department of Veterans Affairs, including Veterans Health Administration
- Municipal courts throughout King County
- Multiple community-based, non-profit behavioral health and housing providers under contract with King County DCHS/BHRD
- DAJD Community Corrections Division (full implementation only)

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?

Senate Bill 6430 (sponsored by State Senator Parlette, et. al.)—and companion House Bill 2850 (sponsored by State Representative Walkinshaw, et al)—was introduced on January 23rd during the 2016 Legislative Session for the purpose of providing continuity of care for recipients of medical assistance during periods of incarceration. Senate Bill 6430 adds a new section to Chapter 74.09 RCW[29] regarding medical care that would require that the Washington State Health Care Authority (HCA), in collaboration with the Washington State Department of Social and Health Services (DSHS), to request federal expenditure authority to provide behavioral health services in jails. The bill also would require that HCA and DSHS provide trainings on outreach, assistance, transition planning, and rehabilitation case management to people who are incarcerated or involuntarily hospitalized. The new section reads as follows:

> The authority shall collaborate with the department, the Washington state association of counties, and accountable communities of health to improve population health and reduce avoidable use of intensive services and settings by requesting expenditure authority from the federal government to provide behavioral health services to persons who are incarcerated in local jails. The authority in consultation with its partners may narrow its submission to discrete programs or regions of the state as deemed advisable to effectively demonstrate the potential to achieve savings by integrating medical assistance across community and correctional settings.[30]

[29] http://app.leg.wa.gov/rcw/default.aspx?cite=74.09.
[30] http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Senate%20Bills/6430.pdf. Accessed 01/23/16.

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?**

There may be resistance by interested parties to expand SUD treatment services in the jail versus increasing SUD treatment capacity in the community. As stated previously, however, research has demonstrated that integrating SUD treatment services with correctional settings has been found to reduce recidivism and to be a cost-effective way to decrease substance use and improve related outcomes and public safety and part of a continuum of care.[31]

Obtaining DAJD jail clearance in King County jail facilities is sometimes delayed due to long wait times and inefficient processing; this is a potential barrier for any new concept proposed and affects program capacity for existing strategies and new concepts when there is staff turnover.

Data sharing is critical for this proposal to be successful. As such, a data sharing requirement will be built into the RFP to secure treatment services at MRJC to prevent problems or barriers associated with the lack of information sharing between all parties that "need to know," which is in the best interests of the offender-patients served.

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?**

An unintended consequence of providing jail-based SUD assessments to prospective referrals from the Department of Public Defense may include such assessments serving a mitigation function only, rather than as a means of ensuring enrollment in appropriate SUD or behavioral health services and re-entry support.

A general unintended consequence may surface with a more robust SUD treatment program in the jail that may influence law enforcement and first responders' perception that incarceration is an effective means of connecting individuals in behavioral health crisis to SUD treatment and other supportive services. This ineffective practice creates more disconnection from the community and adds more experiences of trauma to the clinical picture that will need to be addressed in the treatment and re-entry plans and processes for successful transition back to the community.

Building a model that is operating in the deep end of the criminal justice system via diversion and re-entry options depends on a very costly system to provide linkage to treatment and ancillary services.

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?**

Individuals with SUDs will not receive SUD treatment services during their jail stay, which is not conducive to starting the process of recovery and re-entry support, if this proposal is not implemented. King County needs a continuum of care that includes a "no wrong door" approach so individuals can receive the care they need in a timely and ongoing manner. If individuals are not allowed opportunities to change when they are most ready (after a negative consequence of their use), it is an opportunity that cannot be recaptured. High rates of post-release relapse and recidivism will likely continue to occur.

[31] Ibid, Wexler & Prendergast. (2010).

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?**

It will be important for this proposal to have close alignment with other MIDD II strategies, should they be funded, including the following:

- ES Seattle MHC 11b BP 118, 133, 136 Competency Continuum of Care;
- BP 37, 51, 64, 66 South County Crisis Center;
- BP 20 Implementing Actuarial Risk and Needs Assessment in King County Jails;
- BP 34 39 72 74 Outreach System of Care; and
- BP 44 Familiar Faces Cultural Care Management Teams.

The proposal will support the work of all of these strategies, many of which are on the front end and provide more diversion opportunities. Others, such as *Implementing Actuarial Risk and Needs Assessment in King County Jails* (BP 20, Murphy) provide an assessment framework for services outlined in this proposal and will inform and complement services outlined in this briefing paper.

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?**

This proposal provides treatment for individuals whose substance abuse has led them to troubles with the criminal justice system. It provides intervention in the deep end of the system. The proposal fits within the continuum of care and the following initiatives in King County:

- Health and Human Services Transformation Initiative, Physical-Behavioral Health Integration;[32]
- King County Veterans and Human Services Levy's Service Improvement Plan;[33]
- *Improving Programs and Services for Incarcerated Veterans* Motion Report to County Council;[34]
- 1115 Global Medicaid Waiver, options for Demonstration Programs.[35]

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

Administering jail-based SUD and behavioral health treatment, with evidence-based practices for individual with SUDs and co-occurring mental health disorders, in a therapeutic community model is rooted in all the principles of recovery and resiliency. Trauma informed care via the Seeking Safety curriculum is a vital aspect of this approach.

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

[32] http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx.
[33] http://www.kingcounty.gov/operations/DCHS/Services/Levy/ServiceImprovementPlan.aspx.
[34] http://www.kingcounty.gov/council/news/2015/February/vetsreport.aspx.
[35] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

This proposal, which encompasses the risk/need/responsivity principles, has a close connection to the King County Equity and Social Justice Initiative by serving incarcerated individuals who are overrepresented by persons of color, with a focus on on-going services in the community, in order to impact recidivism rates in King County. Following is a table comparing King County Jail bookings with the King County census by race, which shows that people of color are overrepresented in the jail, particularly Blacks/African Americans.

Table 2: Racial disproportionality of King County Jail bookings

RACE	JAIL BOOKINGS[36]		KING COUNTY CENSUS[37]	
	N	Percent	N	Percent
White	21,804	62.8%	1,325,845	70.1%
Black/African American	9,657	27.8%	119,801	6.7%
Asian/Pacific Islander	2,094	6.0%	298,119	8.9%
Native Amer./Alaska Nat.	934	2.7%	18,076	1.9%
Other/Mixed Race	235	0.7%	355,485	12.4%
TOTAL	34,724	100.0%	2,079,967	100.0%

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.)**?**

Physical office space inside the MRJC (including computer, internet access, phone and fax) will be necessary for several program staff. One office will be required at the Community Corrections Division administrative offices to for the care coordinator position (full implementation only).

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

- **Partial Implementation** Scenario = $ 600,000 (serving 250 individuals per year)
  - Includes a 1.0 FTE master's level care coordinator within King County Jail Health Services
- **Full Implementation** Scenario = $1,250,000 (serving 600 individuals per year)
  - Includes a 1.0 FTE master's level care coordinator within King County Jail Health Services
  - Includes a 0.5 FTE master's level care coordinator within King County Community Corrections

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

Limited CJTA funds are currently available from the State of Washington, which pay for in-custody SUD treatment services primarily for Drug Court participants. This fund source is earmarked for Drug Court in King County and insufficient to pay for an expanded population of offender-patients with SUD treatment needs during their incarceration.

Senate Bill 6430 adds a new section to Chapter 74.09 RCW regarding medical care that would require that the HCA, in collaboration with the DSHS, request federal expenditure authority to provide behavioral health services in jails.

4. **TIME to implementation: 6 months to a year from award**
   a. **What are the factors in the time to implementation assessment?**

[36] http://www.kingcounty.gov/~/media/courts/detention/documents/KC_DAR_Monthly_Breakouts_CY2014.ashx?la=en.
[37] 2014 King County Census Estimate: http://quickfacts.census.gov/qfd/states/53/53033.html. Accessed 1/7/16.

Expansion and new services would require a RFP and hiring processes. Data sharing agreements would need to developed and executied, particularly between the selected provider and King County Jail Health Services.

b. What are the steps needed for implementation?

Upon selection of the treatment provider, a contract will need to be negotiated, developed and executed. Provider staff will need to apply for jail clearance and may not work full-time at the MRJC until jail clearance is approved and the appropriate jail identification is issued.

c. Does this need an RFP? Yes.

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?

This proposal links directly or indirectly to other MIDD II strategies including the following:

- ES Seattle MHC 11b BP 118, 133, 136 Competency Continuum of Care;
- BP 37, 51, 64, 66 South County Crisis Center;
- BP 20 Implementing Actuarial Risk and Needs Assessment in King County Jails;
- BP 34 39 72 74 Outreach System of Care; and
- BP 44 Familiar Faces Cultural Care Management Teams.

22

Working Title of Concept: Expanding Substance Abuse Treatment through Establishing a Modified Variable Length of Stay Therapeutic Treatment Unit in the Regional Justice Center

Name of Person Submitting Concept: William Hayes
Organization(s), if any: DAJD, Jail Health, Prosecuting Attorney's Office, PSB, Department of Public Defense, King County Drug Court
Phone: 206 477 2801
Email: William.hayes@kingcounty.gov
Mailing Address: Mailing Address Here

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.

While not a primary predictor of criminality, untreated substance use disorders when combined with antisocial behavioral patterns and criminal thinking are principally responsible for the alarming rate of return to incarceration of over 60% within 30 days of release. For many persons involved in the criminal justice system, preventing future crime and re-arrest after discharge is impossible without the benefit of addiction treatment. King County has not prioritized addiction treatment in its jails despite clear benefits to offenders, their families, and communities and the fact that jail alone has no effect on the reduction of drug addiction or in promoting recovery. Treatment consistently has been shown to reduce the costs

associated with lost productivity, crime, and incarceration caused by drug use. Holding someone in jail, without access to alcohol and other drug addiction treatment, with no specific plans for intervention and recovery support upon discharge, is not only ineffective, it's expensive and it's time for a change.

Treatment offers the best alternative for interrupting the drug use/criminal justice cycle for offenders with substance use disorders. Our jail should be a place where people can get the help they need to return to their communities with reason for hope. Untreated substance using offenders are more likely to relapse into drug use and criminal behavior, jeopardizing public health and safety and taxing criminal justice system resources. Scientific research shows that treatment that specifically employs fidelity adherent evidence based practices for the criminal justice involved population such as cognitive behavioral therapy, trauma informed practices, contingency management and role play, can and does help many drug using offenders change their criminal attitudes, beliefs, and behaviors; avoid relapse; and successfully remove themselves from a life of substance use and crime. Treatment for the jail population can cut drug use in half, decrease criminal activity, and reduce arrests. Even those who are not initially motivated to change can become engaged in a continuing treatment process. In fact, research suggests that mandated treatment can be just as effective as voluntary admission to treatment.

It is estimated that 68% of the jail population is likely to have a substance use disorder yet only those involved in the Transitional Recovery Program (TRP) for Drug Court have access to addiction treatment. This proposal seeks to address a portion of the unmet addiction treatment needs of offenders in the Regional Justice Center and secondarily to provide the outpatient treatment program, TRP, at a significantly reduced rate by combining resources and using a cost reimbursement rather than a fee for service billing methodology. The proposed change in reimbursement methods could allow the Drug Court to utilize the Criminal Justice Treatment Panel Account that funds TRP to be used for other drug court related needs.

Proposal Implementation: Through an RFP process, a contract provider with demonstrated skill and expertise in employing fidelity adherent evidence based practices in treating the confined CJ population and also has documented experience to train corrections and treatment staff in the implementation of a modified therapeutic community will be contracted to provide a continuum of services including screening, assessment, a variable length of outpatient substance abuse disorder /criminal thinking interventions in the Regional Justice Center. Consistent with evidence based practice participants will be admitted to a designated therapeutic unit and receive services with the expectation that they will be released directly to the community and not returned to general population upon completion of their treatment. The proposal implementation will provide a modified therapeutic community in the L unit where the TRP program is housed. 40 beds will be devoted to the TC model and the remaining 24 beds (expected to be reduced from 30 beds due to anticipated state reductions in the CJTA account) will continue to be served in the TRP program.

The partial implementation scenario; assumes the treatment of the TRP participants under the same provider as the proposal proposal and will assure TRP participants will be included in the therapeutic community milieu and their treatment experience enhanced through participation in this 24-7 therapeutic environment.
Additionally the partial implementation concept will extend outpatient treatment to veterans livening in other units as well as providing gender specific, trauma informed care to women at the RJC.

The full implementation concept will further provide for a coordinated handoff for continued outpatient and other re-entry services with the King County Community Corrections Division for most participants upon release

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.

The rate of return to criminal activity associated with untreated substance use disorder is staggering. King County seeks to reduce recidivism among its criminal justice population particularly those incarcerated in the King County Jail. Through the application of evidence based risk/need/responsivity principles including access to fidelity adherent jail and community based addiction treatment, recidivism can be reduced among the criminal justice involved population. With the exception of the TRP for Drug Court clients, other addicted offenders are not able to access treatment during the term of their confinement in King County jails. This concept seeks to increase access to substance use disorder treatment in the Kent Regional Justice Center beyond those served by TRP and simultaneously reduce the cost per person served in the TRP Drug Court program by as much as 50% per client.

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

This concept seeks to greatly expand addiction treatment capacity for incarcerated persons in King County Jail. This concept will enhance treatment integrity and content for the existing TRP Drug Court program through the application of a modified therapeutic community approach throughout L unit. Further, this concept will expand treatment services to addicted veterans and others residing in other units. Moreover, this concept will provide gender specific addiction treatment to females in P unit. The modified therapeutic community is the most researched and evidence based intervention for addicted, incarcerated persons and a modality that has long been desired at the King County Jail.

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

This concept will benefit unserved, untreated addicted veterans, woman and others who are serving between 31 and 180 days in the Kent Regional Justice Center and Drug Court TRP participants. It is estimated that when fully implemented no fewer than 550 persons will be served per year with various interventions based on assessed need and length of stay. Further, upon referral to the Community Corrections Division (CCD) at release, participants will benefit from the interventions of a CCD Care Coordinator tasked with matching clients to appropriate services.

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.

King County will collect important data on clients that will serve to inform classification, housing, treatment, pre-release planning and community services for participants and other offenders housed in the jail. Cost savings will be realized in the partial implementation model due to changing the funding source for TRP to MIDD allowing for a cost reimbursement model rather than the more expensive fee for service model required by CJTA funds. This will allow King County Drug Court to redirect CJTA funds to other services. Jail staff will benefit from specific training that will help them to better support rehabilitation efforts among the participants. Proposed measures will include but are not limited to # of participants who receive a diagnostic substance disorder assessment, # of participants receiving confinement based treatment and other interventions, # of participants receiving a community re-entry plan and referral based on criminogenic risk and needs, pre and post treatment measures of criminal sentiments, thinking and other CJ related indicators, # of persons transitioned to appropriate community based treatment and other services

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 Re-entry:** 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?

By providing increased access to treatment services and appropriately matching participants to community care based on risk and need principles it is expected that criminal justice involved addicted persons will have an increased opportunity to gain and retain sobriety while achieving stabilization upon return to the community.

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.

Jail and Community Corrections Administration, Corrections Officers and other staff, Drug Court staff, contract staff, Jail Health, the Prosecuting Attorney's Office, the Office of Public Defense, Courts, Community Providers and the County Executive's Office are all partners currently working together in this endeavor as members of the Recidivism Reduction and Re-entry Policy Work Team. They will continue to be vital partners in the successes of this proposed concept.

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?

Proposal/Small-Scale Implementation: $ 400,000 per year, serving 200 people per year
Partial Implementation: $ 664,000 per year, serving 380 people per year
Full Implementation: $ 1,000,000 per year, serving 592 people per year

#81

Working Title of Concept: Jail-based Chemical Dependency Treatment

Name of Person Submitting Concept: Mike Stanfill, PhD
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1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Persons are often arrested and incarcerated for behaviors either directly or indirectly related to substance abuse. While resources are put to initial detoxification, currently there are limited resources for chemical dependency treatment while a patient is in jail outside of drug court programming that is limited to certain case mitigation. While in jail, the nature of the controlled setting and limited "competing demands" offer a great opportunity to initiate evidenced-based chemical dependency treatment once a patient is in a sustained period of sobriety. This work can then be transferred to a community agency for on-going care and aftercare once released. The Addictions Provider (physician level) would oversee the program, address relevant medication options, and work with the CD counselors in developing individual treatment plans.
This concept is an important component of the system transformation that is trying to be accomplished through the Familiar Faces initiative.

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.

By some estimates, upwards of 60-80% of those entering the criminal justice system will have some form of substance use related issue. Furthermore, at times, substance use is directly related to the criminal behavior in question. As a result, our largest community "solution" to managing substance abuse is through crime and punishment and the criminal justice system. This is despite the fact that these systems are often ill equipped to manage these issues and there is no evidence that a punishment-driven methodology actually reduces long-term use.

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

By introducing more evidence-based chemical dependency treatment while persons are incarcerated, this offers an opportunity to (a) introduce a intervention modality other than punishment, (b) work with people in a controlled setting, and (c) stabilize a population and initiate treatment to help then transition to community providers once released.

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

First and foremost, persons with substance use issues would benefit primarily. Additionally, by initially stabilizing the population, community providers would then benefit in not needing to reinitiate services and instead simply continue services. The criminal justice system, including the county jails, would likely see a decrease in utilization; which is cost-effective to the County as a whole.

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.

Decrease in substance utilization using established research protocols for harm reduction research.
Decrease in high-cost service utilization (e.g. jails, EDs, etc.) with increased utilization of preventative care.

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 Re-entry:** 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?

County jails are one of the largest community mental health providers with approximately 30% of the population suffering from some form of mental illness and by some estimates upwards of 70-80% of the population experiencing problems with substance use. By the nature of the setting, involvement with the criminal justice system and current incarceration is connected to current limitations in functioning. Project involvement with county jails therefore by design impact and hopefully improve community health, social and justice outcomes.

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 providers (medical, psychiatric, substance abuse, etc.) and housing partners willing to work with criminal justice involved populations without reservation. Since the positions would base out of the jail, and work within Jail Health Services, integration to the criminal justice system would also be key.

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?

Proposal/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: **$ 954,612 per year, serving estimated 1,000 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*.